NYLAG
New York Legal Assistance Group

New York Legal Assistance Group

Testimony to the New York State Legislature
Joint Hearing of the Senate Finance and Assembly Ways and Means Committees

THE 2024-2025 EXECUTIVE BUDGET

TOPIC: HEALTH/MEDICAID

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New York Legal Assistance Group (NYLAG) uses the power of the law to help New Yorkers experiencing poverty or in crisis combat economic, racial, and social injustice. We address emerging and urgent needs with comprehensive, free civil legal services, financial empowerment, impact litigation, policy advocacy, and community partnerships. We aim to disrupt systemic racism by serving clients, whose legal and financial crises are often rooted in racial inequality.

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I. GOVERNOR HOCHUL'S PROPOSALS THAT NYLAG SUPPORTS

1. SUPPORT Continuous Medicaid eligibility for Children from Birth to Age Six

NYLAG applauds Gov. Hochul's proposal to ensure that young children keep Medicaid during their critical developmental years from birth to age six. This will build on New York's existing one-year of continuous eligibility for those under age 65. Both Oregon and Washington were approved for this waiver, which will ensure substantial matching federal funds for a low-cost policy option that will reap many benefits for our state, including:

- **Greater health equity.** Continuous coverage protections advance health equity by ensuring continuity of treatment for low-income children and children of color, who disproportionately experience health disparities.
- **Better child and family health.** Continuity of coverage supports proven pediatric interventions, including developmental screening, prevention, and family-oriented two-generation services.
- **Reduced costs for families and lower administrative costs.** Cycling on and off Medicaid/CHP burdens families with out-of-pocket expenses and stressful deadlines; it also results in higher administrative costs for the state, insurers, and providers.
- **Stabilized preventive and pediatric health care systems.** Gaps in children's coverage strain the finances of the primary care and pediatric infrastructure of our state. These providers already work long hours for lower reimbursement rates. Ensuring that their patients have continuous coverage will mean this vital component of our healthcare system will flourish.

The loss of coverage—even for a short period of time—disrupts care, increases family expenses, and costs government, providers, and insurance companies money. Most very young children lose their coverage because of clerical errors in processing or because a parent couldn't be notified. Very few lose coverage because they are no longer eligible.[1]

2. SUPPORT authorizing DOH to impose liquidated damages for Managed Care plans that fail to comply with model contract (PART H)

Increased oversight and penalties against MLTC and other managed care plans for failing to comply with their contracts and governing law are long overdue. In the last few years, both federal and state agencies have issued reports criticizing the lack of adequate oversight of MLTC plans in NYS:

[1] See more in coalition letter to Gov. Hochul at https://medicaidmattersny.org/wp-content/uploads/2023/12/0-6-sign-on-ltr-to-Gov-include-in-24-25-Exec-budget_final.pdf.

- U.S. Office of Inspector General, *New York Did Not Ensure That a Managed Care Organization Complied With Requirements for Denying Prior Authorization Requests* (2023), at https://oig.hhs.gov/oas/reports/region2/22101016.asp.
- Comptroller of the State of NY, *Medicaid Program — Oversight of Managed Long-Term Care Member Eligibility* (Aug. 2022), available at https://www.osc.state.ny.us/files/state-agencies/audits/pdf/sga-2022-20s52.pdf. See response to this report by NYLAG and other consumer advocates calling for better oversight of MLTC. [2]
- U.S. Government Accountability Office (GAO), MEDICAID LONG-TERM SERVICES AND SUPPORTS: Access and Quality Problems in Managed Care Demand Improved Oversight, GAO 21-49 (Oct. 2022), available at https://www.gao.gov/assets/gao-21-49.pdf.

NYLAG's MLTC Transparency Project echoed the findings of these reports, illuminating the poor track record of MLTC plans in keeping older people and people with disabilities out of nursing homes report, in part because plans refuse to authorize the amount of home care needed by members with serious chronic conditions.[3] Based on 12 years of experience representing consumers who must aggressively fight MLTC plans for adequate home care, and our MLTC Transparency Project, we urge that the MLTC program be replaced entirely with a different model, as proposed in the Home Care Savings & Reinvestment Act (S7800/A8470). See more in Section III below about our support for this bill, which would save the State hundreds of millions and even billions. The sanctions proposed by the Governor are too little too late, but are urgently needed as long as the MLTC program remains.

