CONSUMER DIRECTED ACTION OF NYS

BUILDING SELF-DIRECTED POWER

New York State Senate Joint Hearing on Consumer Directed Personal Assistance Program

Committee on Health, Senator Gustavo Rivera, Chair
Committee on Investigations and Government Oversight, Senator James Skoufis, Chair

Testimony of:
Bryan O'Malley
Executive Director

Senator Rivera, Senator Skoufis, and all of the Senators here today, thank you for holding and participating in this critical hearing, and thank you for continuing to be a voice highlighting the problems with the switch to PPL as the state's monopoly provider in consumer directed personal assistance, or CDPAP. As we look at the transition to determine what went wrong, it is critical to also examine how we got to where we are. In doing so, we must look at what the stated rationale and goals of the transition were and determine not only whether it has so far met the goals, but whether the rationale was and is strong enough to merit a change of this magnitude.

As this examination is conducted, some undeniable facts must be established. First, we must acknowledge that long-term care is expensive. According to Kaiser Family Foundation, while seniors and people with disabilities make up approximately 20% of the Medicaid enrollment in New York, they account for an estimated 70% of spending.

Of course, part of this expense is due to the fact that community-based long-term care is an effective treatment option. While those in need of long-term care do not get better, the use of CDPAP and home care dramatically increase life expectancy. One study by United Hospital Fund was able to track stable levels of deterioration over a 15 year period among those receiving personal care through Medicaid in New York. Another study found those in nursing homes had a mean life expectancy of five months. This efficacy, while it should come as a policy goal,does mean community-based care options do increase costs.

Second, as the aging population in New York continues to grow, the cost of long-term care services will only continue to grow. The Center for an Urban Future notes that, while the state's under-65 population decreased by 2.6% from 2011-2021, the number of New Yorkers 65 or over increased by over 815,000, a jump of almost one-third. The over-85 population also saw an increase of 1.3%, meaning it also grew at a faster rate than the population as a whole.

Third, not only is the state getting older, the number of those 65 and older living in poverty is growing. Again, the Center for an Urban Future states that 1 in 8 New Yorkers over 65 is living in poverty. This fact does not only mean these New Yorkers will increasingly be eligible for services through Medicaid. The realities often faced by those who live in poverty, such as food insecurity, housing insecurity, more physically demanding employment, and more, mean they are much more likely to require supports offered by home care and other long-term care services.

Together, these facts illustrate that we must do a better job of budgeting for and providing the long-term care services the state has time and again proven committed to providing. Because as the population continues to age, and that aging population wants to live in the community, increasingly that older population will require home and community-based services, utilizing those services for longer and longer periods of time.

With these facts in mind, the state must determine how to deliver these services in the most cost effective manner possible. In 2013, the state realized that this meant working within managed long-term care to prioritize the use of consumer directed personal assistance, or CDPAP. In *The*

Report and Recommendations of the Olmstead Cabinet, the state identified that among the quality criteria that would be used in implementing its new at the time managed long term care program would be a determination of whether it would "offer consumer-directed services as the first option for plan enrollees."[1]

At this time, the state also made a conscious decision, against the wishes of CDPAANYS and other advocates, to allow as many fiscal intermediaries into the market as it could support. In 2013, CDPAANYS proposed to the Department of Health a licensing plan that would have kept the number of fiscal intermediaries at the level that had been in place in fee for service.

At the time, there were approximately 68 FIs operating throughout the state. Two agencies, Concepts of Independence and Chinese American Planning Council, were the FIs for New York City. With a requirement that managed care organizations contract with at least two entities, DOH determined that the most cost effective means of providing the service on a broad scale was to offer it through as many agencies as wished. By flooding the market in this manner, DOH allowed the managed care organizations to lower the overall cost of reimbursement.

Thus, when Governor Hochul and the Division of Budget complained that CDPAP had grown too large and that there were too many FIs administering services, they failed to note that this was not a policy error - it was the successful achievement of a policy goal.

