

Testimony of Art Byrd:

Governor Cuomo's establishment of the Medicaid Redesign Team (MRT) in 2011 launched a crucial effort to realign healthcare spending while improving outcomes for all New Yorkers. By tying compensation to patient outcomes, the MRT's initiatives aimed to elevate care and quality while rewarding the providers committed to delivering it.

During my time as CFO of EmblemHealth, I had direct exposure to the MRT's early evolution, as our CEO Frank Branchini was a founding member. This gave me firsthand insight into the group's intent to transform Medicaid into a more efficient, outcome-driven system.

Many of those early MRT initiatives were forward-thinking: the New York State Diabetes Prevention Program, Electronic Visit Verification, and expanded home- and community-based services, among others. These efforts helped set a foundation for high-value, patient-centered care.

Unfortunately, as with any broad policy shift, good intentions can be compromised by implementation gaps. While the vast majority of providers act in good faith, a small number of bad actors have made oversight difficult and undermined confidence in the system. That small group creates outsized risk and makes it harder for responsible providers to do their jobs.

Speaking on behalf of three large Certified Home Health Agencies serving approximately 60,000 patients annually in a geographic area where nearly 12 million residents across the lower eight counties of New York live, we take our responsibility seriously. We view ourselves as thought partners to the State, aligned in our mission to provide cost-effective, high-quality, compliant, and compassionate care.

Still, the current structure of home care programs isn't delivering on the commitments made under MRT I and II. Accountability measures haven't kept pace, and the transition to a single fiscal intermediary model in CDPAP has introduced new risks without solving the old ones.

We know that many patients both want and need care outside of institutional settings. Home-based care leads to faster recovery, greater comfort, and significantly lower cost benefits that directly support the State's healthcare budget.

But delivering that care has become more difficult. Post-COVID workforce shortages in nursing and therapy have forced us to rely more heavily on LPNs, PTAs, and OTAs. Self-directed care through the Consumer Directed Personal Assistance Program ("CDPAP") has been a critical tool to meet demand, especially for lower-acuity patients.

The intent of CDPAP is sound. As the Department of Health outlines, CDPAP was designed to empower chronically ill and disabled individuals to manage their care with greater flexibility. But in practice, two major breakdowns occurred: first, financial oversight was offloaded to payers; second, compliance enforcement among over 500 fiscal intermediaries was lacking. These gaps allowed some entities to misuse program funds or cut corners on care.

Putting payers in the middle may have eased an administrative burden for the State, but it also enabled them to divert 10 to 15 percent of plan dollars toward their own operating expenses and profits. That is money that should be going to care.

Unfortunately, rather than addressing the real issues with the program, the solution promulgated in the 2024 Budget was an aggressive overcorrection, forcing approximately 300,000 caregivers and recipients to transition to a single provider on an extraordinarily truncated timetable. Over 1.5 million individuals receive care through self-directed programs across the United States. New York's CDPAP program is by far the largest program of its kind. Given the inherent complexities of a diverse population speaking myriad languages and coming from even more cultural backgrounds, a more measured approach was warranted. More importantly, given the lessons that we have learned over the past decade and a half as we transitioned Managed Medicaid, having a diversity of providers is an essential element of driving good behavior and creating healthy competition while providing critical patient choice. Regrettably, this was not contemplated and we have been seeing the real like implications of a single provider through countless service failures, gaps in care and the resignation of an executive at the sole provider.

Now, fast forward to 2025 and what the recently passed OBBBA means to the State of New York. We know that any reduction in federal funding will have significant pressure on the healthcare system in New York and the need to balance available dollars will be even more important. We also know that diverting healthcare resources away from very costly inpatient, ED, and nursing home settings into much more cost-efficient settings like home health will save the State significant dollars and lead to better patient outcomes.

We believe the State should reassert direct oversight of the program and set robust, enforceable standards for caregivers and fiscal intermediaries. Success should be measurable, and funding should follow performance. More importantly, success must include multiple providers and put the power back in the hands of the consumer – the fundamental tenant of self-directed care.

This vision is consistent with Senate Bill 1189 and Assembly Bill 2735, both of which would repeal the single-FI model and replace it with a licensure framework rooted in transparency, accountability, and outcomes.

Done right, CDPAP can remain a cornerstone of patient-centered care in New York—but only if we hold all partners to the same high standard.