華人策劃協會 CPC ADVANCING OUR COMMUNITY

Chinese-American Planning Council, Inc.
Testimony at the New York State Assembly Hearing on Medicaid Program Efficacy and Sustainability
November 1st, 2021

Thank you for the opportunity to testify today. My name is Carlyn Cowen and I am the Chief Policy and Public Affairs Officer at the Chinese-American Planning Council. The mission of the Chinese-American Planning Council, Inc. (CPC) is to promote social and economic empowerment of Chinese American, immigrant, and low-income communities. CPC was founded in 1965 as a grassroots, community-based organization in response to the end of the Chinese Exclusion years and the passing of the Immigration Reform Act of 1965. Our services have expanded since our founding to include 3 key program areas: education, family support, and community and economic empowerment.

CPC is the largest Asian American social services organization in the U.S., providing vital resources to more than 60,000 people per year through more than 50 programs at over 30 sites across Manhattan, Brooklyn, and Queens. CPC employs over 700 staff whose comprehensive services are linguistically accessible, culturally sensitive, and highly effective in reaching low-income and immigrant individuals and families.

To that end, we are here today to urge that there be meaningful investments made to Medicaid. We have seen the detriments of the decisions made under Cuomo's Medicaid Redesign Team II back in January of 2020 where they proposed substantial cuts to the program. This is not only unconscionable but proved to be extremely harmful during the COVID-19 pandemic. Over ⅓ of New Yorkers relied on Medicaid during the COVID-19 pandemic, however, a billion dollars was cut for the program. In fact, CPC is 80% Medicaid funded, meaning that cuts to the program disproportionately impact AAPI, immigrant, and low-income communities that we serve.

CPC serves over 11,000 older adults annually through our culturally-appropriate, linguistically accessible, community-based Senior Centers, where they participate in classes and social activities, access nutrition, health and mental health services, and get connected to resources and supports. We house 300 seniors through our affordable housing units. Our Medicaid-funded public health programs, which support immigrant health, health education, health insurance access, HIV/AIDS prevention and treatment, child and maternal health, transgender health equity, viral hepatitis, and more.

And we serve over 3,000 older adults and people with disabilities through our Home Attendant Program.

Healthcare Access and Medicaid in AAPI and Immigrant Populations

Quality healthcare is inaccessible and expensive for immigrants in the U.S. While Medicaid and Medicare provide an avenue of affordability, only those who fall under an income limit and have documentation status are eligible. Access to private health insurance coverage depends on one's workplace, and assumes steady employment. Immigrants working gig, informal or part time jobs are unable to access insurance through their employer. Even among recent immigrants that are insured privately or through the Essential Plans, lack of culturally competent and in-language medical services provide additional barriers to quality treatment.

The inequities in New York's healthcare system disproportionately impact uninsured and undocumented individuals. AAPIs make up 15% of NYC's population, yet receive less than 4% of city funding. This lack of funding leads to a severe dearth in tailored, in-language social services that our communities need. In the healthcare system, the lack of funding translates to a lack of medical staff that represent and understand our communities, a lack of training to support recent immigrants as they navigate through the healthcare system, and a lack of cultural humility in every level of the medical infrastructure. Even with some efforts to collect disaggregated health data in NYC, these efforts are not enough to cover the significant gaps in funding for tailored AAPI services. Working-class AAPIs are therefore left with very little options for affordable and culturally-accessible care, and the available options are crowded and out of capacity. The city needs to not only treat healthcare as a right, but to also intentionally allocate money to build more comprehensive infrastructure for healthcare that funds immigrant and AAPI healthcare services equitably. The lack of disaggregated data also ends up obscuring the different health outcomes and needs experienced by different Asian groups in New York. Health and financial data vary across different ethnic groups, and suggest different approaches for healthcare services. For example, up to 17% Koreans in New York are uninsured, compared to 11% Chinese, while South Asian New Yorkers are at a higher risk for diabetes and hypertension compared to Chinese New Yorkers.

