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Testimony of The New York State Association of Health Care Providers, Inc. Presented Before a Joint Public Hearing of the Senate Finance and Assembly Ways and Means Committees February 2, 2015

Good afternoon Senator DeFrancisco, Assembly Member Farrell, distinguished members of the Senate Finance, Assembly Ways & Means, and Senate and Assembly Health and Aging Committees. My name is Claudia Hammar, and I am Interim President of the New York State Association of Health Care Providers, Inc. (HCP), a trade association representing approximately 400 offices of Licensed Home Care Services Providers (LHCSAs), Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), and related health organizations throughout New York State. With me today is Megan Tangjerd, Senior Associate for Public Policy at HCP.

On behalf of the HCP Board of Directors and members, thank you for the opportunity to comment on Governor Cuomo's 2015-16 Executive Budget proposal and its impact on home and community-based care providers.

Over the past several years, New York State has embarked on an ambitious overhaul of the health care delivery system that is focused on collaborative models of care across the health care continuum designed to improve quality of care and reduce health care costs. Home and community-based care providers are a central component of these new models because of the industry's unique expertise and ability to provide high quality, integrated care to consumers at a lower cost and in the least restrictive setting possible.

The value of home and community-based care—both to consumers and the State—cannot be overstated. Consumers overwhelmingly prefer to receive care at home, for themselves and their loved ones. Those facing illness, disability and aging are able to maintain their dignity, independence and privacy in the place they are the most comfortable—their own homes. The State has recognized the extraordinary value of home and community-based services, which are on average half the cost of care provided in institutional settings.

Home and community-based care providers are fundamental building blocks in the State's initiatives designed to strengthen and support the ability of individuals to remain in the community and thereby lower costs to the State, including the transition from a Medicaid fee-for-service reimbursement structure to managed care models and the new Delivery System Reform Incentive

Payment (DSRIP) program, among others. Despite evidence that greater investment in home and community-based care saves money, however, home care programs in New York continue to be plagued by inadequate levels of reimbursement, burdensome and costly regulatory requirements, and unfunded mandates that fail to support an industry striving to adapt successfully to myriad systems-altering policy changes underway.

This proposed budget does not recognize the critical challenges facing home care providers, and is largely absent of initiatives to support providers and alleviate the very real financial pressure they are experiencing. There are both longstanding and new issues which threaten not only to put in jeopardy the financial viability of home care businesses, but also the stability of home care worker jobs and, above all, consumer access and continuity of quality home care services. Your support and action is critical to ensure the State does not further destabilize an industry undergoing massive system changes.

To ensure the industry's future viability, home and community-based care providers need funding to support costs related to unfunded wage and benefit mandates – including minimum wage increases and wage parity – the establishment of a new advanced home health aide designation, and the ongoing transition to managed long term care.

The Home Care Landscape in 2015

New York's home and community-based care industry remains in the midst of a massive transition of the State's long term care delivery system from fee-for-service to managed care models. Stemming from recommendations of the Medicaid Redesign Team (MRT) enacted and implemented in 2011, this complete restructuring of the entire Medicaid long term care system has taken a toll on providers, home care workers and consumers. All stakeholders are striving to understand and work within this new system, which itself continues to evolve alongside the implementation of additional large-scale State initiatives, such as the Fully Integrated Duals Advantage (FIDA) demonstration program, the DSRIP program, the upcoming shift to value-based payment systems, and the proposed establishment of an advanced home health aide designation.

The majority of New York State counties are now deemed "mandatory managed long term care" (MLTC) counties, and for those home care providers that have made or are currently undergoing the transition, the struggle to secure adequate and prompt reimbursement from managed care plans while continuing to provide the same level of services and meet payroll each week continues, as do challenges related to securing timely authorizations for services and inefficiencies in managed care plan billing processes and procedures. Providers operating in areas of the State where the transition has recently begun or will soon begin are doing so while simultaneously addressing fee-for-service challenges and attempting to prepare for what is to come. No matter where in the managed care transition process home care providers find themselves, there are significant challenges that must be addressed, including:

