

Testimony of
Consumer Directed Action of New York to:
Joint Legislative Budget Hearing

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Good evening, Chairs Krueger, Weinstein, Paulin, Rivera, and other members of the committees. On behalf of the over 150,000 older and disabled New Yorkers who rely on Medicaid's consumer directed personal assistance (CDPA) program for their personal care services, and the agencies that administer their services, I want to thank you for the opportunity to present testimony to you today. My name is Bryan O'Malley, and I am executive director of Consumer Directed Action of New York (CDANY), a new sister organization to Consumer Directed Personal Assistance Association of NYS (CDPAANYS).

Over the course of the pandemic, New York learned the value of providing long-term care services in the community. People receiving care in their homes were more protected from the spread of the virus than those in institutional settings. Home care workers, including personal assistants (PAs) in CDPA, went above and beyond to make sure that those they were providing services to were safe, both from the virus and through continuity of care.

As a result, the Legislature and the Governor saw fit to acknowledge that this work was critical, and not a minimum wage job. The 2023 budget provided a down payment on Fair Pay for Home Care, raising wages to \$18/hr over the course of two years and, more importantly, indexing home care wages to the minimum wage so that they would remain higher - forever.

This was a critical investment in community-based long-term care. It was deserved and necessary. Unfortunately, this year's proposed Executive budget cannot be viewed as favorably. This budget would make the workforce crisis preventing people from accessing CDPA worse through a series of actions that would cause dramatic disruptions in continuity of care, return home care to a minimum wage job across the board, and impose even deeper wage cuts of up to \$4/hr. in CDPA. This workforce crisis unfortunately will compromise the Governor's ability to implement excellent proposals like the Medicaid Buy-In for Working People with Disabilities (MBI) expansion because it will not actually result in ensuring that those newly eligible will be able to receive services for which they qualify.

Medicaid Buy-In for Working People with Disabilities

We applaud the Governor's proposal to increase eligibility for the Medicaid Buy-In for Working People with Disabilities (MBI or Buy-In). This move, which emerged from her Office of the Chief Disability Officer, would go a long way towards allowing more people with disabilities to join the workforce.

Because typical commercial insurance products do not include long-term care services, the MBI allows people to work and earn an income while still maintaining access to the Medicaid long-term care services that allow them to do so and live in the community. Importantly, many people who use the MBI actually rely primarily on CDPA; if they need services during their working hours, traditional personal care models will not provide for it.

Today, the MBI is extremely limited. Income is capped at less than \$69,000, a limit that has resulted in many people who use the program being forced to earn less than those they supervise. Assets are capped at \$28,133. While a house, a vehicle, and certain retirement accounts are exempt, this asset limit prevents people from accruing wealth of any kind, or even any type of savings for potential emergencies. Those who seek to use it are faced with a marriage penalty, as their spouses income and assets will disqualify them from eligibility, forcing them to go without both work and marriage in many instances.

The Governor's changes will fundamentally shift this. People will qualify for the program up until earning almost \$600,000/year. The asset limit will shift to almost \$300,000/year, still exempting a home, a vehicle, and many retirement accounts and settlements. Further, only the disabled individuals income and assets will be counted, as the Governor proposed to eliminate the spousal penalty.

In all, New York will join Massachusetts, Colorado, Texas and ten other states in opening the MBI to a broad population, and it is a testament to the value of the Office of the Chief Disability Officer that this is occurring.

Unfortunately, while the Governor is proposing to expand benefits, the rest of her budget will make it nearly impossible to actually use the newly expanded benefit.

Repealing the Request for Offers for Fiscal Intermediaries will create chaos and cause harm

The Governor proposes to eliminate the request for offers process from CDPA that has been carefully negotiated over the course of the past four years. After spending up to \$500,000 in order to submit applications, upgrade systems, and jump through the numerous hurdles that the Department has created, the Governor would undo the entire process and revert to language mirroring what was originally proposed by former Governor Cuomo, and rejected by the Legislature, giving the Commissioner of Health sole authority, through emergency regulations, to determine how many and which fiscal intermediaries (FIs) are allowed to continue operation.

Worse, this process would occur over a period of eight months, as the budget calls for a "cease operation" date for FIs that are not selected on January 1, 2024.

All of these changes are proposed in spite of the fact that the Department could move forward tomorrow with issuance of contracts. They have completed the survey of non-selected FIs that was agreed to in last year's budget and there was a contract award date that had been set for January 15, 2023. Awardees were notified two days before this date that contracts would now be issued on April 1, 2023. A mere two and a half weeks later we learned that it was a ploy to undo the entire process.

By adopting the Governor's proposal and moving forward in this way, the Department of Health would not only undermine a carefully negotiated process, they would throw the entire system of CDPA into chaos. Approximately 150,000 people rely on this program to receive services that

keep them alive. A move like this, with as many moving pieces as it would have over such a short period of time, would invariably lead to breaks in continuity of care for well over a hundred thousand people.

With no fiscal attached, the Legislature should protect the safety and services of those who rely on CDPA for critically needed services that allow them to live high-quality, independent lives in the community by keeping the negotiated RFO in place and rejecting the Governor's return to an arbitrary and opaque process controlled solely by the DOH.