As of January 1, 2024, using information from DOH about how their managed care rates were developed, CDPAP was $3.34 per hour less expensive than traditional, agency-based personal care in the wage parity region including New York City, Nassau, Suffolk, and Westchester. Across the rest of the state, it was $10.87 per hour less expensive.[2]

When we look at that across the spectrum of people using the service, we can begin to get a better understanding of the true picture of costs. According to the State's request for proposals in relation to a single, statewide fiscal intermediary, the breakdown of CDPAP usage across the state was predominantly focused in the wage parity region, with about 15% of services delivered outside the New York City Metro area.
Further, while the number of hours in the wage parity region comprised of the New York City Metro area were slightly lower than those in the Lower Hudson Valley, when the Rest of State hours were averaged, they came to approximately 28 hours per week.

Region	% of total consumers per region	Avg. hours/week

[1] New York State Office of People With Developmental Disabilities. 2013. Report and Recommendations of the Olmstead Cabinet… Prepared by Roger Bearden, Special Counsel for Olmstead. Accessed on August 15, 2025. https://www.criminaljustice.ny.gov/opca/pdfs/9-Olmstead-Cabinet-Report101013.pdf
[2] New York State Department of Health, "Home Care Worker Minimum Wage Webinar" (PowerPoint presentation or webinar slides, New York State Department of Health, December 13, 2023), PDF file, accessed August 15, 2025, https://www.health.ny.gov/health_care/medicaid/redesign/mrt61/docs/2023-12-13_hcw_min_wage_webinar.pdf.

New York City Metro	84.55%	30
Lower Hudson Valley	3.25%	33
Northeast/Western	8.54%	28
Rest of State	3.66%	25

Using these numbers supplied by DOH, we know that of the 280,000 people receiving CDPAP, approximately 238,000 were in New York City, Nassau, Suffolk, and Westchester counties while 42,000 were located across the rest of the state.

The 238,000 consumers in New York City utilized approximately 7.1 million hours per week combined, and 321.25 million hours per year.

The 42,000 consumers across the rest of the state utilized approximately 1.2 million hours per week, and 61.2 million hours per year.

At a savings of $3.34/hour compared to personal care services delivered by a licensed home care services agency (LHCSA), consumers using CDPAP in New York State as of January 1, 2024, were saving New York's Medicaid program $23.85 million per week, or $1.25 billion per year.

For those consumers not in the wage parity region, their use of CDPAP saved the state $12.75 million per week. Over the course of a year, this amounted to $664.75 million.

This means that statewide, CDPAP was saving New York's Medicaid program almost $2 billion annually. Because it is critical to remember that CDPAP was not driving the growth in need for long-term care - the state's aging and impoverished population growth was. We know this because, while many FIs did advertise their services, it was the State that determined eligibility for the program.

The Legislature, working with the Governor, establishes clear eligibility criteria for all Medicaid programs. The State's vendor, New York Medicaid Choice, operated by Maximus, conducts an assessment of almost every individual wishing to utilize long-term care services to ensure that they meet the guidelines established. If New York Medicaid Choice makes a positive eligibility determination, a managed long-term care plan conducts another assessment to determine if the individual is eligible for CDPAP or LHCSA services, authorizing those services and the number of hours to be provided. It is only once the authorization is provided that the FI is involved, registering the consumer's workers so that services can begin.

Since the State establishes the eligibility criteria, a determination can be made that the goal is to provide services for all of those currently receiving them. Therefore, the use of CDPAP was critical in helping to meet the goals of the state - namely, to provide those services as inexpensively as possible.

Thus, to determine the effectiveness of not only the transition to PPL, but the policy, we must determine whether or not that policy, and the subsequent transition, met the stated goals.

Throughout the process, Governor Hochul reiterated that this was necessary because CDPAP cost $9 billion and was growing too quickly; there were too many FIs and the system was inefficient; and many of those FIs were committing fraud and/or wage theft.

Each of these, if accurate and in context, is a valid reason to move forward with a policy change of this sort if that change will address the condition. But, Governor Hochul's statements often were not accurate or in context.

