Testimony to the New York State Legislature

Joint Hearing of the Senate Finance and Assembly Ways and Means Committees

THE 2026-2027 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.

SUMMARY

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- C. Reject Cut in Medicare Coinsurance Paid to Certain Providers on Behalf of Dual Eligibles and Qualified Medicare Beneficiaries (Part M, §1)
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II. PRESERVE COVERAGE FOR IMMIGRANTS AND OTHERS WHO WILL LOSE FEDERAL COVERAGE UNDER H.R.1 & INCREASE FUNDING FOR NAVIGATORS AND THE MCCAP PROGRAM.

III. ENSURE ACCESS TO HOME & COMMUNITY BASED SERVICES -

- A-B. Repeal Home Care "ADL" Minimum Need Restrictions and 30-month "Lookback"
- C. Enact the "HOME CARE SAVINGS & REINVESTMENT ACT" to Replace MLTC Program with Alternate Model, or Alternately, Improve MLTC Data Transparency
- D. Enhance Transparency and Restore Choice to the CDPAP program (S9142 - Comrie)
- E. Raise Home Care Worker Wages
- F. Improve Access for those Obtaining Services from Local Districts

IV. REDUCE THE ROLE OF MANAGED CARE IN PROVIDING ESSENTIAL SERVICES & ENSURE ACCESS TO CARE – KEEP I/DD, NHTD AND OTHER WAIVERS OUT OF MANAGED CARE, CARVE OUT BEHAVIORAL HEALTH & SCHOOL BASED HEALTH CENTERS, ADDRESS CAPACITY CONCERNS IN MANAGED CARE; ENSURE ACCESS TO DENTAL CARE & GENDER-AFFIRMING CARE

V. INCREASE THE PERSONAL NEEDS ALLOWANCE FOR NURSING HOME RESIDENTS

I. REJECT MEDICAID CUTS PROPOSED BY GOV. HOCHUL'S BUDGET

A. Do Not Prematurely Terminate Continuous Medicaid Coverage for Children under age 6 (Part M, §13).

The 2024 NYS budget authorized the State to request a waiver from CMS authorizing continuous coverage for children under age 6. While CMS has said it will not extend these waivers, it has not said that current waivers must end early. The current waiver should continue through its expiration date of March 31, 2027, not July 1, 2026. The legislature originally enacted this provision because of the importance of continuing health care for children. This includes Medically Fragile Children who are dependent on around-the-clock care from nurses or ventilators, as well as healthy children who should receive *fifteen* well-child visits before age 6 for vaccinations, assessments to ensure they are reaching developmental milestones and to detect chronic conditions, and treatment when they get sick. H.R.1 will increase the paperwork burden for parents, increasing the risk that Medicaid could be cut off for children – making continuous coverage through March 31, all the more essential.

B. Reject Increase in Premiums for Medicaid-Buy-In for Working People with Disabilities (Part L, § 12)

The proposed budget would impose a monthly premium for working people with disabilities under age 65 with incomes between 150% and 250% Federal Poverty Level (FPL). The premium would be three percent of net earned income and 7.5 percent of Social Security Disability benefits and other net unearned income. This is a severe increase from premiums of $25/month – which has long been in the state statute but was never approved by CMS nor implemented. The State should implement the premium now in statute before imposing a higher premium.

C. Reject cut in Medicare coinsurance paid to certain providers on behalf of Dual Eligibles and Qualified Medicare Beneficiaries (Part M, §1)

Since Medicare is always billed first, Medicaid pays only the Medicare deductibles and coinsurance for Dual Eligibles and Qualified Medicare Beneficiaries (QMB). But Medicaid does not pay the Medicare coinsurance if the Medicaid rate is "less than" the Medicare rate – which it usually is. NYS carved out exceptions to the "less than" rule, requiring Medicaid to pay psychologists and ambulance providers the entire 20% Medicare coinsurance, even if the Medicaid rate is less than the Medicare rate. Gov. Hochul proposes to remove those exceptions, which will **reduce access to psychologists – of which very few accept Medicare – and will cause fewer ambulances to accept Medicaid.**

Also, the Governor's budget will reduce the Medicaid coinsurance paid for all members of Medicare Advantage plans. Until now, providers could count on receiving at least 85% of the Medicare coinsurance–even if the Medicaid rate is less than the Medicare rate. The Governor's budget repeals that minimum payment, meaning that many providers will receive NO Medicare coinsurance form Medicaid, since the Medicaid rate is usually lower than the Medicare rate. This cut will hurt consumers since more providers will refuse to accept Medicaid, and will demand that the consumer pay the full Medicare coinsurance.

