Testimony of

Consumer Directed Action of New York to

Joint Legislative Budget Hearing on Health

Submitted by Bryan O'Malley, Executive Director

Tuesday, January 23, 2024

Good evening Senator Krueger, Assemblymember Weinstein, Senator Rivera, Assemblymember Paulin, and all of the Legislators joining us tonight. Thank you for the opportunity to testify regarding Governor Hochul's proposed SFY 2025 budget. My name is Bryan O'Malley, and I am Executive Director of Consumer Directed Action of New York (CDANY), which is a sister organization to and has taken over advocacy duties for Consumer Directed Personal Assistance Association of NYS (CDPAANYS). CDANY works to strengthen and build the state's consumer directed personal assistance program, better known as CDPA, for the approximately 200,000 older and disabled New Yorkers who rely on this benefit and the agencies who administer it.

In her budget address, Governor Hochul said, "We need to control Medicaid spending while taking care of people who do need our help."

At CDANY, we could not agree more with the Governor's sentiment. Where we disagree is how to achieve this goal. The Governor's budget makes or continues short-sighted cuts that only impact workers or older and disabled consumers that will actually only drive costs and enrollment in future years. What is needed instead are larger scale systemic changes that impact portions of the system that do not provide health care. These changes may take time to implement, but will curb growth, improve outcomes, and better allow New York to deal with the continuing wave of older New Yorkers that demographics dictate will turn 65 and need services over the next decade and longer.

$200 million wage parity cut to workers

The clearest example of these short-sighted cuts is the $2.54 per hour, or 12%, cut to the wages and compensation for primarily Black, LatinX, and immigrant women. This 12% wage cut is due to the elimination of wage parity only for CDPA, leaving the mandate for higher wages and benefits in place for other home care services. This makes CDPA personal assistants, who provide critical personal care, home health, and nursing services, second-class home care workers worth 12% less than other home care workers.

This proposal is wrong for a large number of reasons; however, primarily because it fails to achieve any discernible goal while causing direct harm to a low-wage workforce and the older and disabled New Yorkers they provide life-saving services to. Begin analyzing this policy by asking yourself one fundamental question - if your wages and benefits were cut by 12%, would you keep doing what you are doing?

When we look at what it means to this workforce, the cruelty becomes even more pronounced. This is not a reimbursement cut, it is a cut to direct wages and compensation for workers. For someone who works 37 hours a week, the average CDPA case, they will lose $94 from their paycheck, bringing their compensation from $780/week to $686/week. That is almost $200 per pay period, and almost $5,000 per year.

But even these numbers do not tell the full story. The Governor's proposed 12% wage cut will bring total compensation to $0.54/hour below what it was prior to the home care minimum wage adjustment in 2022. Indeed, the total compensation will be the lowest it has been for these workers since 2019, before the minimum wage increase to $15 was fully implemented. Factoring in inflation, the devastating impact of the cut is even more pronounced. In December of 2019, according to the Bureau of Labor Statistics, that 18.09 compensation package from December 2019 had the buying power of $21.59 today. This means the workers lost money against inflation even before this cut; but will lose over $3 per hour in purchasing power if it goes through.

In her Budget Briefing Book, the Governor states that this cut was made because of projections indicating that enrollment in Medicaid managed long-term care (MLTC) is set to increase by 10%, while spending on the insurance program will increase by 20%. The only way that a $2.54 per hour direct cut to the wages and benefits of a low-wage workforce will address this is a cynical, but likely accurate, thought-process that the workers will quit, the consumers will not be able to replace them with the low pay offered, and, after 30 days, the consumer will be disenrolled from MLTC not because they no longer need services, but because they cannot find workers to provide the services they need.

However, while this cut will result in consumers who lose services because they cannot hire workers, history shows that this cut will not likely increase growth in CDPA. When wage parity became law in 2011, CDPA was not included. Over the next several years, MLTCs pressured LHCSAs to transfer personal care cases to CDPA, with or without the knowledge of the consumer. Workers still reported to the agency, not the consumer. The agency was still determining the schedule; not the consumer. The agency was still supervising the plan of care, not the consumer. However, the case was called CDPA.

Even though the agency and the MLTC received less reimbursement for this case, the lower wages, lower regulatory requirements, and the lack of a need for nursing services meant the plan and the agency still profited at higher levels than if the case were run through traditional personal care. The losers were those who were exploited for this profit - the workers, who made less money; the consumers, who relied on these workers for the provision of care; and the state, who paid for it all. That is why we supported the addition of CDPA to wage parity - to stop the program from serving as a legal loophole.

Eligibility cuts to consumers

A similar analysis can be had of one proposal that will likely be implemented this year unless it is repealed in this budget. That is the cut in Medicaid home care eligibility for those who do not need assistance with three or more activities of daily living (ADLs), two or more if the individual has dementia or Alzheimers' disease. CDANY attempted to utilize the state's numbers to determine the number of individuals expected to be newly ineligible for services; however, we were told the information was not subject to FOIL. Therefore, our best estimates indicate that if implemented this eligibility cut will prevent 9,000 people from accessing services.

The out-year costs of this eligibility cut will quickly dwarf any savings that accrue in the short-term. The National Institute of Health defines ADLs as "...a term used to collectively describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility."[1] When we analyze that if one can eat and bathe independently, but is not mobile, their ability to eat and bathe is instantly called into question. What about the individual who can bathe or go to the bathroom, but cannot get dressed? Are you independent if you can shower but cannot dress afterward?

