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 2025-2026 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

I. ALLOCATE SOME OF THE INCREASED REVENUES TO REPEAL 2020 MRT-2 CUTS, INCREASE HOME CARE WORKER PAY, IMPROVE QUALITY OF LIFE FOR NURSING HOME RESIDENTS, AND GUARANTEE HEALTH CARE FOR ALL IMMIGRANTS

With New York's strong fiscal condition, we urge that some of the billions in surplus funds and the MCO tax be used to protect access to quality care for the state's most vulnerable residents who depend on Medicaid long-term care services, and to expand access for medical care to all immigrants. Part of the billions in proposed middle class tax cuts, inflation rebates, and health care provider increases should be devoted to the most vulnerable.

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

Two Medicaid cuts that reduce access to crucial Medicaid home and community-based services [HCBS] were enacted in the early dark days of the COVID pandemic, when the state's fiscal condition was dire. As neither of these cuts have yet been implemented because of federal "Maintenance of Effort" requirements linked to federal COVID relief, repeal would maintain the *status quo* and prevent the state from having to incur huge costs of implementation. Most importantly, repeal will ensure access to vital home care services that prevent costly institutionalization.

1. Repeal the discriminatory minimum of three Activities of Daily Living (ADL) required for eligibility for Medicaid personal care and consumer-directed services (S358/ A1198)

The ADL thresholds enacted in 2020 not only requires help with ***three*** ADLs, such as bathing, dressing, and ambulating, but says the *type* of help needed must be hands-on physical assistance. Only people with dementia may qualify if the type of help they need with ADLs is *cueing and supervisory* rather than physical assistance. Individuals with developmental disabilities, traumatic brain injury, visual, and other impairments often need *cueing and supervisory* assistance with ADLs – but they will qualify for home care only if they need *physical* assistance with three ADLs. 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.[1] 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 limited type of Personal Care with 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 IADLs without help. Many people will need higher cost care if denied this preventative service.

Also, New York could lose $500 million/year in an enhanced federal Medicaid match for the Community First Choice Option (CFCO), a federal Medicaid option under the Affordable Care Act that New York adopted. Soc. Serv. Law § 365-a, subd. 2(bb). NYS has drawn down **$3.6 billion** in the enhanced federal match since 2016. Many applicants who fail the new ADL test will nevertheless qualify for CFCO services because they have a "nursing home level of care" and live in the community, even if they fail the new ADL test. The State risks losing this funding if it denies eligible individuals CFCO services, which include both cueing and physical assistance with ADLs and IADLs.

2. Repeal the lookback and transfer penalty for home care (A1907).

While there has long been a 5-year lookback and transfer penalty for Medicaid to cover nursing home care, New York never imposed a lookback for community-based long-term care until it enacted the 30-month lookback in 2020. Given the minimal projected savings ($11.75 mill in 2020), the difficulties in adopting the lookback for the home setting, and the hefty cost of implementing this change, which has been on hold because of the Public Health Emergency, it should be repealed.

Importantly, the projected savings would be even less now than in 2020 because the Medicaid asset limit was doubled in the 2023 budget. With people allowed to retain more savings they have less need to transfer assets.

[1] 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.

Also, the rules for transfers for nursing home care cannot simply be adopted for home care. For example, a home can be transferred to a caregiver child without a penalty prior to entering a nursing home, but not prior to applying for home care. Unlike people applying for Medicaid to cover nursing home care, applicants for Medicaid to cover home care will face long delays in getting services while the Medicaid agency processes the copious paperwork required for a lookback review. They cannot receive home care until that review is complete and Medicaid is approved. Those applying to Medicaid to cover nursing home care, in contrast, are already in the nursing home receiving care. So the delay in processing the application does not harm them; Medicaid will retroactively cover the services once it is approved. Unwinding the laws regarding treatment of exempt transfers will require significant administrative time and attention from the Department of Health.