CLAIM 1 - The system was inefficient because of too many FIs. Governor Hochul repeatedly cited that there were over 600 FIs and the system was too large to be efficient, citing California, which she routinely said had only one fiscal intermediary for the entire state.

Over the course of a year, the Governor time and again stated that New York had too many FIs. She said it was her job to fix a mistake in how the program was allowed to develop. She indeed never stated why having as many FIs as New York has was a negative; the implication was that one entity could achieve greater savings through efficiency - an efficiency that even having one competitor would not allow.

Reality - Competition improved efficiency and offered additional benefits. First, to address a factual error. California does not have only one fiscal intermediary for the entire state. The system in California allows for a single, county run fiscal intermediary to operate in each county as an authority. This means that the state has 58 different fiscal intermediaries, each able to work in and relate to the residents of their particular county in a large, diverse state.

While New York's system still had significantly more than 58 fiscal intermediaries, and even more than one per county, we must recall that was by design. The Department of Health intentionally built a system that relied on a large number of fiscal intermediaries to increase the leverage of managed care plans by watering down the pool of agencies.

This resulted in a system that had an added benefit. While there were large fiscal intermediaries that operated across the state, a region or regions, or just across New York City; there were also numerous agencies that operated in small portions of a borough, working explicitly with particular languages and cultures. This type of culturally and linguistically tailored approach, from individuals in the community that consumers know and trust, is the gold standard of service delivery. It increased service takeup because people had a relationship with the agency and knew they could be trusted. That unintended side effect of the Department's original policy choice from 2013 led to the robust network of providers serving this group.

But was this the most efficient way to deliver services? We know that rates were substantially lower than the rates paid to LHCSAs for less service. But CDPAANYS member reports from the

time reported that the agencies generally operated on administrative margins that were much lower than any other sector. After personal assistant fringe benefits were calculated, most agencies were operating between 3-5%. The smallest agencies typically had the largest percentage of revenue as an administrative expense; but, that was due to the relatively small size of their budgets and the large expense that PA fringe would add to it. In fact, many FIs reported plans reimbursing FIs approximately $25 - $26 per hour in New York City, a rate that was below cost and is less than PPL is purported to receive today.

CLAIM 2 - CDPAP was one of the most fraud-ridden programs ever. Possibly the Governor's most oft-repeated line in support of the shift to PPL was that CDPAP as it existed was one of the most fraud-ridden programs ever. She would routinely make this claim, a popular one amongst those who wish to cut Medicaid. However, like National Republicans seeking to cut Medicaid, Governor Hochul was always short on details.

The Governor did produce anecdotes - a woman who was arrested on a cruise ship in 2020 and an agency that had entered into a settlement regarding wage theft almost a decade prior; but by and large the facts did not support for the Governor's claims.

As time went on, her claims became less grounded. For instance, after CDPAANYS obtained a temporary restraining order against her demand to transfer protected health information to PPL, the Governor would routinely state that FIs complying with the order were in violation of the law. She even asked the Attorney General to investigate FIs and other entities who were challenging her proposals.

Reality - CDPAP had low amounts of fraud and violations of worker rights have only increased under PPL, with no accountability. CDPAP is one of programs with the least fraud. FIs administer a benefit for consumers and support them in their efforts. They do not provide a benefit, nor do they authorize one. This dramatically limits the areas where a FI could commit fraud. Further, with consumers controlling all aspects of their services, a consumer would have to go without needed services to allow their worker to commit fraud on any kind of scale.

Indeed, Governor Hochul's claims were not even supported by her own Medicaid Inspector General. Prior to the shift to PPL, over 80% of the fiscal intermediaries that were audited by the OMIG received completely clean audit reports. Of those who had findings, the findings were errors that, after OMIG extrapolation, amounted to less than 1% of billed claims.

Even after an exhaustive investigation into purported fraud by both DOH and PPL during a period when the transition was in shambles and one would have thought efforts of both entities might have been focused there, the two were only able to report billing for 30 consumers who were dead and 5 who were hospitalized - or 0.01%.