The provision of personal care is, at its core, preventive health care. It prevents the need for disabled and older people to use more costly levels of care and occupy much needed space in an already stressed health care system. Failure to provide supports for these "fundamental skills" invariably leads to a need for hospitalization, institutionalization, and longer hours of care. One study showed that 59% of older individuals with no need for ADL assistance prior to entering a hospital were discharged with a need for assistance with 1+ additional ADLs, while 37% left with a need for assistance with 3+ additional ADLs.[2] Another study found that 35% of older individuals with no need for ADL assistance two weeks prior to admission to a hospital experienced an increase in need for assistance with ADLs between two weeks prior to admission and upon discharge.

Examining this data, the out-year costs associated with denying low hours of personal care as a preventive measure make less financial sense. Even using conservative estimates, in year 2 (the first year after denied eligibility) we can expect to see approximately a 50% increased rate of hospitalizations for those denied preventive personal care benefits under Medicaid. Then, upon discharge, these individuals will require substantially higher levels of care. In many ways, it is like telling a diabetes patient that we will not provide any coverage for their diabetes care until there is a need for a foot amputation.

This analysis demonstrates that, much like the wage parity cuts, the eligibility cuts imposed by MRT 2 for personal care were short-sighted and will lead to further costs to the Medicaid program in short order, necessitating further cuts.

Additional $200 million in undisclosed cuts

It also bears mentioning that there is an additional $200 million in cuts that are yet to be determined. CDANY is unclear whether we are among the stakeholders who will be engaged to determine the additional cuts planned or whether CDPA is being envisioned for even more that

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[1] Edemekong PF, Bomgaars DL, Sukumaran S, et al. Activities of Daily Living. [Updated 2023 Jun 26]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK470404/

[2] O'Brien MW, Mallery K, Rockwood K, Theou O. Impact of Hospitalization on Patients Ability to Perform Basic Activities of Daily Living. Can Geriatr J. 2023 Dec 1;26(4):524-529. doi: 10.5770/cgj.26.664. PMID: 38045878; PMCID: PMC10684306.

the $200 million we are already absorbing. We obviously would strongly oppose cuts that enact deeper cuts to this critical program.

Systemic changes to address root issues without causing harm

CDANY is sympathetic to the Governor's desire for achieving savings in the Medicaid program. However, we maintain that when looking at ways to save, we must do so in ways that allow us to have the least impact on recipients and the direct provision of services.

Eligibility is fundamental to the provision of services. Likewise, wages and benefits for home care workers, who provide the services disabled and older adults need to live independently in the community, is fundamental to Medicaid recipients receiving services. Managed care is not.

The state's managed long term care (MLTC) program is "partially capitated", meaning that definitionally, the plan is responsible for or authorized to care manage or coordinate care for the full array of services an enrolled beneficiary may require, such as Medicare services and acute care Medicaid services outside the benefit package of a MLTC. This was why New York undertook the experiment to shift long-term care services to MLTC.

Over a decade into the experiment, we can see that the responsibilities are not being met and the experiment has failed. The experience of CDPA beneficiaries with MLTC plans is uneven and inconsistent at best. Most consumers CDANY speaks with:

- do not know their care manager or if they have one;
- do not report receiving care management calls; and,
- report that when trying to contact a care manager, they are directed into a voicemail system or other automatic repository to receive a call back 24-48 hours later.

Even the services the plans were providing have now in many cases been taken away, leading to even greater costs to the state. For instance, the state took assessments away from MLTCs, paying Maximus to perform the service instead, because the Department of Health saw inconsistencies in their data that led them to believe plans were manipulating these critical procedures. They have also taken nursing homes away from MLTCs, creating a financial incentive for plans to shift high need members to the state in institutional settings while rapidly increasing enrollment among low hour cases from whom they reap enormous profits.

While it is unclear what value the MLTC value brings to the system, it is clear that there is a cost. Estimates indicate that the MLTC program costs the State Medicaid program $3B annually for plan administrative and overhead costs (including profits and salaries). That is $3 billion in money that is not health care and is not improving the overall quality of health care for those on Medicaid.

That is twice the purported amount by which we have exceeded the Medicaid global cap.

Legislation introduced by Chairs Rivera and Paulin called the Home Care Savings and Reinvestment Act would address this systematic failure. And I want to be clear, the fact that it is

a failure is ok. We supported the state's experiment to shift long-term care services to MLTC because of the promises it offered, as did many others now supporting the Home Care Savings and Reinvestment Act. We have to be willing to try new things to address shortfalls in the system. But we also have to be willing to admit when those ideas did not work, and move on to another idea. We cannot allow the failed ideas of the past to remain solely because that's how we do things now.

Passing the Home Care Savings and Reinvestment Act will not be an immediate fix. It took time to shift to MLTC, and it will take time to unwind it, fully developing and shifting to a new system. The state must understand that and use existing funds as one-time investments to cover expected losses in the short-term, relying on the out-year savings to balance the long-term financial plan. Once this transition has been completed, the state will be in a position to deal with the increased enrollment that demographics tells us is coming in a Medicaid program that focuses on the delivery of high-quality services in a cost-efficient way to those who need our help.

This budget puts New York's Medicaid program at a crossroads. We can make decisions that will move the system forward or break it. Let's choose the former.