Written Testimony from Dan Savitt, President and CEO, VNS Health
Joint Legislative Budget Hearing on Health and Medicaid
SFY 2027 Executive Budget

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Chairpersons and Members of the Legislature, thank you for the opportunity to submit written testimony on the SFY 2027 Health and Medicaid Budget. VNS Health appreciates the Legislature's continued focus on strengthening home- and community-based care and on ensuring that Medicaid resources are used responsibly to support New Yorkers with the greatest needs. This testimony is grounded in a simple principle that runs through all of VNS Health's work: **equity for New Yorkers with the greatest care needs requires care models and reimbursement structures that reflect the real cost of keeping people safely at home.**

Recent reforms to Managed Long Term Care (MLTC) and the Consumer Directed Personal Assistance Program (CDPAP) have produced unanticipated impacts that now require urgent attention. Without timely legislative action in the SFY 2027 budget, these impacts will continue to compound, placing access to high-acuity, high quality home-based care, including from VNS Health, at urgent risk.

Put plainly: **the current rate structure cannot sustain high-acuity managed long-term care.** Without targeted correction in this budget, plans that serve the most medically complex New Yorkers will be forced to reduce capacity or exit entirely, not because care is unnecessary or inefficient, but because rates no longer reflect the cost of delivering it.

VNS Health: More than 130 Years of High-Quality Home-Based Care in Partnership with New York State

VNS Health is a nonprofit home- and community-based care organization with more than 130 years of experience helping New Yorkers receive care where they want to be: in their homes and communities. We combine managed care with hands-on clinical care, including home-visiting nurses and rehabilitation therapists, behavioral health mobile crisis teams, and specialized disability support.

We operate the **State's highest-acuity 5-star MLTC plan** and the **only 5-star integrated care health plan** that serves people who need long-term care services. We are also the highest quality MLTC statewide (54 counties) and care for the largest number of people with significant physical disabilities.

VNS Health also operates the State's largest nonprofit Certified Home Health Agency (CHHA) and Hospice, as well as a licensed home care services agency (LHCSA) that employs nearly 6,500 1199SEIU-unionized home health aides. Through this integrated model, we deliver high-quality care to New Yorkers with the **most complex medical, behavioral health, and functional needs**, helping them remain safely at home and avoid more expensive hospital or nursing facility care.

VNS Health has consistently partnered with New York State to stabilize long-term care for people with the greatest needs. When New York's long-term care system has faced disruption, VNS Health has consistently stepped in to preserve continuity of care for the State's most vulnerable residents—from **stabilizing thousands of people with** severe **disabilities after an MLTC plan closure in 2019 (ICS)**, to maintaining care for rural communities during MLTC

market exits, to protecting high-need CDPAP members and caregivers during the transition to a single statewide fiscal intermediary.

Today, VNS Health cares for more than **95,000 New Yorkers each day** and over 150,000 annually. For the people we serve, care at home means stability—sleeping in their own bed, staying close to family and community, and maintaining control over daily life.

Why Current Rate Policies Disproportionately Harm High-Acuity Care

Today, due to rate setting actions related to the transition to the CDPAP SFI, these high quality services and the New Yorkers we serve are at significant risk. Current MLTC rate-setting and risk-adjustment policies **do not reflect the real cost of caring for high-acuity populations.** Plans that serve members with the most complex needs are systematically disadvantaged, while incentives continue to favor enrollment growth among lower-acuity populations.

1. **The Statewide Fiscal Intermediary (SFI) carve-out was applied without regard to actual CDPAP utilization.** As part of the transition to the SFI, the State reduced MLTC capitation rates to fund the intermediary's administrative costs. This reduction—often referred to as an administrative "carve-out". Plans with very different service mixes were subject to the same reduction. This meant that plans with 30% of their members receiving CDPAP had the same amount of funds carved out for the SFI as a plan with 70% CDPAP.
2. **The inequity was compounded by how the SFI administrative carve-out was applied.** High-acuity plans receive higher premiums because their members have greater care needs, while lower-acuity plans receive lower premiums. By applying the carve-out before risk adjustment, the State reduced funding more heavily for high-acuity plans and less for lower-acuity plans—effectively requiring plans serving the sickest members to pay a carve-out *premium*, while plans serving lower-need members received a relative *discount*.
3. **The impact is reinforced by the State's risk adjustment model that doesn't reflect the cost of caring for people with the most complex needs.** The State and its actuary have acknowledged that the risk adjustment model assigns too much funding to lower-need members and too little to higher-need members. This not only reduces resources for plans serving medically complex populations, but it also creates incentives for plans to focus growth on lower-acuity members.
4. **These issues were magnified when utilization shifted rapidly from CDPAP to significantly higher-cost LHCSAs.** During 2025, utilization across the MLTC program has shifted from about 60% CDPAP/40% LHCSA to about 66% LHCSA/34% CDPAP. MLTC rates were not adjusted to reflect this change. Plans whose members require more care absorbed the largest cost increases.
5. **Finally, higher-than-expected SFI costs fell disproportionately on high-acuity plans.** The costs required to operate the SFI were higher than initially assumed, including mandated payments to PPL to increase wages higher than the home care minimum wage (and higher than LHCSAs typically pay home health aides) Because high-acuity plans serve members with more hours and greater reliance on CDPAP, these higher-than-expected PPL costs translated into larger unfunded expenses for plans serving the most complex populations, without corresponding increases in capitation rates.

