Testimony of the New York Health Plan Association

to the

Senate Health, Investigations and Government Operations Committees

on the subject of

Consumer Directed Personal Assistance Program (CDPAP)

August 21, 2025

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 20 health plans that provide comprehensive health care services to nearly 11 million fully-insured New Yorkers, including 18 plans participating in Medicaid managed care and managed long-term care (MLTC), appreciates the opportunity to present its members' views on the Governor's budget proposals.

For the past three decades, New York's managed care plans have partnered with the State, establishing and growing the extremely successful Medicaid managed care program, working together to expand coverage, increase access and improve quality of care. With plans' leadership, New York's Medicaid managed care program routinely meets or exceeds the national average on quality measures and improving patient satisfaction. Today, nearly five million of New York's Medicaid beneficiaries — approximately 70%, receive their care through a Medicaid managed care plan. For 30 years, plans have successfully implemented many significant population and benefit transitions into managed care, working collaboratively with the State and other stakeholders.

The growth of the consumer directed personal assistance program (CDPAP), which drove the transition to a single fiscal intermediary (SFI), has largely been a consequence of state policy – not the actions of the plans. Plans operate under a contract with the State, in addition to extensive regulatory requirements and other policy guidelines – all outlining compliance requirements. The State has broad existing oversight and audit authority – along with the ability to penalize plans for not following State policy requirements. For CDPAP and personal care services provided by a licensed home care services agency (LHCSA), the state determines eligibility for the services and performs the initial assessment of eligible individuals – not the plans. Plans are obligated to provide services to eligible individuals. When CDPAP utilization began to grow after the first Medicaid Redesign Team (MRT) expanded the program, the plans alerted DOH to their concerns about the rapidly growing cost. As CDPAP costs grew, we have

suggested improvements to the program, including changes to administrative reimbursement for FIs, limiting the number of FIs and requiring submission of cost reports to be audited by DOH.

Aggressive Implementation and Delays

The implementation timeline for the transition to an SFI in CDPAP, enacted as part of the FY25 budget, was overly aggressive and too compressed to avoid disruption for the thousands of individuals who rely on CDPAP to remain independent. Historically, Medicaid transitions of this magnitude and complexity never take place in this short a timeframe. For example, the move to mandatory MLTC took place over several years and was done by region. The carve-out of pharmacy from managed care was transitioned over a full year, with clear guidance from the New York State Department of Health (DOH).

Our primary concern with the SFI transition has been – and will continue to be – making every effort to avoid disruption to the care of approximately 250,000 members rely on CDPAP to remain independent and safe in the community. Since last year, plans have worked diligently and in good faith with DOH and its chosen contractor, Public Partnership LLC (PPL) to implement the SFI initiative. However, the aggressive implementation and delays in execution of the contract between DOH and PPL meant that plans were unable to begin working on their own contracts with PPL until very late in 2024 and without understanding the plan rates for the contracted period. The operational work of the transition didn't begin in earnest until early 2025 for an April 1 implementation date and was marked by a great deal of confusion and misinformation.

PPL Readiness & Impact on Plans

The plans' contracting process was slowed by PPL's demand for significant funding advances and its efforts to shift operational responsibilities of the CDPAP program, which

appropriately belong to the FI, onto plans, indicating that PPL was neither financially nor operationally prepared to manage the transition of a CDPAP program the size of New York's. As a result of the lack of PPL's operational readiness, DOH requested support from the plans for the initial implementation period.

The demand for advance payment was described as necessary to allow PPL to be able to cover payroll for the personal assistants (PAs) in CDPAP. While the demand was rescinded for smaller plans, larger plans were expected to comply. In aggregate, we believe the amount of the advances was in the hundreds of millions of dollars. With PPL's undue leverage as the single FI, the demand for advances also came with no willingness to provide contemporaneous security of the advances, with no timeline for repayment and little recourse for plans to recover the advances if PPL experienced financial challenges.

In addition to financial readiness concerns, it was clear that PPL was ill-prepared to manage the operational requirements of the transition. As a result of PPL's difficulty in managing the process to both register eligible consumers and onboard their PAs, DOH requested that the plans administratively support the transition and oversight of the implementation process. Plans handled massive – but not entirely unexpected – increases in the volume of calls from members with questions, concerns and difficulties. Plans educated members on the process and corrected misinformation that workers and members had received from other sources. Members often reported difficulty registering themselves and getting their PAs onboarded with PPL. Plans have worked diligently for more than six months to facilitate member registration and PA onboarding with PPL, reporting to DOH when calls to PPL had extensive wait times, were not answered or were not returned.