Repealing wage parity for CDPA makes PAs "second class" home care workers

The Governor also proposes to do away with wage parity for personal assistants (PAs) working in CDPA, replacing it with subsidies to purchase health insurance on the exchange. This is a deeply flawed proposal that will result in a wage cut of up to \$4/ hour to PAs across New York City, Long Island, and Westchester while also returning to an era where unscrupulous actors use CDPA as scofflaw home care so that they can avoid wage parity costs in the traditional LHCSA based model.

CDPA was not originally included in wage parity but was added in 2015. This addition was made because LHCSAs across New York City were incentivized to transfer personal care cases to CDPA. These cases would not be consumer-directed though. The agency would continue to send the same workers to consumers on a schedule determined by the agency. The difference was that the workers would not receive the extra wages or benefits required by wage parity, and in many instances would no longer be a part of the union agreement they had in place on their LHCSA side.

This behavior stopped when CDPA was added to wage parity.

The Governor has proposed this policy change because she believes only fiscal intermediaries pay wage parity in wages, and that wage parity was never meant to provide anything except benefits. This is factually incorrect. Many licensed agencies also pay wage parity in wages, or a combination of wages and benefits. Many offer benefits or a wage, only to have the strong majority of workers choose higher wages with no, or few, benefits.

They do this because many home care workers are not interested in employer sponsored health insurance. According to [PHI](#), while over 90% of home care workers have health insurance, almost two-thirds of them receive that insurance from Medicaid (49%) or through subsidies on the exchange (12%). This means her proposal to subsidize health insurance on the exchange in lieu of wage parity is hollow, as home care workers are not uninsured, and are already receiving the benefits she proposes to offer - or more through Medicaid.

Consumers across the state already cannot recruit and retain enough staff to provide services for authorized hours. Many FIs report that upwards of 30% of consumers for whom they receive an authorization never actually begin services, as they cannot hire workers. Adding in a 20%

wage cut will only make this worse, jeopardizing the lives of over a hundred thousand individuals across the city and plunging these essential workers into even greater financial peril than they already find themselves.

PAs in CDPA are not second class home care workers. They perform critical services, including many nursing tasks traditional PCAs are not allowed to perform. This proposal should be rejected.

Repealing the home care minimum wage and passing Fair Pay for Home Care

The cuts to CDPA merely throw fuel on the fire of a larger home care workforce crisis. This crisis, which Mercer consulting has identified as the worst in the nation, is not only negatively impacting CDPA and traditional personal care. It is greatly exacerbating the staffing shortages across health care sectors, as we routinely hear from hospitals and nursing homes that their inability to discharge people due to the lack of home care workers is preventing them from accepting new patients and driving the use of trailers and other make-shift “solutions” to accommodate the overcrowding.

Wage parity is a patch for the home care crisis in the downstate region, but it is not a solution. We know from [surveys](#) of consumers and workers that, ultimately, the bottom line wage is most important to most home care workers. The way to improve that is maintaining the wage increase commitment from last year’s budget while making sure that the funds the state invests in wages are not merely windfall profits for insurance companies while providers who have to pay the workers try to figure out how they will meet payroll on a week to week basis.

The Governor’s budget would go back on the promise she made to home care workers ten months ago - a promise that home care is not a minimum wage job. Her proposal to index the minimum wage to inflation starts an important conversation, but it caps home care wages at \$18/hour until her minimum wage can catch up. At that time, home care will again become a minimum wage job, rising at the same rate as the minimum wage itself, and undoing any progress that was made through last year’s investment.

This is why Fair Pay for Home Care remains necessary. Last year’s budget invested significant funds into home care worker wage increases. But It was only a downpayment. We must finish the work and ensure that the wage increases do not create a benefits cliff, where the increase is not enough to offset the value of public benefits that are lost.

We also must ensure that the funds the state makes available actually make it to the agencies so that they can afford to pay the workers. Fair Pay for Home Care not only creates a system that values home care through the wages that are paid, it creates accountability, so that we know the funds the Legislature appropriates to pay home care workers these increases are actually going through the entire system to the workers and are not stolen by insurance companies to help fuel stock prices while agencies struggle to meet their obligations.

When fringe costs are factored in, the \$2.00/hour wage increase for home care workers cost fiscal intermediaries and other agencies approximately \$2.66. The Legislature recognized this, and almost \$1 billion was included in the budget to pay for this wage mandate. However, after the money went to the insurance companies, the average hourly rate increase to FIs and other agencies was \$1.85, not even enough to offset the wage increase itself. This left providers at an \$0.81/hour loss.

In a survey of CDPAANYS, NYAIL, and HCP members, all have reported that their contracted reimbursement rates since October 2022 have either not improved, or improved slightly but are not sufficient to pay the wage and benefit mix. This has meant that nearly one-third of these these are tapping into lines of credit or expanding existing lines to cover the wage increase. This is not sustainable, and without remedy these FIs, that thousands of consumers rely on, will be forced to cease operations.