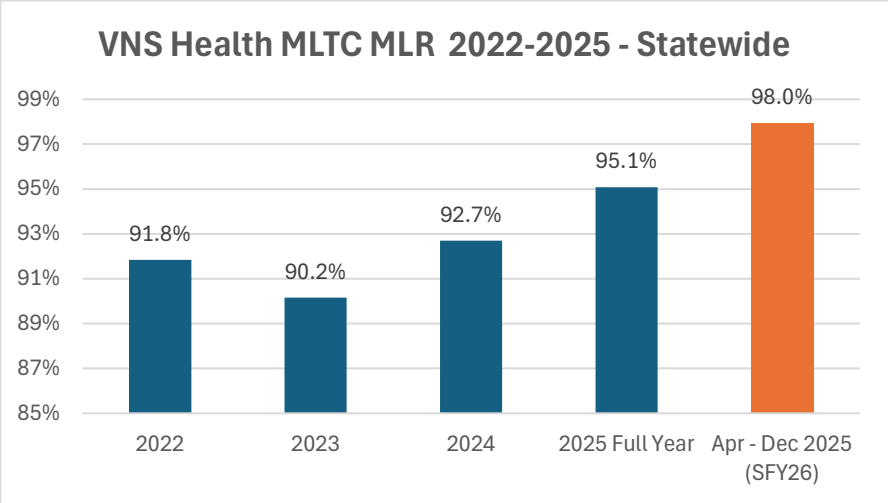
Across the country, recent reporting has highlighted how some **managed care plans are exiting hard-to-serve communities,** avoiding **higher-need members**, or pursuing other growth strategies that prioritize volume over care complexity to maintain profitability. This is leaving states scrambling to protect access and continuity, and New York is not immune to these pressures.

MLTC rate and risk-adjustment incentives continue to actively reward enrollment strategies that prioritize lower-acuity members over higher need members. In the past, these incentives, combined with the proliferation of hundreds of fiscal intermediaries, helped fuel rapid growth in low-acuity CDPAP utilization. While low acuity CDPAP enrollment growth stabilized last year, those incentives, left unaddressed, are likely to shift low-acuity enrollment growth to LHCSA services. This behavior is not accidental; it is the rational response to a rate structure that continues to reward volume and lower acuity enrollment while undervaluing complex care.

How Rate-Setting Factors have Directly and Disproportionately Impacted the Financial Sustainability of VNS Health's MLTC

The State assesses whether MLTC rates reflect the true cost of care through the Medical Loss Ratio (MLR), which measures how much of a plan's funding is spent directly on member care and quality. The State's minimum MLR is 89%, meaning at least 89% of plans funding must be spent on direct care and quality. (By contrast, Obamacare and Medicare Advantage have 85% minimum MLRs.)

Because VNS Health's MLTC absorbed a disproportionate share of the rate impacts detailed above, its MLTC MLR jumped **from 90.2% to 98%** in less than two years. This has resulted in an **$80M annual shortfall**, which will increase its **MLR to 100%** next year based on increased PPL costs and continued rate inequities. This has a direct impact on our ability to support the home care and other providers who are essential to our high-quality care. (*See chart.)*



No MLTC can sustainably operate with a 98% or higher MLR. Absent timely corrective action, VNS Health's MLTC is at serious risk. Our members rely on intensive care coordination and include people with severe disabilities, complex conditions, and individuals living across 55 NYS counties with few alternatives to care. Disruption at this scale would lead to care gaps, loss of trusted providers, and avoidable hospitalizations and institutional placements for thousands of New Yorkers.