3. SUPPORT Authorizing DOH to Establish New Subsidy for Marketplace Qualified Health Plans for those with incomes up to 350% (Part J §6)

Thousands of New Yorkers are underinsured, with unaffordable coverage in Qualified Health Plans. The proposed subsidies would provide essential financial support for people with incomes too high for the Essential Plan but not high enough to afford high deductibles and coinsurance. Without these subsidies, these consumers are

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[2] *Consumer Advocate Statement on New York State Comptroller Report of Aug. 5, 2022: Medicaid Program – Oversight of Managed Long Term Care Member Eligibility* (Nov. 2022, available at https://medicaidmattersny.org/wp-content/uploads/2022/11/OSC-MLTC-report-consumer-advocates-statement-11.2.22-final.pdf, citing CMS, *Promoting Access in Medicaid and CHIP Managed Care: Managed Long Term Services and Supports Access Monitoring Toolkit*, June 2022, *available at* https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-access-toolkit.pdf.

[3] *NYLAG MLTC Data Transparency Project*, available at https://nylag.org/MLTCdatatransparency/. Complete project report available at https://nylag.org/wp-content/uploads/2022/09/MMCOR-Report-FINAL.3.pdf.

deterred from accessing medical care when they need it, which can lead to acute medical episodes, exacerbation of chronic conditions, and worse.

4. SUPPORTContinued Funding – and Expand - the Managed Care Consumer Assistance Program (MCCAP)

NYLAG thanks the Governor for continuing funding for the MCCAP network and urges an increase in this funding. NYLAG is one of six organizations in the MCCAP network providing vital counseling and advocacy for low-income Medicare beneficiaries desperate to reduce their out-of-pocket costs. They need help navigating the barrage of marketing mail they receive to pick the Medicare plan that best covers their prescriptions and preferred providers. A $1 million increase above the $1.76 million appropriation is needed to cover rising costs and meet increased demand.

5. Qualified Support for Expanding Scope of Tasks to include Certain Nursing tasks for Unlicensed Direct Support Professionals for OPWDD Participants in Community Settings (Section EE)

We support expanding the scope of tasks of Direct Support Professionals who work with participants in the OPWDD waiver who are living in community settings, so that these workers may perform certain nursing tasks, just as has been successfully done in the Consumer-Directed Personal Assistance Program (CDPAP). To meet the goals of expanding independent living options for people with DD, this must be accompanied by training, commensurate wage increases for aides who take on medication administration, and supervision. All this must be funded. Lack of funding for these costs has impeded implementation of the Advanced Home Health Aide program since it was enacted in 2016. Chapter 471 of the Laws of 2016; https://www.health.ny.gov/facilities/home_care/advanced_home_health_aides/. Funding the true cost of both programs could help even more people remain in the community, both those in the OPWDD waiver and others who need assistance with medication administration and other skilled tasks that traditional home care workers are prohibited from doing.

6. Qualified Support for Procurement of Managed Care Contracts (Part P)

NYLAG supports the Home Care Savings and Reinvestment Act to repeal and replace the MLTC program – see more below. If MLTC plans remain, we support the recommendations of Medicaid Matters NY for a procurement process. See https://medicaidmattersny.org/wp-content/uploads/2022/03/22-23-budget-MC-procurement-MMNY-statement-Final.pdf.

II. GOV. HOCHUL PROPOSALS THAT NYLAG OPPOSES

7. NYLAG OPPOSES Elimination of Wage Parity for CDPAP (Part G)

NYLAG strongly opposes the elimination of wage parity increases for the Consumer –Directed Personal Assistance Program (CDPAP) in New York City, Nassau, Suffolk, and Westchester counties. The home care worker shortage – in NYS as well as nationally – was exacerbated by COVID and has not abated.[4] Increasing pay for home care workers is crucial to ensure that home care approved by MLTC or other managed care plans or local districts as medically necessary can actually be provided. To that end, the Governor and legislature have worked together over the last few years to increase the minimum wage by $2 per hour and wage parity requirements. Even with these initiatives, the worker shortage continues. Id. fn 4.

Moreover, these recent wage increases have already been chipped away, especially for CDPAP workers. Last year, CDPAP home care workers in NYC, Long Island, and Westchester had wage parity cut by the amount of the raise in the minimum wage, essentially depriving these workers of the $2 increase in the minimum wage. The new proposed wage parity cut would reduce the wage and compensation for CDPAP personal assistants by $2.54/hour, or twelve percent. The result is a wage LESS than what they were earning in 2018.

This cut will have a disproportional impact on women who are black, indigenous and other people of color (BIPOC), who make up the vast majority of the home care work force.[5] In turn, this wage reduction will harm their families.