Further, the delays in processing the lookback will most harm the poorest applicants – not those who did transfer assets. Wealthy people will use trusts and other Medicaid planning techniques to privately pay for care while waiting for Medicaid to process the lookback. 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.

B. RAISE wages for the Home Care Workforce

The ongoing workforce shortage for home care workers, along with the growth in the aging population, compels New York to continue past efforts to increase wages for home care workers to meet the demand and compensate workers for difficult work.

C. RAISE the Personal Needs Allowance for Nursing Home Residents

About 80 percent of the 100,000 New Yorkers who live in nursing homes are on Medicaid. All of their income goes toward the cost of nursing home care except a $50/month Personal Needs Allowance (PNA) or $55/mo. for residents who receive Supplemental Security Income (SSI). The PNAs has not had a cost of living increase since established in 1981. The state pays $20 of that allowance ($25 for SSI recipients) with the remaining $30/mo. covered by federal funds. This allowance is woefully inadequate to pay for haircuts, newspapers, clothing, toiletries, internet, outings, or even a greeting card. New York must increase this allowance to provide dignity and quality of life for nursing home residents.

D. Expand Essential Plan to Include Noncitizen Immigrants (A1710/S3762)

NYLAG applauds the recent expansion of the Essential Plan (EP) to cover those with incomes up to 250% FPL and state health coverage for noncitizens age 65 and over – and urges coverage of all undocumented immigrants in the EP. There are nearly one million younger NYS residents who do not have any form of health insurance coverage -- the "last mile" of achieving universal coverage that has significantly shrunk in the last decade.

In 2024, NYLAG's LegalHealth unit, a medical-legal partnership, helped 250 undocumented immigrants attain Medicaid eligibility by establishing PRUCOL status. Unfortunately, many more people do not get this help. Expansion of EP would give them crucial medical care with federal funds at no cost to the state. NYLAG helps immigrants like these obtain Medicaid, but lacks resources to help all who urgently need medical care:

- NYLAG obtains Medicaid for many immigrants by filing for Medical Deferred Action which secures PRUCOL status. This 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 aneurism. This care is not covered by Emergency Medicaid, the limited coverage available for undocumented immigrants.

- 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.

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

II. REPEAL AND REPLACE THE TRANSITION TO A SINGLE FISCAL INTERMEDIARY FOR CDPAP (S1189/A2735)

NYLAG strongly supports the repeal of last year's ill-conceived and rushed transition of 600+ Fiscal Intermediaries (FI) to a single FI. The Commissioner selected Private Partnerships LLC (PPL), a private equity backed corporation with a poor track record in other states with very small programs -- and *no experience* managing a CDPAP program for over 240,000 consumers.

At a minimum, the roll-out of the transition must be postponed to allow time for all consumers to transfer. Given the experience of other states, a minimum of two years is essential to avoid disruption of services. Pennsylvania transitioned from 36 FIs down to one in 2013. There, only 22,000 consumers were supposed to be

transitioned—less than ten percent of the number in New York State. Yet, even with that small population, about one-third of consumers failed in making the transition and lost services. Thousands of PAs were not paid, in some cases for months and quit.[2] In January 2024, Massachusetts set a timeline of 19 months to transition just 70,000 caregivers in its program to a new single FI. In stark contrast, New York's timeline of only three months to transition over 240,000 consumers and some 400,000 caregivers is both unrealistic and risky to the disabled people the program is designed to support.

It is not feasible for all New York's CDPAP consumers to transition to PPL by March 28, 2025. The transition process must postponed to protect CDPAP consumers from an abrupt discontinuance of home care services without due process. As of this writing, it has been reported that only approximately 35,000 consumers have *started* the enrollment process with PPL. It has been further reported that managed care plans have not yet completed the required contracts with PPL. Such contract negotiations could only start after January 6, 2025.