D. Reject Substituting "Medicaid Aides" for Nurses to Administer Medication in Nursing Homes (Part N, Subpart B)

The dire shortage of aides and nurses in nursing homes will get worse now that H.R.1 has permanently rescinded the federal minimum staffing rule promulgated in 2024. Some nursing homes have closed entire wings because of the shortage. Shifting aides to administering medications means longer waits for residents to get help with transferring from bed into a wheelchair, changing diapers, using the bathroom, eating, getting dressed, and other vital tasks. Moreover, nurses cannot meaningfully supervise aides unless they are present for every instance of medication administration – which of course is not feasible. More medication errors can be predicted putting residents at risk.

E. Reject Repeal of the Adult Home Advocacy and Adult Home Resident Council programs (Part S, § 1).

Repealing this program saves only $230,000 per year. Adult home residents are among the most vulnerable of all New Yorkers. These programs provide vital support to give residents a voice and protect their health and safety.

II. Preserve Coverage for Immigrants and Others who Will Lose Federal Coverage under H.R.1 – Use $1 Billion from MCO Tax + other resources

While we appreciate the Governor's stated commitment to funding Medicaid with state funds for some immigrants who will lose the federal Medicaid matching dollars under H.R.1, her budget does not go far enough to ensure continuing coverage for 1–1.5 million people expected to lose public insurance coverage. This includes 450,000 who are losing Essential Plan coverage when the income limit is reduced from 250% to 200% FPL, and about one million more who will lose Medicaid because of work requirements, bi-annual renewals, and other H.R.1 cuts. We appreciate that the Commissioner of Health is working on implementing new federal requirements–including six-month renewals and work requirements–in ways that will keep as many people covered by Medicaid as possible.

The State must utilize **$3 billion in available** resources including **$1 billion from the extension of the MCO tax** just approved by CMS and **$2 billion** from likely federal approval of the conversion of the Essential Plan[1] to fund immigrant health care and navigation support.

[1] The budget assumes a loss of $2 billion based on predicting that CMS would not approve reversion of the Essential Plan back to the 1331 waiver. However, Paul Francis, former NYS Budget Director and Deputy Secretary for Health & Human Services, predicts approval of the waiver. "This would eliminate the need for the State to spend more than $2 billion that is currently reflected in the FY 27 Executive Budget as being spent to provide State-only Medicaid to the Aliessa population." Paul Francis, *New York City's Budget Deficit*, Step Two Policy Project, Feb. 4, 2026, available at https://steptwopolicyproject.substack.com/p/new-york-citys-budget-deficit?utm_source=post-email-title&publication_id=1968987&post_id=186784120&utm_campaign=email-post-title&isFreemail=true&r=15h0xx&triedRedirect=true&utm_medium=email.

A. Continue its historic commitment to covering most immigrants as a matter of public health and pursuant to the State Constitution (Aliessa v. Novello)

While we support the State's decision to move away from the Essential Plan and revert back to the Basic Health Program, we urge the State to establish an affordable coverage option for the approximately 450,000 New Yorkers who will lose coverage, who have incomes between 200% - 250% FPL. This includes immigrants as well as citizens.

We further urge New York to continue State-only public coverage for lawfully present immigrants who lose Medicaid coverage due to the narrower definition in H.R.1 of which legal immigrants qualify for federal Medicaid. Many refugees, asylees, domestic violence victims, and other *lawfully present* immigrants will no longer qualify for federal Medicaid. These individuals will now need state-funded Medicaid, which before only had to cover those with "PRUCOL" status. In 2025, NYLAG's LegalHealth unit, a medical-legal partnership, helped 250 undocumented immigrants attain state-funded PRUCOL Medicaid eligibility by filing for affirmative immigration relief. Examples are as follows.