The proposed reduction in wages will make it difficult and even impossible for consumers to recruit and hire CDPAP personal assistants, since these workers can earn more in jobs that are much less physically and emotionally taxing than caring for people who have physical and mental disabilities.

If the Executive expects that consumers will opt to receive services through the traditional personal care model instead of CDPAP, this assumption is flawed in several ways:

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[4] Amanda D'Ambrosio, Jacqueline Neber, *Report: NY could be nearly 1.5 million home health care workers short of serving state's aging population,* Crain's NY Business, Mar. 24, 2023, available at https://www.crainsnewyork.com/health-pulse/report-ny-could-be-nearly-15-million-home-health-care-workers-short-serving-states#:~:text=In%20the%20next%20decade%2C%20there,health%20assistance%2C%20the%20institute%20said; Ai-jen Poo and Ilana Berger, *Many of Us Want to Age at Home. But That Option Is Fading Fast,* NY Times, Mar. 30, 2022 (Opinion Guest Essay), available at https://www.nytimes.com/2022/03/30/opinion/home-care-aides-industry.html?referringSource=articleShare.

[5] See https://www.nyc.gov/assets/dca/downloads/pdf/workers/Lifting-up-Paid-Care-Work.pdf

a. **Capacity -** We question whether capacity exists to deliver traditional personal care services as needed. NYLAG represents consumers in New York City who have faced long delays in receiving traditional personal care services even after they were approved, whether by an MLTC plan or by the NYC Human Resources Administration. In October 2022, the NYS Comptroller found that NYS paid **$2.8 billion** in premiums to MLTC plans that provided *little or no services* to their members –in large part due to the worker shortage.[6]

   CDPAP plays an essential role in enabling MLTC plans as well as local districts to meet demand for staffing home care cases. The Governor's proposal fails to provide assurances that capacity exists if fewer workers are willing to do CDPAP. Even in 2018, in the metropolitan area affected by this proposal, which includes NYC, Long Island and Westchester, the percentage of members who received CDPAP as opposed to personal care was 48.4% for Integra MLTC, 43.1% for Alphacare (which was since acquired by Senior Whole Health), 36.7% for Fidelis, 34% for Centers Plan for Healthy Living, and 25% for Agewell (since acquired by Senior Whole Health).[7] The proportion of members receiving CDPAP versus personal care has reportedly increased since then, especially with the worker shortage caused by COVID.

b. **CDPAP is indispensable for consumers with "skilled" needs.** Many consumers must use the CDPAP program because their personal assistants must perform "skilled" tasks that a traditional aide may not perform. These include injecting insulin or administering eye drops, oxygen, medications, tube feeding, and other tasks. The CDPAP program achieves substantial cost savings for the State by permitting CDPAP personal assistants to perform these skilled tasks at a far lower cost than a private duty nurse. The projected cost savings of $200 million in 2025 and more in later years fails to take into account these cost savings of CDPAP. At least some CDPAP consumers who need skilled services will be forced into nursing homes if they are unable to recruit and hire personal assistants, at greater cost to the state and violating their rights under the Americans with Disabilities Act as interpreted by the U.S. Supreme Court in *Olmstead*.

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[6] New York State Comptroller, *Medicaid Program — Oversight of Managed Long-Term Care Member Eligibility*, Aug. 5, 2022, available at https://www.osc.state.ny.us/files/state-agencies/audits/pdf/sga-2022-20s52.pdf.

[7] Data from NYS Managed Care Cost & Operating Reports (MMCOR) filed by MLTC plans for 2018. Data is visualized interactively in *Long Term Care Service Mix* at https://nylag.org/mmcor-long-term-care-service-mix/. The cited data is obtained by viewing the data by Percent rather than Numbers, by selecting the NYC Metro region, and in the Services dropdown selecting *PCS only* and CDPAP *only*. This is one of the interactive visualizations in the *NYLAG MLTC Data Transparency Project*, available at https://nylag.org/MLTCdatatransparency/. Complete project report available at https://nylag.org/wp-content/uploads/2022/09/MMCOR-Report-FINAL.3.pdf.

c. **Violate Right Enacted in State Law Guaranteeing Consumer Choice.** By making it difficult if not impossible to recruit and hire CDPAP personal assistants, this budgeting change would violate the state law establishing the CDPAP program, which "…is intended to permit chronically ill and/or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services." Soc. Serv. Law. 365-f, Subd. 1. The law provides, "All eligible individuals receiving home care shall have the opportunity to apply for participation in the program." Sec. 365-f, Subd. 2. A consumer's right to apply is meaningless if it is impossible to hire and retain a personal assistant.