Many CDPAP consumers have not been notified of the requirement to transition to PPL as of the writing of this testimony. New York City residents as well as those on Long Island and Westchester, the vast majority of CDPAP consumers, must be formally informed of this process by **February 10, 2025,** leaving these consumers only 46 days to complete the transition.[3] The transition requires the consumer's current FI, which must cease to exist by April 1, 2025, to provide such notice unless they receive services from an FI transitioning to a PPL facilitator role. Many FIs are under a Temporary Restraining Order (TRO) enjoining them from sending such letters.

If the transition timeframe is not postponed, disabled and older New Yorkers who rely on this program to stay in the community will be harmed when their home care services stop. The current transition plan lacks any continuity of care for a consumer who is unable, even with their best efforts, to complete the enrollment process by March 28, 2025. Instead, they lose access to services and supports that keep them in the community. Some of these CDPAP consumers will require expensive interventions up to and including hospitalizations—all will be frantic and anxious. Meanwhile, the MLTC plans will be paid the monthly capitation amount, despite such

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[2] Commonwealth of Pennsylvania, Department of the Auditor General, *Performance Audit: Department of Public Welfare's Oversight of Financial Management Services Providers, November, 2013, available at https://www.paauditor.gov/Media/Default/Reports/speDPWPPL111413.pdf*.

[3] NYS Department of Health Memo dated Dec. 6, 2024, at p.3. Available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2024/docs/current_fi_transition_policy.pdf

members receiving no home care services. A transition process that protects consumers' care must be developed.

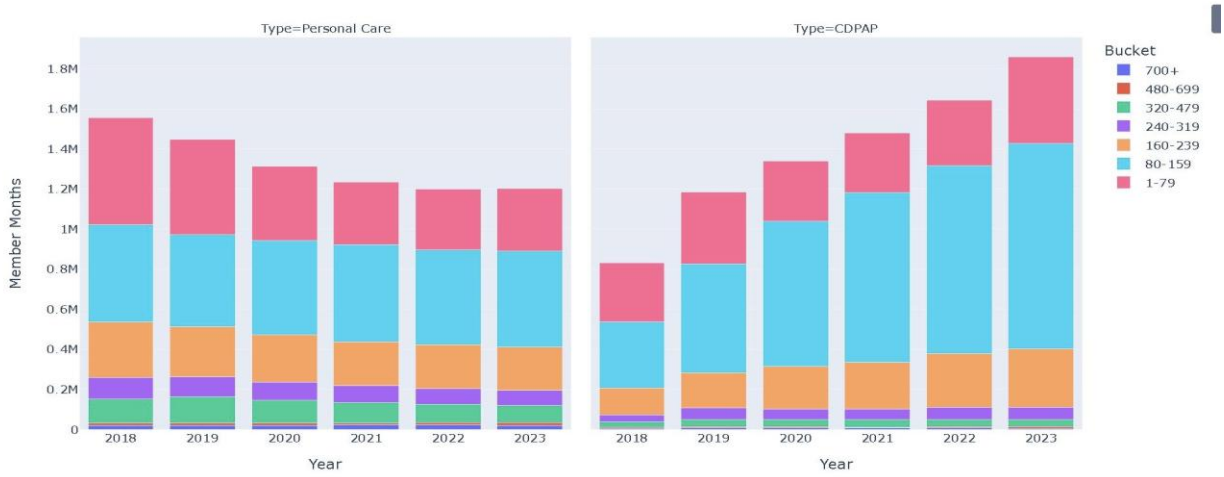
NYLAG calls for repeal of last year's law eliminating all FI's and engaging in the more rational process described in S1189/A2735 of selecting and licensing a reasonable number of FIs, to ensure choice for consumers and preserve the quality of service and cultural competence of experienced non-profit FI's.

The Commissioner has scapegoated the CDPAP program for the growth in MLTC enrollment. In doing so, the State ignores the root cause of this growth – the incentives created by the capitation system that motivate MLTC plans to recruit new members who need minimal home care services. MLTC plans receive a fixed Per Member Per Month premium for each of their members, so they want more members who need low-cost services. The plans make deals with their contractor FI's to recruit new enrollees who need relatively few hours of home care services and reward the FIs with higher rates.