- Applying for Medical Deferred Action enabled Fred, a pastor from Barbados, to have a heart and kidney transplant and Polina, an immigrant from Poland, to receive the rehabilitation she needed after a severe aneurysm.
- Armed with a law enforcement certification, NYLAG obtained a "U Visa" for Maria, from Mexico, who was physically attacked by a co-worker. The attack caused depression and anxiety on top of her kidney failure. With Medicaid she obtained a life-saving kidney transplant.

The care NYLAG fought for is not covered by Emergency Medicaid, the limited federally funded coverage available for immigrants without legal status or a status eligible for Medicaid-funded care under HR1. Aggressive immigration enforcement under Trump has made it riskier and more time-consuming to file for immigration relief, including Medical Deferred Action, but it is still often the only pathway to life-saving care for many immigrants.

B. Funding for increased navigation support for consumers is needed to cope with the demands of H.R.1

Increased funding for consumer assistance, as the demand for help with individual cases will significantly increase as consumers navigate the burdens of H.R.1. This includes expanding funding for the Managed Care Consumer Assistance Program (MCCAP). 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. A $1 million increase above the $1.76 million appropriation is needed to cover rising costs and meet increased demand – not only to navigate the confusing Medicare program but to access crucial Medicare subsidies through Medicaid.

C. Support A176A (Cruz) affording state agency and local discretion to provide public benefits to immigrants not eligible under HR1

NYLAG supports this bill to give state agency and local discretion to offer certain local public benefits necessary to ensure the health, welfare and safety of any individual who would otherwise be deemed eligible absent federal immigration restrictions. New York State would not be the first to enact such a law. Currently, California, Illinois, Texas and Florida

have laws ensuring that certain benefits necessary for health, welfare and safety are provided to individuals regardless of their immigration status.

III. Ensure access to Home & Community Based Services (HCBS):

A. Repeal the 2020 MRT II cuts requiring a minimum of three Activities of Daily Living (ADL) to qualify for Medicaid personal care and CDPAP services

(**S358/A6346 Rivera/Paulin**) These ADL thresholds were implemented in September 2025, after being suspended because of COVID maintenance of effort protections. The ADL thresholds illegally deny home care to people with intellectual & developmental disabilities (IDD), traumatic brain injury, visual, and other impairments who do not need *physical* assistance with three ADLs, such as bathing, dressing, and ambulating. Under these rules, applicants are denied home care even though they need *cueing and supervisory* assistance with two ADLs, even though people with dementia qualify with those needs. Such blatant discrimination based on the type of diagnosis is unlawful. Denying "cueing" assistance with ADLs also puts billions of federal dollars in jeopardy under the Community First Choice Act (CFCO).

We urge repeal of the ADL limits, rather than the modifications proposed in A9266 Davila/S1747 Rivera which would add IDD and a few other diagnoses to the list of who could qualify if they need cueing assistance with two ADLs. No finite list of diagnoses could capture the needs of all individuals who need cueing assistance with two ADLs rather than hands-on help with three ADLs.

Restore the longstanding "Housekeeping" program, which was eliminated with implementation of the ADL test. For decades, consumers who can bathe, dress and perform other ADLs themselves but, because of their disability, need help shopping, cleaning, or doing laundry, could receive Personal Care up to 8 hours/week. Now, a consumer who fails the ADL test is denied all personal care or CDPAP, even if they need help with household chores. The Housekeeping-only program has been eliminated. This puts consumers at risk from a fall or other injury that would lead to higher cost care. Eight hours a week of laundry, housekeeping, and shopping has kept many New Yorkers out of costly nursing homes.