The Executive Memorandum in support explains that the purpose of this cut is to keep spending within the global cap. Enacting the *Home Care Savings and Reinvestment Act* (S7800/A8470) would save many times the projected savings of this wage cut by replacing the MLTC program with a managed fee for service model. This change would eliminate the extraordinary profits and administrative costs of the MLTC program, which could be repurposed to enhance worker wages while also reducing state costs below the global cap. Similarly, adopting better oversight of plans as recommended by the NYS Comptroller would save more money without harming consumers and workers.[8] See fn. 5. It is shocking that at a time of well-known home care worker shortages, and the increasing demand resulting from aging baby boomers and greater longevity, wage increases enacted in past years -- which were not enough at the time -- would be rolled back.

8. Retain "Prescriber Prevails" for Prescriptions (Part I § 2)

The Executive Budget once again proposes to eliminate the longstanding principle that the "prescriber prevails" in determining the medical necessity of medications in fee-for-service (FFS) Medicaid and Medicaid managed care (Part I, Section 2). This proposal would have a detrimental impact on people with disabilities and chronic conditions, as well as on those who rely on specific drugs and drug combinations. For these individuals, medical providers are best suited to determine which drug would treat their patients most effectively. Denials of necessary drugs, even if appealed and ultimately resolved in a patient's favor, can endanger Medicaid beneficiaries when they face sudden disruptions in treatment. Providers are best equipped to ensure that their patients have access to the safest and most effective treatments for their conditions.

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[8] The report found the " … Department does not perform reviews to identify instances where MLTC members remain in MLTC but receive few services during their enrollment period…The Department should consider a process to determine the reasons such limited services were received, and ensure members are receiving the required level of care…" NYS Comptroller Report, supra at fn 2 at page 13.

9. Reject Proposal to Allow DOH to reduce coverage of Over-the-Counter drugs and supplies without prior notice and comment (Part I Section 1)

NYLAG opposes the provision that would allow DOH to unilaterally remove non-prescription (a/k/a "over-the-counter" ["OTC"]) drugs from the list of such drugs that Medicaid covers -- without soliciting public comment through the rulemaking process. The Executive's memorandum in support disingenuously explains that this change would align NYS Medicaid coverage with the federal Medicare Part D program. On the contrary, since all OTC drugs are explicitly *excluded* from the federal Part D benefit, Medicaid is aligned with Part D when it *covers* all OTC drugs excluded from Part D, thus wrapping around Medicare coverage for dual eligibles. 42 C.F.R. § 423.100.[9] Removing OTC drugs from Medicaid coverage *defeats* alignment between Medicare and Medicaid that is vital for dual eligibles.

Coverage of OTC drugs is a crucial benefit both for Dual Eligibles and those whose sole health coverage is Medicaid. Without Medicaid coverage, they would have to pay for these drugs out-of-pocket. Since 1976, the FDA has switched 700 drugs from requiring prescriptions to being available over the counter.[10] New ones are added to this list frequently, most recently Narcan to treat opioid overdoses and a contraceptive pill.[11] Other OTC drugs at risk of being unilaterally removed without public input include allergy medications, protein pump inhibitors for acid reflux and other digestive conditions, laxatives, head lice treatment, and medications for smoking cessation. Id. These vital drugs are no less "medically necessary" just because the FDA approved their sale over the counter. Medicaid recipients lack the disposable income to pay for these drugs out of pocket.

The Commissioner was already authorized to *add* drugs to the list of covered drugs, but should not be authorized to *remove* drugs or otherwise modify the list without soliciting public comment through rulemaking.

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[9] For a list of Part D excluded drugs see CMS, CMS, Prescription Drug Benefit Manual, Chapter 6: Formulary, 20.1 – 20.4, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/Pub100_18.pdf, revised 1/15/2016.

[10] See Consumer Healthcare Products Association, *FAQs About Rx-to-OTC Switch,* available at *https://www.chpa.org/about-consumer-healthcare/faqs/faqs-about-rx-otc-switch#:~:text=How%20many%20medicines%20available%20today,products%20on%20the%20market%20today.*

[11] U.S. Food & Drug Administration, *Prescription to Over-the-Counter (OTC) Switch List* https://www.fda.gov/about-fda/center-drug-evaluation-and-research-cder/prescription-over-counter-otc-switch-list, current as of 7/17/2023, last accessed 1/19/2024.