What we do know is that, since the transition, fraud and abuse of worker rights has been rampant at PPL with wage theft, a failure to provide required sick time, and actual theft.

However, the Governor's response to these claims has been much different - shielding PPL from accountability at every point. When CDPAANYS and other advocates facilitated PAs use of the Department of Labor to complete wage theft forms, instead of meaningful reform or transparency, DOL quietly removed the ability of workers to call their offices for assistance with the completion of a wage theft report.

Similarly, not only did the Governor and DOH not hold PPL accountable for wage theft, they often seemed to be active participants. In a DOH issued press release that ironically quotes Commissioner McDonald as saying the partnership with PPL allows for a more "accountable" system, they go on to state, "Also as of May 15th, 198,000 personal assistants – about 98 percent of those fully onboarded – had successfully submitted timesheets and been issued a paycheck from PPL."[3]

Even if we accept the DOH's claims that all but 2% of the approximately 218,000 workers - or almost 5,000 workers - have been paid, New York wage and hour law does not allow for mistakes in this manner. Failure to issue timely payment for one worker is wage theft - a class E felony. Failure to issue timely wages for almost 5,000 workers is therefore a systemic violation of worker's rights, not something that DOH should be bragging about in a press release.

PPL's abuses do not end there. New York law requires workers to receive between 40-56 hours paid sick time per year. PPL only provides workers with accrual for five days of paid time off, which must be scheduled ahead of time.

These failures to comply with basic Labor law is something that the Governor, her DOH, and her DOL should be investigating. Either failure represents, by itself, reason to invalidate the contract. In fact, I have asked multiple state vendors across multiple sectors if their contracts would be retained if they engaged in similar behavior, and all of them had no doubt it would not.

CLAIM 3 - CDPAP was growing too rapidly and was unsustainable. As established, the growth in CDPAP was by design. With a rapidly aging population living in poverty, the population needing home and community-based services and qualifying for Medicaid was dramatically increasing. The State's policy was to prioritize provision of these services through the least costly means possible, which meant CDPAP.

This was furthered by a workforce shortage among personal care aides (PCAs) and home health aides (HHAs) in both LHCSA and certified home health aide (CHHA) services. This shortage meant that many seeking to use traditional, agency-based services could not be served by those services. However, the ability of consumers to hire friends and family in CDPAP meant that they could receive home and community-based services through this program.

---

[3] "CDPAP Update: State Department of Health Provides Data on Number of Consumers and Personal Assistants Registered With Statewide Fiscal Intermediary Ahead of June 6 Deadline." New York State Department of Health. May 19, 2025. https://doi.org/May 19, 2025.

The growth and economic shift of the aging population combined with the economic demographic data regarding New York's aging population demonstrates that the growth should have been expected and applauded as policies that are proving effective. Indeed, a report from Fiscal Policy Institute verified this. It looked at the growth in CDPAP combined with agency-based LHCSA services and determined that the two programs together demonstrated that home and community-based services usage overall had grown by just 3.9% over the previous six year period[4], consistent with the rate of growth of the aging population, particularly when the decline in economic resources is factored in for that population.

Reality - The transition has increased costs. The shift to PPL was supposed to save money. The budget attributed $500 million in state share savings to the switch. However, by the State's own admission, 80,000 consumers who used CDPAP have switched their services to LHCSA rather than make the switch to PPL,[5] a dramatic reversal from the policy goals of the state in 2013.

Using the previous numbers, the 80,000 consumers who have begun to receive services through LHCSAs will cost the state $550 million.

However, that is not where the costs end. The state, which was requiring PPL to implement a transition plan, was forced to pay dozens of state employees to facilitate the transition of consumers to PPL from their previous FI.[6] This meant substantial hours of overtime were paid by the state to facilitate an award that the contractor was contractually obligated to provide for itself.