The Table below shows that the CDPAP program grew significantly since 2020, mirroring growth in MLTC enrollment, which grew from 224,857 in January 2019 to 281,303 in Dec. 2023.[4] However, if this growth was spurred by CDPAP greed one would expect to see FI's recruiting prospective MLTC members who need high hours of care. This is because plans pay FI's for each hour a personal assistant works, and FI's keep part of that hourly rate. FI's would therefore make more money on cases receiving higher hours of care. However, in the chart below, the huge growth in CDPAP has been in low-hour cases shown by the turquoise and pink bars. These represent consumers authorized for 80-159 hours/month (20- 40 hours/week - turquoise bar), and 1-79 hours/month (under 20 hours/week - pink bar). The highest hour cases represented by the four colors at the bottom of the bars are for cases authorized for more than 240 hours/month (about 56 hours/week or 8 hours/day). The deep blue bar for the highest hours of 700+ month representing two 12-hour shifts is virtually invisible at the bottom of each year's bar. Those four high-hour bars had virtually no growth since 2019.

[4] MLTC enrollment data from NYS Dept. of Health Medicaid Managed Care Enrollment Reports at https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/. MLTC enrollment growth during that period would have been higher except that about 20,000 MLTC members were disenrolled because of being in a nursing home for more than 3 months, beginning in August 2020. See GIS 20 MA/06 – MLTC Enrollees Receiving Long Term Nursing Home Care – "Batch" Disenrollment Process) and http://health.wnylc.com/health/entry/199/.

Table 1. Number of Member Months Authorized for Seven Different Ranges of Hours per Month from 2018 – 2023 in MLTC plans.



Source: Medicaid Managed Care Operations Reports (MMCOR) filed by each MLTC plan on a quarterly basis. Thanks to Michael Kinnucan at Fiscal Policy Institute for data, obtained through a Freedom of Information Act request, and graph. [5]

The same table also shows that the number of "member months" in which Personal Care services, a Medicaid service distinct from CDPAP in which a Licensed Home Care Service Agency (LHCSA) coordinates aide services, decreased from 2018 to 2023. Some of the growth in CDPAP is because this service replaced Personal Care for many consumers, both because of individual preference and because of the staffing shortage that particularly affects areas outside New York City especially following the Covid pandemic. Consumers have reported that MLTC plans urge them to switch from Personal Care to CDPAP because the plan cannot find sufficient personal care staff.

This background about the growth of CDPAP shows that the real culprit in the dramatic increase in growth of MLTC is the capitation system. Without that, the incentives for FI's to recruit low-need consumers would disappear. Instead of blaming the network of FIs, many of which are mission-driven non-profit organizations, we support the bill S1189/A2735 to license FIs and further

[5] All years except for 2023 show annual data. The 2023 data is extrapolated from data reported for the first half of the year. Plans report much of the MMCOR data by "Member Month," which "is equivalent to one person for whom the plan has recognized capitation-based premium revenue for one month." MMCOR Instructions. This figure adjusts for turnover so that plans whose enrollees stay enrolled or receive certain services for shorter or longer periods can be appropriately compared. For example, if the plan gave the highest amount of 700+ hours/mo. of personal care to 100 members for 2 months in the year, it would be misleading to say that 100 members received 700+ hours of personal care. Instead, the plan would report it provided 700+ hours for 200 member months.

recommend that the entire MLTC program should be overhauled and replaced with a managed FFS program as proposed in last year's MLTC Savings & Reinvestment Act.