10. Reject One-year Delay in Expanding Essential Plan to include Long Term Services and Supports (LTSS) and Expand Essential Plan to Include Undocumented immigrants (Part J)

NYLAG opposes postponing the expansion of the Essential Plan to include home care and other long term services and supports ["LTSS] for another year. We also urge that the Essential Plan be expanded to cover all immigrants, as proposed under A880/S1572. This would build on the previous expansion to cover undocumented immigrants age 65 and older, which is just now going into effect. Expanding EP coverage to undocumented immigrants will reduce unsubsidized system-wide healthcare costs driven by those without access to timely and affordable healthcare.

Adding LTSS to the Essential Plan should not be delayed because it will help reduce delays in access to care to homecare, which is currently out of reach for people in the 138%-250% FPL income bracket. Access to homecare and LTSS is an important tool for reducing the negative impacts of social determinants of health on low income people. \ The expansion will also ensure continuity of LTSS coverage when people transfer between the Essential Plan and Medicaid.

NYLAG's LegalHealth unit, a medical-legal partnership, helped 96 undocumented immigrants successfully attain Medicaid eligibility in 2023. In addition, LegalHealth provided Medicaid or immigration assistance for **2,624** clients who were undocumented and *under the age of 65* – all of whom need expanded health insurance coverage in New York State. Here are examples of people who were fortunate to get our legal help to obtain Medicaid through establishing PRUCOL status, such as by obtaining Medical Deferred Action.

The only chance for survival for Maria, age 61, following a serious medical event was a heart transplant. However, as an immigrant from Latin America who overstayed her tourist visa several years ago, she could not access that care. Referred by NYC H+H Bellevue Hospital, her NYLAG attorney determined that the only option was a complex application to US Center for Immigration Services (USCIS) for deferred action for medical reasons. The application, filed within weeks of the referral, was well-supported by a client affidavit, physician medical letter, and research on the inability to receive the needed care in Maria's home country. Upon filing the application, Maria obtained Medicaid eligibility, and soon received a successful heart transplant.

Roberto, a young working man in his 20's and father of a 3-year-old son, lacked health insurance to cover a stem cell transplant for leukemia. Referred by a social worker at Montefiore Hospital, the NYLAG attorney determined that the best strategy was for his wife, a U.S. citizen, to file a family relative petition for him. Money was tight since he juggled work and cancer treatment, but they were finally able to afford the $585.00 filing fee. Once the petition was filed, NYLAG worked with the hospital to enroll him in the Essential Plan. Roberto will soon receive the life-saving stem cell transplant.

Most immigrants lack access to the sophisticated legal representation needed to obtain PRUCOL status as required in the above cases.

11. OPPOSE Repeal of Enhanced Quality of Adult Living (EQUAL) Program for Adult Home residents (Part L)

We join the Coalition of Institutionalized Aged and Disabled (CIAD) in opposing repeal of this cost-effective program that enhances quality of life for the 13,000 residents of adult homes, who are among the most vulnerable New Yorkers with mental and physical impairments. This 2018 program replaced an earlier program that, since 1996, has provided vital funding for essential winter clothing, air conditioners, transportation, healthy food, and enhancements to the adult homes like laundry facilities for resident use, ramps, and patios. We refer to CIAD testimony for further information.

III. NYLAG URGES NYS TO BUILD ON LAST YEAR's INITIATIVES THAT NARROW THE RACIAL GAP IN ACCESS TO HEALTH CARE BY PHASING OUT THE MEDICAID ASSET TEST (S4881A).

NYLAG strongly supported Gov. Hochul's initiative enacted last year that made headway in equalizing Medicaid eligibility for all New Yorkers, by increasing the income limit for seniors and people with disabilities to the same limit used for younger people under the Affordable Care Act (138% of the Federal Poverty Level (FPL)).

Unfortunately, Gov. Hochul's proposal to eliminate the asset test in last year's budget was not enacted. Repeal of the asset limit is essential to eliminate racial disparities in health care access. The current rules are biased against people of color, who statistics show are less likely to own homes[12] or retirement funds,[13] assets that have special exemption from the current asset limit, while cash assets count. People whose savings are in cash rather than a home or IRA will be able to save money for emergencies, rather than be forced to spend it down to a level that causes instability when the next urgent expense arises.[14] Also, most retirees with income at even the increased level need to depend on savings just to make ends meet. S4881a would

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[12] Stefanos Chen, *The Resiliency of New York's Black Homeowners*, New York Times, Aug. 17, 2021, available at https://www.nytimes.com/2021/08/17/realestate/new-york-black-homeowners.html?referringSource=articleShare. "From 2002 to 2008, the number of Black homeowners in the city dropped 10 percent… and there is evidence that the share dropped another 3 percent by 2017."