B. Repeal the lookback and transfer penalty for home care

(S4786/A1907). Since it was enacted in 2020, the proposed 30-month lookback and transfer penalty for community-based care was put on hold during the Public Health Emergency and has been pending with CMS since March 2021. The lookback should not move forward. The lookback rules encourage institutionalization in violation of *Olmstead*. Wealthy people will use trusts to circumvent these rules, while low-income people will be denied home care if they transfer modest amounts to family. Most applicants have no assets to transfer, but will be harmed by long delays in applications, delaying access to home care. For someone seeking nursing home care, on the other hand, the paperwork for the lookback is processed while they are in the nursing home receiving care. The lookback for home care will push people into nursing homes when they cannot endure the months it will take to process the paperwork.

C. Replace the MLTC Program with a Cost-Effective Home Care Model ("Home Care Savings & Reinvestment Act")(A2018A/S2332A), or Alternately Increase MLTC Data Transparency (MLTC Data Transparency Act (S707/A700 May/Gonzalez-Rojas)

NYLAG urges elimination of the MLTC program based on its experience of representing thousands of consumers fighting lengthy appeals against MLTC plans for home care needed to live safely at home. NYLAG launched the *MLTC Data Transparency Project*[2] which made data public that show that paying plans a fixed "capitation" premium for each member allows plans to profit while denying needed home care. An insurer must be able to spread the risk of high-cost claims across a large pool of people, most of whom will never make a claim. In MLTC, however, every enrollee *has been determined* to need long-term care *now*. As a result, the MLTC plans:

- **Delay and deny claims** – rarely approving a request without forcing the member through a long series of appeals, which consumers need an expert to fight.
- **Recruit low-need members** through marketing and by incentivizing their home care contractors to recruit low-need members–causing MLTC enrollment and costs to skyrocket.
- **Approve minimal hours of home care for most members**, at a cost far below the monthly premium paid by the State.
- **Force high-need members into nursing homes**, who are then disenrolled from the plan after 3 months, thus relieving the plan of high-cost members.
- **Fail to pay home care agencies** enough to recruit workers and to pay wage increases approved in a recent State budget.

Recent studies have identified the potential for immense savings by eliminating managed care. See, e.g., Physicians for a National Health Program, *Removing the Middleman from Medicaid*, Sept. 2, 2025, available at https://pnhp.org/removing-the-middlemen-from-medicaid/. This system will allow more accountability and transparency than the opaque MLTC system. It will also reduce State spending. The proposed model would follow Connecticut's lead, replacing managed care with a managed case management system, a smart choice that will save money for New York and help New Yorkers.

Meanwhile, enact the **MLTC Data Transparency Act - S707/A700 (May/Gonzalez-Rojas)** that would increase accountability for how MLTC plans spend over $22 billion in public funds annually. Numerous government and watchdog reports have found State oversight of MLTC plans to be deficient.[3] NYS has failed to adopt recommendations by the

[2] See https://nylag.org/MLTCdatatransparency/ and full report at https://nylag.org/wp-content/uploads/2022/09/MMCOR-Report-FINAL.3.pdf.

[3] An October 2023 report commissioned by the NYS legislature in 2022 to evaluate managed care procurement options (Part P, Ch. 57 L. 2022) states in part, "There is significant room for improvement in … improving [MLTC] plan quality (especially Upstate); enhancing measurement of access and quality data…." Boston Consulting Group, Final Report on Managed Care Organization Services, p. 47 (available at https://www.health.ny.gov/health_care/managed_care/reports/docs/final_report_mco_services.pdf. In 2022, the NYS

federal Medicaid agency, CMS, which urge numerous quality and outcome measures to better track access to home and community-based services, and to further the national goal of "rebalancing" long term care from institutional care to community-care.[4] Collection of data about staffing shortages is crucial especially since thousands of MLTC members switched from CDPAP to Personal Care because of problems with PPL, the single Fiscal Intermediary putting more pressure on plan capacity

D. Support S9142 (Comrie) to Increase Transparency about Consumer Directed Personal Assistance Program (CDPAP) and Restore Consumer Choice to CDPAP. While claiming cost savings from the disruptive transition to the single Fiscal Intermediary (FI), the Executive has provided no data. We support **S9142** to require crucial data about cost and continuity of care. Also, we ask to restore choice for consumers to select Independent Living Centers as FI's (S7954 (Rivera)/A8355 (Paulin) and support S1189 (Rivera)/A2735 (Stirpe) that would repeal the single FI statute and establish a licensure process.