Undocumented immigrants are even more likely to be uninsured. Around 500,000 undocumented immigrants live in NYC, and around half of those immigrants (250,000) are uninsured. The limited safety nets of the current healthcare system indicate that those who are currently uninsured will likely remain uninsured, as there are very little pathways for undocumented and uninsured individuals to attain health insurance that covers quality healthcare. The only type of Medicaid eligible for undocumented immigrants is Emergency Medicaid, and the previous Federal Administration's recent attempts of expanding the Public Charge rule to include Emergency Medicaid to this day has left a chilling effect that discourages immigrants from utilizing this benefit. NYC's other two safety net systems - New York City Health and Hospitals Corporation (HHC), and Federally Qualified Health Centers (FQHCs, also known as community health centers) - all rely on Medicaid and Medicare reimbursements. Both safety net systems include special provisions for those who are uninsured and low-income, and healthcare workers generally assume that low-income individuals who seek out these services instead of Medicaid are undocumented. Without careful measures to hold these assumptions accountable, undocumented individuals who seek healthcare through these avenues risk revealing their immigrations statuses to public officials. CPC has also heard cases of H+H workers asking our community members to apply for Medicaid first regardless of immigration status, which deters undocumented community members from applying to Medicaid or returning to H + H due to Public Charge concerns. In addition, these safety net systems do not cover most specialists, leaving undocumented and uninsured immigrants who have chronic conditions in need of specialty care out of affordable treatment options.

In addition to the chilling effect in the aftermath of proposed changes to Public Charge rule, the threats of the previous Federal Administration to limit naturalization processes exacerbates the chronic stress experienced by working-class immigrants. Adding on the fact that the majority of undocumented and recent immigrants work under the table jobs that may not provide any health insurance in order to sustain their families, the accumulated stress of survival result in long term health impacts that are expensive to treat. The constant demands placed on working-class immigrants also limit their capacity to navigate and seek out quality healthcare in an already-confusing healthcare system. In addition, most health insurance plans do not cover undocumented individuals, and this factor eliminates many affordable healthcare options for those without status.

Older Adults, Disabled New Yorkers and Long Term Care Workforce

Asian Americans are the fastest growing population in New York State, and seniors are the fastest growing subset. Over 1 in 3 Asian American seniors lives under the poverty line, and over 2 in 3 are Limited English Proficient (LEP). This makes the issue of aging in place of particular concern to CPC, and we are grateful for the opportunity to testify about issues that impact the individuals and families we serve.

Broadly speaking, New York State has the fourth oldest population in the nation, with 3.7 million people age 60 and over. By 2030, 5.2 million people in the state will be 60 and older, with 1.81 million New Yorkers will be 75 or older. An estimated seven out of 10 people over the age of 65 will need some kind of long term care. In addition, there are over a million New Yorkers with disabilities, chronic illnesses, or other functional complications that require direct care, creating a significant population in New York State that requires direct care support to live and age in dignity. Direct care in homes and communities is either provided by unpaid family caregivers, paid family caregivers, or home health workers through an agency. Care that takes place in homes and in communities is often higher quality, preferred by consumers, and less costly overall than institutionalized care. Many immigrant seniors and families prefer home health care because they can receive language accessible and culturally competent care that they would not find in institutionalized settings.

Because of the growing needs of people with disabilities and an increasingly aging population, the home care sector is the largest employer in the nation, yet continues to face shortages. In NYC alone, there are 187,000 home health workers, and in New York State, there are over 330,600 home health workers. Yet because of growing need, by 2025, New York State will see a 33 percent growth in need for home health aides and face a shortage of 23,000 workers. While automation and investments in technology serve to improve the function and efficacy of hospitalization and institutionalized care, this portion of the healthcare industry is highly reliant on human work, adding urgency to investments in this workforce.

A primary driver of this workforce shortage is chronic low wages and poor working conditions pervasive throughout the sector. More than one in seven low-wage workers in New York City is a home care worker. According to the New York Department of Labor, the median annual salary for home care aides is $24,810. One in four workers lives below the federal poverty line and more than half rely on some form of public assistance to make ends meet. The workforce is primarily women (90%), people of color (60%), and approximately one in three workers are Limited English Proficient (LEP). We know much of this thanks to the work of the Caring Majority, a coalition of seniors, people with disabilities, family caregivers, domestic workers, and home care providers from all across the state that seeks to improve the future of long term care.