[13] Kelly Anne Smith, *America's Racial Wealth Gap In Retirement Savings,* Forbes, 9/1/2020, available at https://www.forbes.com/advisor/retirement/retirement-racial-wealth-gap/.

[14] New York's asset poverty rate, including the equity in a home, is 26.9 % higher than the national average of 24.1%, based on 2016 data. Prosperity Now Scorecard, available at https://scorecard.prosperitynow.org/data-by-issue#finance/outcome/asset-poverty-rate.

increase the asset limit in 2025, then repeal it the following year. This approach follows California's lead, which repealed the asset limit for Medicaid in two stages and was fully approved by CMS.

IV. REPEAL MRT II HOME CARE RESTRICTIONS AND "LOOKBACK" ENACTED IN SFY 2021

12. Repeal the restrictive minimum of three Activities of Daily Living (ADL) required for eligibility for Medicaid personal care and consumer-directed services (S328/ A6346)

The ADL thresholds enacted in 2020 discriminate against people with developmental disabilities, traumatic brain injury, visual, and other impairments. Individuals with these impairments qualify for home care only if they need *physical* assistance with ***three*** ADLs, such as bathing, dressing, and ambulating, even though the nature of their impairments causes them to need *cueing and supervisory* rather than hands-on physical assistance. Yet people with dementia will qualify if they need *cueing and supervisory* assistance with ***two*** ADLs. Such blatant discrimination based on the type of diagnosis is unlawful.

Even the Commissioner acknowledged that people with Serious & Persistent Mental Illness (SPMI) would be denied home care under the new standards, and when the state Office of Mental Health pointed this out, promised to set up a procedure for these individuals to request a "reasonable accommodation" and obtain an exception from the new standards.[15] Any such procedure would be terribly burdensome for the very people who would need this exception. And, this procedure would not be available to those who are blind, have traumatic brain injuries and other disabilities.

The minimum ADL requirements will also eliminate the longstanding "**House-keeping**" program entirely. "Housekeeping" is a type of Personal Care limited to a maximum of 8 hours/week for those who can bathe and dress themselves and perform other ADLs, but need help shopping, cleaning, or doing laundry because of their disability. These housekeeping activities are commonly called "Instrumental ADLs" (IADLs). Since personal care eligibility will now require two or three ADLs, this service will no longer be available – putting a person with a disability at risk from a fall or other injury when they try to perform these tasks without help. Many people will need higher cost care if denied this preventative service.

[15] Final DOH regulations posted Nov. 8, 2021, available at https://regs.health.ny.gov/sites/default/files/pdf/recently_adopted_regulations/Personal%20Care%20Services%20and%20Consumer%20Directed%20Personal%20Assistance%20Program.pdf at pp. 186-187.

13. Repeal the lookback and transfer penalty for home care (S6414).

NYS enacted a 30-month lookback and transfer penalty for community-based care in 2020, in the dark early days of COVID. Implementation was not allowed because of the Public Health Emergency – and it should be repealed. Wealthy people will use trusts and other Medicaid planning techniques to circumvent these rules. However, low-income people will be denied home care if they transfer modest amounts to family. Even those with no assets to transfer will be harmed by long application delays from the added paperwork. The NYC Human Resources Administration and other Local Medicaid agencies have lost thousands of workers and are struggling to keep up with new Medicaid applications, the renewals that re-started with the "unwinding" of the Public Health Emergency, and many other responsibilities. The lookback would add a massive amount of new paperwork that neither consumers nor the local districts can cope with.

V. SUPPORT HOME CARE SAVINGS AND REINVESTMENT ACT TO REPLACE MLTC MODEL WITH MANAGED FEE FOR SERVICE (S7800/A8470)

NYLAG strongly supports the Home Care Savings and Reinvestment Act (S7800/ A8470) to replace the Managed Long Term Care (MLTC) model with a managed fee-for-service program that works for consumers and home care workers alike and will save New York State billions of dollars. Since enrollment in MLTC plans became mandatory in 2012 for adults who need Medicaid home care to remain safe in their homes, NYLAG has represented thousands of older New Yorkers and people with disabilities. They must fight these MLTC plans that routinely deny them enough hours of Medicaid home care to remain safe in their homes. Consumers who, because of dementia, Parkinson's Disease, stroke, and a host of other infirmities need higher hours of care must accept the minimal hours offered by these plans in order to enroll, then fight for more hours in multiple appeals. In the meantime, they are at risk of falls, fractures, bed sores, and other harms resulting from inadequate care.