Budget and rate-setting decisions directly impact whether New Yorkers with the greatest medical and care needs can remain in their homes or are pushed into institutional settings

because stable home-based care is no longer viable. For families and caregivers, these decisions translate directly into disruption, uncertainty, and impossible choices.

One example from VNS Health's MLTC illustrates what is at stake:

A VNS Health MLTC member living upstate has advanced neuromuscular disease, requires extensive daily assistance, and depends on a long-standing caregiver relationship to remain safely at home. The caregiver understands subtle changes in breathing, mobility, and skin integrity that signal when intervention is needed. During recent system transitions, VNS Health's care management team worked intensively to preserve this arrangement—coordinating services, supporting the caregiver, and preventing gaps in care that would almost certainly have led to hospitalization or nursing facility placement.

For members like this, continuity is not a convenience; it is the difference between living at home and losing independence.

Risk to VNS Health's Integrated Home and Community-Based Services

Decisions affecting VNS Health's MLTC plan will also ripple across our other services. Without timely fixes to reimbursement rates, **VNS Health's ability to sustain the full range of care we provide is at risk**, including home health services, behavioral health crisis response, hospice, Nurse-Family Partnership, nursing for Naturally Occurring Retirement Communities (NORCs), and other essential community-based programs. When care becomes fragmented, patients lose continuity and are separated from caregivers who know their needs, routines, and histories, driving up costs and worsening outcomes.

During the recent winter storm, a VNS Health aide walked through heavy snow to reach a wheelchair-bound client who had been left alone when transportation failed. She stayed throughout the day to ensure the client was fed, safe, and cared for.

This kind of continuity is made possible by VNS Health's integrated model, which allows our MLTC plan and personal care teams to work together to prevent avoidable harm. **More than 2,500 MLTC members receive support from VNS Health personal care aides** with advanced falls-prevention training, reinforced by nurse visits focused on home safety and mobility. These efforts reduce emergency room visits and hospitalizations, improve quality outcomes, and allow members to remain safely at home—exactly the outcomes the State seeks to promote through value-based care.

Continued underfunding threatens workforce stability, making it harder to retain experienced caregivers and disrupting the trusted relationships that high-need patients rely on every day, particularly in upstate and rural communities where alternatives are limited. This will directly disrupt the lives of family caregivers. Many are already balancing work, raising children, and caring for aging parents or loved ones with disabilities. Stable home care enables them to keep jobs and families intact. **When care breaks down, caregivers are often forced to leave work and take on complex care they are not trained to provide**, pushing families toward crisis and making it more likely that their loved ones will end up in hospitals and nursing facilities, especially in upstate and rural communities with few alternatives.

MLTC High Acuity Stability Pool: A Targeted, Disciplined Solution to Protect High-Need New Yorkers

There is a clear and responsible path forward that protects high-need New Yorkers, reinforces quality, and preserves State fiscal discipline.

We urge the Legislature to include **a $50 million (FMAP matching funds-eligible) High-Acuity Quality and Stabilization Pool in the SFY 2027 budget.** This pool would be narrowly tailored for MLTC plans that deliver high-quality care and serve a disproportionate share of members with complex, high-cost needs. This pool would only be accessed if those plans remain above a sustainable cost threshold after final rates and risk adjustment are applied. The pool would be capped, discretionary, and non-inflationary, and be used only to offset costs above a defined MLR threshold. Any unspent funds would remain with the State.

This is **not a broad rate increase or a substitute for accurate rate-setting**. It is a limited, conditional backstop to address the unanticipated impacts of recent reforms on high-acuity care. By targeting support only where quality and acuity intersect, and only when needed, this approach aligns reimbursement with post-transition realities, protects recent reforms, and avoids far more costly and disruptive outcomes, while ensuring that plans serving the most vulnerable New Yorkers can continue to do so.

With timely action in SFY 2027, the State can **preserve high-performing care models that prevent avoidable hospitalizations and institutionalization**. Without action, the system will continue to reward lower-acuity growth while placing high-acuity care at risk, forcing families, providers, and the State into more costly and destabilizing alternatives.

Conclusion

VNS Health has long been a trusted partner to New York State, stepping in during periods of transition, preserving access to care, and serving New Yorkers with the most complex needs. Now we need targeted and equitable financing to ensure VNS Health can continue to provide care to those who are most in need.

We respectfully urge the Legislature to take targeted action in the SFY 2027 budget to protect high-acuity New Yorkers, support caregivers, and preserve the nonprofit care model infrastructure that keeps people safely at home.