Furthermore, Medicaid, the largest payer of home care and long term care in New York State, has not only created but exacerbated the workforce shortage through depressing wages in their reimbursement rates. Particularly for nonprofit providers, home care agencies are beholden to the rates and requirements laid out by Medicaid and the State, and cannot compensate their workers adequately when faced with inadequate Medicaid reimbursement. In addition, Medicaid rates have been artificially depressed by the Medicaid Global Spending Cap, an arbitrary limit on spending growth that was put in place in 2011. This cap does not allow Medicaid spending to keep pace with essential program growth or respond to the number of people supported by Medicaid, causing a weakened public health system in New York State. These complexities have ramifications across nonprofit providers' operations, from higher fiscal and stability levels to daily operations and home care worker scheduling as cases move in and out of eligibility. As the minimum wage rises in New York, these gaps widen for providers and home care workers alike. Increasingly, the emotionally and physically demanding labor of home care, in addition to

inconsistent scheduling as providers balance underfunded plans and agreements, has become less attractive than other minimum wage jobs. We urge the swift passage of Fair Pay for Home Care (S5374 May / A6329 Gottfried) to begin to address wage issues in the sector.

In addition to low wages, home care workers face high levels of uninsurance (twice that of the overall population), and inconsistent schedules. While the Fair Labor Standards Act was extended to home care workers in 2013, it has not been fully implemented in New York State, making scheduling and labor issues like overtime and spread of hours difficult for workers and providers to manage.

One of the most stark examples is that home care workers who work 24 hour shifts for round-the-clock care are being paid for 13 hours of work, with 8 hours allocated for sleep and 3 hours allocated for meals. Nonprofit home care organizations work hard to ensure that the home care workers have adequate space and uninterrupted time for sleep and meals. Despite these efforts, many home care workers report that realities of caring for someone that is homebound often mean that they must attend to their clients during break hours. The consequence of this is that the effective hourly pay of the home care workers ends up being far below minimum wage. It is critical that we pass the bill (A3145 Epstein/S359 Persaud) to end 24 hour shifts and make 12-hour split shifts the norm, ensuring that home care workers are paid for every hour worked by Medicaid.

Recommendations

Below is a summary of recommendations below that would address the short-term as well as long-term health care needs of all New Yorkers:

- **Increase funding for Medicaid and community-based public health programs:** To address the growing demands of New Yorkers and to ensure a just pandemic recovery, there must be an increase of Medicaid funding in the budget that addresses years of austerity budgets.
- **Ensure fair pay for home care workers: We urge the Governor and legislature to pass the Fair Pay for Home Care bill (S5374 May / A6329 Gottfried)**, which would increase home care minimum wages to 150% of the regional minimum wage. The bill would ensure wages are fairly raised across the sector via Medicaid reimbursements, without leaving the burden on nonprofit providers who do not have the funds to implement these raises unilaterally. This legislation would significantly address the poor worker pay that perpetuates New York's workforce shortage.
- **Pass the home care bill (A3145 Epstein / S359 Persaud) to fully compensate all 24 hours of 24-hour shifts, making split 12-hour split shifts the standard, and ensure workers are fully paid for every hour worked via Medicaid reimbursements to providers:** We must advance a solution that fully funds 24-hour care through Medicaid reimbursement rates to cover the full and actual cost of providing home care services, providing a living wage, and incentivizing innovation. This could be accomplished through breaking up round the clock care into 12-hour split shifts that would create better conditions for the worker, and by extension the consumer as well. This would also be consistent with best practices in the medical and healthcare field.
- **Raising revenue by raising taxes on the ultra-wealthy and corporations**
    - One of the biggest concerns that some have with investing in our social safety net is the question of how it will be funded. Communities of color in NYC have lost jobs and have been unable to make ends meet during the COVID-19 pandemic. Meanwhile, New York State's billionaires have gained billions during

    the pandemic. In order to raise revenue to fund crucial programs like Medicaid, we need to tax the ultra-wealthy

- **Eliminate the Medicaid global spending cap**
    - This cap does not allow Medicaid spending to keep pace with essential program growth or respond to the number of people supported by Medicaid, causing a weakened public health system in New York State. Any robust solutions in the home care sector must include the removal of the Medicaid cap.
- **Pass the New York Health Act**
    - In order to address health disparities, we need to ensure that every single New Yorker has access to affordable and comprehensive health care.The New York Health Act would build a long-term system that would serve the needs of our most vulnerable communities.

We can no longer balance the budget on the backs of communities of color, immigrant, and low-income New Yorkers. We are not a budget line to be cut. We urge the State legislature to take these recommendations into consideration and to ensure that there is an increase in Medicaid funding during this upcoming budget session. Thank you for your time and if you have any questions, please contact ccowen@cpc-nyc.org.