It is now abundantly clear that paying insurance companies to provide ONLY long-term care services cannot work because a health insurance model requires the insured population includes healthy members, who need only preventive care and minimal services, balancing out the few who will need expensive care. With MLTC, however, all 280,000 members *by definition have chronic conditions* for which they *have been determined* to need costly home care services. Plus – the plans are relatively small and cannot – or will not – absorb the cost of the few who need high hours of care such as 24/7 home care. So they make a profit by DENYING needed home care services and DELAYING approvals for months – forcing frail seniors and people with disabilities through endless appeals. Historically, only a small percentage of the home care population need the highest amounts of home care – 24 hours/day. However, MLTC plans are incentivized to deny 24/7 care, only

authorizing it if they lose an appeal. Most consumers lack access to a legal representative and lack the wherewithal to appeal at all, or lose their appeals when up against an insurance company lawyer. Those who can navigate the system win, especially with an experienced advocate.[16]

The current capitation model incentivizes insurance plans to enroll members with limited needs, enhancing profits since NYS pays the plans the same "per member per month" premium for every member. Likewise, the plans deny increases in hours when needed, and refuse to reinstate home care after a temporary stay in a rehabilitation facility. We have represented hundreds of seniors who desperately want to return home. Without our aggressive advocacy, they would be forced to remain permanently in a nursing home. This defeats federal and state goals of "rebalancing" long-term care from institutional to community-based care – and violates our clients' rights under the Americans with Disabilities Act (ADA) as interpreted by the U.S. Supreme Court in *Olmstead v. L.C.*

Lack of Accountability & Transparency in MLTC Plans. A managed care system requires scrupulous oversight of insurance companies, which this administration has been unwilling or unable to do. In 2022, the NYS Comptroller found that NYS paid $2.8 billion in premiums to MLTC plans that provided little or no services, and another $701 million for consumers who had died, moved to Assisted Living, or were otherwise not eligible for MLTC.[17] The Comptroller found that the "Department does not perform reviews to identify instances where MLTC members remain in MLTC but receive few services during their enrollment period." *Id*. In response, consumer advocates called on DOH to adopt long term care access standards recommended by CMS, and to post a public quality dashboard with performance metrics such as the maximum wait time for home care services to be initiated after authorization.[18] Yet

[16] A study of Fair Hearing decisions in NYS found that over 90% of all MLTC decisions to reduce hours of home care were reversed in a Fair Hearing. *See Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans, June-December 2015,* by Medicaid Matters NY and NYS Chapter of National Academy of Elder Law Attorneys (July 2016), available at https://medicaidmattersny.org/mltc-report/. The report was featured in a story in the New York Times, Nina Bernstein, *Lives Upended by Disputed Cuts in Home-Health Care for Disabled Patients*, July 21, 2016, available at https://www.nytimes.com/2016/07/21/nyregion/insurance-groups-in-new-york-improperly-cut-home-care-hours.html?_r=0.

[17] New York State Comptroller, *Medicaid Program — Oversight of Managed Long-Term Care Member Eligibility*, Aug. 5, 2022, *available at* https://www.osc.state.ny.us/files/state-agencies/audits/pdf/sga-2022-20s52.pdf.

[18] *Consumer Advocate Statement on New York State Comptroller Report of Aug. 5, 2022: Medicaid Program – Oversight of Managed Long Term Care Member Eligibility* (Nov. 2022, available at https://medicaidmattersny.org/wp-content/uploads/2022/11/OSC-MLTC-report-consumer-advocates-statement-11.2.22-final.pdf, citing CMS, *Promoting Access in Medicaid and CHIP Managed Care: Managed Long Term Services and Supports Access Monitoring Toolkit*, June 2022, *available at* https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-access-toolkit.pdf.

the Commissioner of Health failed to adopt any accountability measures to address the Comptroller's concerns, and Gov. Hochul recently vetoed a bill that would have required some transparency about home care usage. A1926/S1683.

MLTC MODEL INFLATES ADMINISTATIVE COSTS AND PROFITS. In NYS, the average profit margin for MLTC plans was 5.5% in 2021, more than double the national average Medicaid managed care plan profit margin of 2.6% (2015).[19] In 2018, 23 of 30 partially capitated MLTC plans made a profit after paying all medical as well as administrative expenses, which include marketing and lobbying expenses. Five plans with the highest net income (profit) in 2018 were Centers Plan for Healthy Living with $69 million, then Fidelis, Integra, Healthfirst, and Wellcare with net revenue over $30 million.[20] See Table 1 below showing profit margins of MLTC plans.