The almost \$1 billion included in last year's budget for worker wage raises was intended for workers, not insurance company executives and shareholders. Without the oversight and accountability set forth by Fair Pay for Home Care, this behavior by the insurance companies will continue. Some of these companies made record-breaking profits during the pandemic while FIs and workers struggled to keep the lights on and support their families. Worker wage increases should not provide another windfall for plans and we do not believe this was the intent of the legislature.

The arguments for Fair Pay for Home Care have been made time and again, and we have a number of excellent champions in the Legislature who are committed to making sure the hard work and dedication of home care workers is recognized. We now just need to finish the job.

Ensuring accurate data about CDPA exists in public

While home care, including CDPA, accounts for the majority of Medicaid spending, the data that is readily available to the public is more limited and less transparent than that of any other sector. Efforts to determine basic information, such as how many people use CDPA or personal care, or how many hours were billed last year, are only obtainable through a FOIL request.

The state collects information from every insurance company, every LHCSA, and every Fiscal Intermediary about their costs, services usage, and more. However, this information is not turned around in any way so that it is easily searchable by the public. This prevents consumers from knowing critical information about both managed care companies and agencies.

A.1926 (Gonzales-Rojas)/S.1683 (Hinchey) would rectify this problem, requiring the Department of Health to make public, in a searchable format, information about personal care usage, including CDPA, across all plans. The information would allow consumers to know how many hours different plans tend to authorize, how many people statewide are using the service, and much more vital information.

Making such data available will allow the public to track the state of the industry. Researchers will have easy access to the most current information so that they can easily identify trends in the sector, as well as identify weak points. We will also be able to much more easily identify bad actors, both among agencies and insurance companies, to ensure the highest levels of transparency and accountability in the use of public funds.

The fundamental access to information is crucial for the home care system to thrive and empowers those who need these services to make informed decisions. We encourage inclusion of the Gonzalez-Rojas/Hinchey bill language in the budget.

The Independent Assessor is causing significant harm and must be eliminated

As part of the MRT 2 process, the state shifted responsibility for assessments away from the managed care plans and to Maximus, in the form of an independent assessment. While CDANY agrees that managed care plans have a significant conflict of interest, Maximus lacks both the expertise and the capacity to perform this indispensable task.

As the state has moved this role to Maximus the authorization process has ground to a halt. While there are timelines for the completion of tasks in almost every part of the process, they are notably absent when it comes to the performance of the independent assessment. Medicaid applications must be forwarded to the Independent Assessor within seven days. The plan or social services district must authorize services within seven days of receiving the assessment from Maximus. It is only Maximus, as the Independent Assessor, that has no time frame within which to perform their job.

This has resulted in a process where those seeking services are waiting two, sometimes three, months for an appointment. Even those seeking Immediate Need Personal Care or Immediate Need CDPA are forced to wait weeks or months for an appointment - undermining the entire premise of the definition of the words immediate need.

Even though managed care is not the long-term solution to this issue, that system at least allowed people to receive the assessment they needed in a timely fashion. As the public health emergency ends, more and more of this process will fall to Maximus, including redundant and discriminatory "safety assessments" for those most in need of services who receive over 12 hours per day, and those renewing their authorizations on an annual basis. With the waits we are currently seeing, the provision of home care in New York will cease. People will go without services. They will be institutionalized. They will die.

Unless this was the intent, Maximus must have this life and death task taken away from them. At the very least, they must have clear timelines within which to work, with recourse for Medicaid recipients if they do not meet their deadlines.

CDANY stands ready to work with the Legislature and the Executive to determine a long-term solution.

Restore the eligibility cuts to personal care

On top of the devastating changes to the assessment process and the unnecessary and redundant high needs assessment for those receiving over 12 hours of services per day, the MRT 2 also changed eligibility rules. Individuals will now require physical assistance with at least three activities of daily living (ADLs), such as toileting, showering, or eating. If the individual has Alzheimer's Disease or dementia, they would only require physical assistance with two or more ADLs.

When combined with the high needs assessment, this makes New York's home care system a Goldilocks program. Many will be excluded because they are deemed "not disabled enough". Many others will be excluded and forced into institutions because they are deemed "too disabled." It is only those who are "just disabled enough" who will be allowed by the state to receive services.

The ADL limitation is not only discriminatory, it is the definition of "penny-wise and pound foolish." A report by The Medicaid Institute, which is dated but remains accurate, demonstrated that those who receive personal care services tend to stop using acute care facilities and hospitals at a level almost equal to the cost of their personal care. The same report found that the provision of personal care resulted in a stabilization that meant folks received the same number of hours for years.

By denying a small number of hours up front, New York is not avoiding costs, they are amplifying them. Individuals with a need for assistance with one ADL will very quickly need assistance with three or more due to the inability to receive services to aid with that one. Unfortunately for New York, by the time they qualify, instead of needing eight hours a week, they will require 38, further straining Medicaid resources.

In a state that prides itself on equity and protecting Constitutional rights to access health care services and being a nationwide example in how to provide services for both the older and disabled populations this is just not acceptable.

Thank you for the ability to provide testimony to you. I am available throughout the budget process to answer any questions.