III. REJECT REPEAL OF "Prescriber Prevails" for Prescriptions (Part C)

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. What is different than in past years when this change was proposed is that since 2023, all Medicaid recipients who do not have Medicare must access prescriptions through the Medicaid Pharmacy Program (NYRx). This system lacks any procedure to appeal the denial of a prescription. When it rolled out NYRx, the Commissioner justified the absence of an appeal process by citing the "prescriber prevails" rule as sufficient protection for consumers. As a basic matter of due process, "prescriber prevails" cannot be repealed without enacting an appeal process for NYRx denials.

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. 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.

IV. REJECT REPEAL OF ENHANCED QUALITY OF ADULT LIVING (EQUAL) PROGRAM FOR ADULT HOME RESIDENTS (Part H § 1, repealing Social Services Law § 461-s).

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.

V. REJECT ALLOWING CERTIFIED MEDICATION AIDES IN NURSING HOMES (Part V, Subpart A, Sec. 1)

We oppose allowing certified medication aides to administer routine medications including insulin injections to nursing homes residents. Though the law requires that administration be under the supervision of a registered nurse, we are skeptical that -- with the nursing and aide shortage -- meaningful supervision is possible. We are concerned about resident safety – both because of medication errors and because

aides now redeployed as certified medication aides will reduce the availability of regular aides to assist with daily needs.

We are disappointed that the Governor did not repeat her proposal from last year expanding the scope of tasks allowing Direct Support Professionals working in the OPWDD waiver in community settings to perform certain nursing tasks. In the community expanding the scope of tasks for DSPs would increase independent living options for people with Developmental Disabilities, who are otherwise forced to remain in institutional settings. In either setting – nursing homes or the community- this change 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.[6]

Allowing medication aides in nursing homes, however, does not further the goals of living in integrated settings in the community and puts residents at risk.

VI. QUALIFIED SUPPORT FOR CARVING LONG-TERM NURSING HOME CARE OUT OF MAINSTREAM MANAGED CARE (Part E, Sec. 2)

NYLAG gives modified support for the Executive budget proposal to remove long-term Nursing Home care ["LTNHS"] (defined as more than three months) from the Medicaid managed care benefit package (Part E, Sec. 2). The justification given is to align mainstream managed care with Managed Long Term Care, from which LTNHS was carved out starting in 2020. NYLAG strongly opposed carving out LTNHS from the MLTC benefit package because it incentivizes MLTC plans to push high-need members into nursing homes and/or refuse to provide the increased home care services members may need in order to return home. After 90 days in the nursing home, the member is disenrolled from the MLTC plan – relieving the plan of a member who needs high hours of care. For mainstream plans, however, there have always been financial incentives for plans to permanently place a high-needs member in a nursing home. Since Nursing Home care was added to the mainstream benefit package in 2015, plans have received a supplemental payment called a "rate cell" to pay the extra cost of permanent nursing home care after 60 days. MLTC plans did not receive this extra payment.

Given that mainstream plans already had an incentive to approve nursing home care instead of home care, we do not oppose carving out LTNHS from the benefit package. However, the proposed Article VII bill language should be strengthened that states, "In implementing this provision, the department shall continue to support service

[6] Chapter 471 of the Laws of 2016; https://www.health.ny.gov/facilities/home_care/advanced_home_health_aides/.

delivery and outcomes that result in community living for enrollees." The statute should specifically require policies and incentives encouraging plans to approve home care where needed to prevent or shorten a nursing home placement. Examples are:

- Retain and improve the incentive payment now paid to mainstream plans if they transition members home from a permanent nursing home placement with home care services successfully, defined as for at least three months.[7] We recommend that this rate increase should be paid for at least a year, rather than just three months as the contract now provides. Data should be made public showing each plan's track record in transitioning members to the community from nursing homes, in furtherance of rebalancing goals and plan accountability.
- Members who are dis-enrolled because of a long-term nursing home stay should have the same right to re-enroll and resume home care within 6 months of the disenrollment that applies in MLTC.
- Plan should send notice to the member and their designated representative of the plan's determination that a nursing home placement is "permanent," with the right to appeal and maintain MMC enrollment. The notice should explain how to request an assessment for services needed to return home.