Costs have also increased even further because, instead of driving reimbursements down, as promised by Governor Hochul, the switch to PPL has seemingly increased those costs. In a letter to Medicaid Director Amir Bassiri, the Health Plan Association, the Coalition of New York State Public Health Plans, LeadingAge New York, and the Home Care Association of New York State, on behalf of the managed care plans they represent, stated, "PPL has insisted on reimbursement rates for the Direct Care Service Costs that are higher than what is contemplated by the current plan capitation rates and **higher than what plans now pay**."[7]

As the letter notes, PPL is only permitted by the terms of their contract to bill the plans for direct care costs. Notably, those direct care costs have, in most cases, decreased since almost all PAs

---

[4] Kinnucan, Michael. *How Fast is New York's Home Care Program Growing.* Fiscal Policy Institute. Accessed on August 18, 2025, https://fiscalpolicy.org/how-fast-is-new-yorks-home-care-program-growing

[5] Jefferson, Austin. "DOH and PPL Identify Fraud in Previous Home Care Program." *City & State*, July 30, 2025. https://www.cityandstateny.com/policy/2025/07/doh-and-ppl-identify-fraud-previous-home-care-program/407081/.

[6] Justin, Raga. "State Workers Asked to Assist with CDPAP Transition." *Times Union*, March 26, 2025. https://www.timesunion.com/state/article/state-workers-asked-volunteer-assist-cdpap-20242202.php.

[7] Health Plan Association, LeadingAge New York, Coalition of New York State Public Health Plans, and Home Care Association of New York State. Letter to Amir Bassiri. Albany, NY, January 7, 2025.

report receiving a wage cut. However, despite this, and with the knowledge and support of the DOH, PPL is billing plans more than those plans paid the FIs under the previous system.

Where are new cases?

Apart from the claims DOH and PPL have made is an interesting claim they have not made. In June, 2024, Commissioner McDonald noted that CDPAP had approximately 280,000 consumers. Over the course of the past year, numbers have continued to focus on those 280,000 people. Indeed, in their most recent press release, DOH spoke of the fact that 200,000 people successfully transitioned and approximately 80,000 changed their services to LHCSAs.

This begs the question - has nobody new entered the program since June, 2024?

If they have, and reports, including conversations with representatives of health plans indicates they have, where are they? How many new people entered the program? What does that do to DOH's numbers regarding the transition?

For instance, even if we assume 5% growth over the past year, that would mean 14,000 people began using CDPAP. Since the numbers published by DOH are still working off of those continually published, that is 14,000 people who are completely unaccounted for in the transition. It is 14,000 people who DOH says transitioned properly, but who in reality started using services with PPL.

The failure to present this new data not only creates new questions about the efficacy of the model, it calls into further question all of the Governor's claims of increased transparency and accountability.

Conclusion

Franklin Foer, a journalist with *The Atlantic*, once said, "Monopolists always defend their monopolies by arguing that competition is wasteful. When the railroad barons completed their monopoly, they argued it would be wasteful to have competing rail lines, AT&T said the same thing. But today, the size and scope of these monopolies is different."[8]

PPL and the Governor would continually have you believe that a monopoly is necessary for CDPAP in New York because anything else is wasteful.

They would have you believe CDPAP was full of fraud and PPL fixed it.

They would have you believe the entities that had been administering CDPAP and supporting consumers for almost 25 years exploited workers and that only PPL could fix the system.

---

[8] Franklin Foer Quotes. BrainyQuote.com, BrainyMedia Inc, 2025. https://www.brainyquote.com/quotes/franklin_foer_855705, accessed August 19, 2025.

They would have you believe that CDPAP was an out of control health program that was growing at speeds unreasonable relative to demographics, and only PPL could slow the growth.

But we know the truth. These were lies masked as rhetoric and PPL, like all monopolies, serve the interests of PPL and its owners the private equity backers in Linden Capital and DW Healthcare and Public Consulting Group and its executives. Like any good monopolist, PPL serves the interests of the monopolist. They are profiting off the shift to a single FI and Consumers, workers, and the State of New York are losing.