E. Raise home care wages by enacting Fair Pay for Home Care and invest in higher wages for direct support professionals (DSP) who support people with I/DD.

F. Improve access for those who obtain HCBS from local districts rather than managed care plans, by

- Establishing a formal grievance process for HCBS services approved by the local DSS
- Prioritizing timely administration of immediate needs home care requests pursuant to NY Soc. Serv. L. §366-a(12) (as amended L. 2015).

IV. Reduce the Role of Managed Care in Providing Essential Services and Ensure Access to Crucial Services

In addition to the recommendation above (I.3.) to replace the MLTC managed care model with an alternate non-capitated model, NYLAG recommends reducing managed care role in other ways:

A. Carve out from mandatory managed care people in the OPWDD and NHTD waivers. NYLAG urges the State to abandon the move of people with intellectual/ developmental disabilities (I/DD) in the OPWDD waiver to managed care, and permanently carve out the Nursing Home Transition and Diversion waiver, for which the exemption ends Jan. 1, 2027.. Studies from other states have shown there are no savings associated with

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Comptroller found that NYS paid $2.8 billion in premiums to MLTC plans that provided little or no services**.** 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. See also 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), available at https://oig.hhs.gov/oas/reports/region2/22101016.asp); 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 (2022), available at https://www.gao.gov/assets/gao-21-49.pdf.

[4] Deborah J. Lipson, *Measures of State Long-Term Services and Supports System Rebalancing: HCBS Quality Measures issue Brief*, Mathematica, Nov. 2019, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-3-rebalancing.pdf, p. 6.

managed care for people with I/DD, and there is no evidence of improvements to access or quality of services. The NHTD waiver should be carved out permanently just as the TBI waiver was permanently carved out in 2024.

B. Carve behavioral health services out of Medicaid managed care. Medicaid managed care has proven detrimental to the ability of New Yorkers to secure mental health and substance use disorder care they need. Removing these services from managed care would eliminate unnecessary barriers to care, simplify the reimbursement process, and return scarce resources to the Office of Addiction Services and Supports and the Office of Mental Health systems of care to address workforce shortages and gaps in services.

C. Repeal the 2024 NYS budget's transfer of School-Based Health Centers to managed care, which will now into effect in April 2026.

D. Ensure that Medicaid enrollees have timely access to medical, mental health and dental providers.

E. Codify Medicaid coverage for certain dental services – root canals, crowns, replacement dentures, and dental implants – now covered under a lawsuit that sunsets in 2028 (**A.1931, Paulin/S.3566**, Cleare)

F. Codify Medicaid coverage for gender-affirming care, regardless of federal funding, and prohibit discrimination by health care entities and insurers **(A.6596-A,** Rosenthal/ **S.6377-A**, Hoylman-Sigal)

G. Address systemic inequities by collecting and reporting managed care data based on race, ethnicity, and disability, at a minimum, and by adding health equity standards to the model contracts and managed care rate setting methodologies.

V. Increase the Personal Needs Allowance for Nursing Home Residents

The Personal Needs Allowance (PNA) is the small portion of income that nursing home residents may keep each month to pay for essential personal items that are not covered by Medicaid. These include clothes, haircuts, books, hobby materials, snacks, cell phone services, cable/internet, cards and more. Small comforts that support everyday dignity. The rest of the resident's income, known as a "NAMI" goes to the nursing home towards the cost of their care.

The PNA is $50 and *has not been adjusted or increased since 1988*. $50 in 1988 is the equivalent to ~$140 today. NYLAG supports **A2048/SS4744A** (Solages) that i**ncreases PNA to $200 per month with annual COLA.** Alternately, we support **A6028** (Simon), which would increase the PNA to $100 per month, but with no COLA increase.

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