VII. QUALIFIED SUPPORT FOR AUTHORIZING COMMISSION TO PENALIZE MCO'S THAT FAIL TO MEET STANDARDS (PART E SEC. 3) AND SUPPORT FOR THE MLTC DATA TRANSPARENCY ACT (S 707/A700)

Increased oversight and penalties against MLTC and other managed care plans for failing to comply with their contracts and governing law are long overdue. Consumers and their advocates must be included in any commission that determines which standards merit enhanced penalties. Beyond these penalties, NYLAG strongly **supports the MLTC Data Transparency Act (S 707/A700**) that would greatly improve public accountability for how MLTC plans spend billions in public dollars. The Act incorporates many evidence-based quality measures long recommended by the federal Medicaid agency CMS, such as performance metrics for the maximum wait time for home care services to be initiated after authorization, and tracking times with no services delivered[8] -- especially important in light of the workforce shortage.

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[7] Medicaid Managed Care Model Contract, Sec. 3.21(d) (March 1, 2024) available at https://www.health.ny.gov/health_care/managed_care/providers/docs/mmc_fhp_hiv-snp_harp_model_contract.pdf

[8] *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-

The bill would also track progress in meeting goals of keeping people out of nursing homes. Regional differences would be illuminated in access to care. The Act would also make public data on claim denials, outcome of appeals, etc. Importantly, the data in Table 1 on page 7 above, showing the proportion of MLTC members who receive the lowest and highest amount of hours and ranges in between, would be made public broken down by plan and region, allowing a true comparison between plans. See NYLAG's Memorandum in Support of this bill posted at http://health.wnylc.com/health/file/858/?f=1 for more info.

In the last few years, both federal and state agencies have issued reports criticizing the lack of adequate oversight of MLTC plans in NYS:

- 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. [9]
- 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.

The Act would adopt many recommendations made by these government watchdogs and in NYLAG's MLTC Transparency Project.[10] 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

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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.

[9] *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.

[10] *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.

otherwise not eligible for MLTC. See n. 7. 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*. Yet, the Commissioner of Health failed to adopt any accountability measures to address the Comptroller's concerns, and Gov. Hochul vetoed a previous bill that would have required some transparency about home care usage. A1926/S1683. The sanctions proposed by the Governor are too little too late, but are urgently needed as long as the MLTC program remains. We further urge that the MLTC program be replaced entirely with a different model, as proposed in the **Home Care Savings & Reinvestment Act (A2018).** See Part IX below.

VIII. SUPPORT CONTINUED FUNDING OF THE MANAGED CARE CONSUMER ASSISTANCE PROGRAM (MCCAP)& INCREASE FUNDING TO MEET NEED

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.

IX. REPEAL & REPLACE MLTC MODEL WITH MANAGED FEE FOR SERVICE – ENACT HOME CARE SAVINGS AND REINVESTMENT ACT (A2018)

NYLAG strongly supports the Home Care Savings and Reinvestment Act (A2018) 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 who must fight MLTC plans that routinely deny enough hours of Medicaid home care to remain safe in their homes. Consumers who, because of dementia, Parkinson's Disease, stroke, and 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 harm at home – or stuck in a nursing home unable to leave without adequate care at home. Either way, 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 to include 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 or the wherewithal to appeal, or lose their appeals when up against an insurance company's lawyer. Those who can navigate the system win, especially with an experienced advocate.[11]

As shown in Table 1 on page 7 explaining our opposition to the Single FI CDPAP transition, the 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. When plans deny needed high-hour care, forcing members into nursing homes, 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.*

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).[12] 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

[11] 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.

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

Living with $69 million, then Fidelis, Integra, Healthfirst, and Wellcare with net revenue over $30 million.[13]

Managed Fee for Service is a Better Way. The 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.

At a Minimum – enact the MLTC Data Transparency Act (S 707/A700). See Part VII above.

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

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[13] 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.