Managed Fee for Service is a Better Way. The proposed bill replaces MLTC with a managed fee for service model. As shown to work in Connecticut, Washington State, and Alabama, a care management entity would be paid for the job of developing a care plan and authorizing services. This model is truly conflict-free, unlike the MLTC model in which the MLTC plan has a conflict of interest with its own members that leads it to deny crucial services. Providers would bill Medicaid for services on a fee-for-service basis. Medicaid would pay for the services actually provided, instead of an inflated premium to an insurance plan that is much higher than the few services actually provided. *Our clients will be able to get the home care services they desperately need.* Managed Fee for Service will also promote accountability and transparency. Providers will bill the state Medicaid program instead of MLTC plans, so rates will be transparent and calculated to cover increases in the minimum wage.

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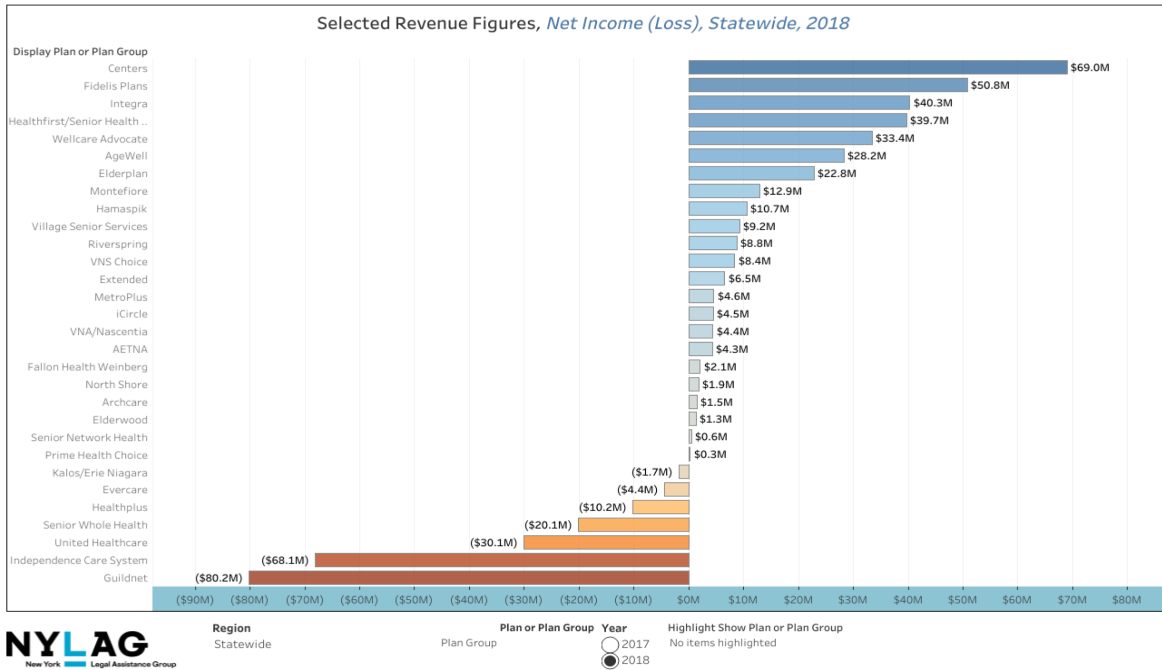
[19] Service Employees International Union (SEIU), Oct. 2023.

[20] Data from NYS Managed Care Cost & Operating Reports (MMCOR) filed by MLTC plans for 2018, using statewide reports. Data is visualized interactively at https://nylag.org/mmcor-consolidated-finance-table/, allowing user to select data by year, geographic region, or by specific types of expenditures or income. This is one of the interactive visualizations in the *NYLAG MLTC Data Transparency Project*, available at https://nylag.org/MLTCdatatransparency/. Complete project report available at https://nylag.org/wp-content/uploads/2022/09/MMCOR-Report-FINAL.3.pdf.

Table 1. 2018 Statewide Plans – Net Revenue sorted from High to Low



SOURCE: 2018 MMCOR Reports and NYLAG MLTC Data Transparency Project, see n. 3.

Thank you for the opportunity to submit this testimony. Please feel free to contact me with any questions.

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