By the end of February 2025, only a small percentage of CDPAP consumers had been registered with PPL with their PAs fully onboarded – with plans required by DOH to end all prior FI contracts on March 31st. Plans were instructed to reach out to members who were not

fully registered in PPL's system along with their PAs, but did not have the necessary information from PPL to perform such outreach appropriately and efficiently – notwithstanding that plans had been submitting CDPAP member data to PPL since the beginning of 2025. Data that came back to the plans from PPL's system was often inaccurate and sometimes completely missing, requiring significant resource investment on the part of the plans to understand where their members were in the enrollment process. In addition, reporting from PPL on status of consumers and PAs was unclear. Processing problems continued, requiring DOH to provide a "grace period" after April 1st to allow PPL to continue to register and onboard consumers and PAs, all with significant ongoing support and effort from the plans. Given these issues, it is unclear at this time how payment reviews and audits will be conducted by the Office of Medicaid Inspector General.

With the preliminary injunction issued under *Engresser et al v. McDonald*, the administrative burden on plans expanded to get consumers and their PAs fully enrolled in PPL. This included expanded requirements on plans for frequent and ongoing outreach to members who had completed their registration but did not have a PA onboarded and to members who were not registered and had no PA onboarded. Very frequently members indicated to their plan that they had been trying to register and/or that their PA was trying to complete the onboarding process but were having difficulty with PPL. The plan outreach requirements also had to be reported frequently to DOH.

The *Engresser* preliminary injunction also required the State to allow consumers who had not registered with PPL and/or did not have a PA fully onboarded with PPL to go back to their prior FI – requiring plans to re-establish terminated contracts with FIs and move authorizations from PPL back to the prior FI. During this time, many consumers chose to move their care from the CDPAP program to a personal care worker through a LHCSA, which has been extremely difficult for plans to manage, especially upstate where 90% of personal care is provided through CDPAP and there are very few LHCSAs. More recently, many plans noticed

that the PPL was not adequately monitoring PA hours, with many consumers facing situations where they would run out of hours of care before their authorizations ended. We expect that the additional administrative burden on plans will be ongoing as the transition continues.

Financial Considerations

The SFI initiative is expected by DOH to save $1 billion per year, with most of that funding coming out of plan rates. Since the beginning of the transition process, however, plans have incurred significant costs that have not been reflected in current plan premium rates and that raise questions about the amount of savings to be realized.

None of the costs we have outlined above, associated with the aggressive implementation timeline and the additional administrative and care management burden imposed on plans by PPL's difficulties, are reflected in plan premiums. Moreover, in addition to demands for funding advances, PPL also demanded unit cost reimbursement rates from plans that were often higher than what they were paying existing FIs. There was no leverage to negotiate with PPL and plans were told by DOH that any new plan enrollment would be suspended if contracts reflecting PPL's reimbursement demands were not signed.

As stated above, plans have also seen a substantial shift of members from the CDPAP program to a personal care worker under a LHCSA. In addition to the administrative effort required of plans to make those transitions, LHCSA costs are usually higher than CDPAP costs because of the additional administrative and regulatory requirements for LHCSAs. When initial plan premiums for April 2025 – March 2026 were developed, the State's actuary, Deloitte, assumed that personal care services would be provided 60% through CDPAP and 40% through LHCSA. As a result of the difficult transition, those percentages are currently inverted, with 60% now being provided through LHCSA. At this time, plan premiums do not reflect the more expensive cost structure of the program. Plan premiums must be actuarially

sound under federal law and actuarial standards of practice. Currently, we have concerns about the adequacy of plan premiums and are hopeful that appropriate adjustments will be made by the State.

CONCLUSION

We thank you for the opportunity to share our views on this critically important transition. We are certain that were it not for the monumental efforts of the plans in assisting members over the last several months, the transition would have been much, much worse. With the *Engresser et al v. McDonald* settlement finalized and a new deadline for PPL to fully takeover the program, plans now face a new set of member notification, outreach and reporting requirements with short turnaround times to meet the deadline. While the transition has not been smooth, we believe that any additional change at this point will only add more complexity and disruption for consumers. Plans will continue to work collaboratively with both DOH and PPL to identify and resolve policy, operational and fiscal issues as they arise.