- Outdated and inadequate Medicaid fee-for-service reimbursement rates;

- Unfunded wage and benefit mandates, including wage parity, living wage and minimum wage increases that threaten continuity of care for patients, home care worker jobs and business viability;

- Cash flow crises stemming from inadequate reimbursement rates and delayed or non-existent payments from managed care plans;

- A lack of standardization among managed care plan procedures and processes, which contribute to issues related to authorizations, billing, payment and more;

- An overwhelming lack of support for home and community-based care providers as the State rolls-out a variety of new collaborative health care models focused on reducing hospital admissions and transitioning patients into home care and community-based settings to reduce costs;

- Federal Medicare reductions, costly unfunded mandates and additional costs stemming from the Federal Affordable Care Act employer insurance mandate and the possible enactment of the (currently halted) elimination of the Companionship Exemption; and

- An outdated and duplicative regulatory structure centered on a fee-for-service health care delivery system that does not translate in the managed care setting, and a regulatory environment that remains hostile to cost-effective home and community-based care.

Despite the uncertainty, uneasiness, and in many cases exasperation at the changes underway, home care providers are doing everything possible to operate effectively and efficiently to continue to deliver high quality care to consumers that are determined to remain in the comfort and security of their own homes. Home care providers are working extremely hard to adapt to new ways of doing business amid the ongoing introduction of new policies, regulations and large-scale State initiatives that put their viability at risk, showing again the remarkable resilience, tenacity and dedication of this industry.

Home and community-based care is the centerpiece of the nation's long-term care strategy. Without a strong network of providers, the prospects for maintaining a professional system of caregiving in the community are bleak. HCP and home care providers appreciate the need to control the cost of Medicaid and providers are all too familiar with having to do more with less. State Medicaid policies, however, must not destroy Medicaid home and community-based care services, which ultimately reduce the need for more costly care.

HCP urges the Committees and State Legislature as a body to support legislation and policies that help support home care and/or small businesses in the context of the challenges that these job creators face on a daily basis.

Codifying the Medicaid Global Spending Cap

The Executive Budget seeks to codify the Medicaid Global Spending Cap and its related provisions. Since 2011, the Global Cap has given the State Department of Health unilateral authority to impose utilization controls, provider cuts or other spending reductions if State Medicaid spending exceeds 4%. While there has not yet been a need to exercise such powers, the specter of cuts is always there, and the limitations on the ability to address other funding issues within these limits is difficult. If policies imposed by the State, such as wage parity, are unable to be funded adequately because of global cap limitations, providers and patients suffer as a result of conflicting State policies.

Last year, HCP applauded the Executive and Legislature for eliminating the 2% across-the-board (ATB) reductions in Medicaid fee-for-service reimbursement as of April 1, 2014. These spending provisions, which were originally part of the 2011-12 State Budget, are aimed squarely at funding needed to provide direct patient care, with patients and workers experiencing the brunt of deep cuts as agencies have been forced to reduce services, programs, staff or, most troublesome, close entirely.

While the spending reductions have been eliminated under State law, at this time impacted agencies continue to be subject to the cut as the State awaits Federal approval to formally restore Medicaid rates to their full levels. The restoration was applied for a short period of time, from April 1 through May 21, 2014, only to be repealed after it was found that the State would need to secure formal Federal approval to reinstate the cut. Accordingly, providers have continued to bear substantial rate reductions, with no clear indication or timeline on when Medicaid rates will return to normal levels.

Upon securing Federal approval, the State Department of Health has signaled that the State intends to reimburse providers for the reductions retroactively, back to May 23, 2014. While the formal elimination of these spending reductions will make a difference for home care providers still operating under Medicaid fee-for-service, the impact of past years' reductions will continue to be felt in the years ahead.

Home Care Reimbursement

<u>Trend Factor Adjustments</u>

The 2015-16 Executive Budget does not address the future of Trend Factor adjustments in Medicaid provider reimbursement rates, which were again eliminated under the 2013-14 State Budget through March 31, 2015. HCP has opposed this elimination since its initial implementation, which directly impacts patients and workers by forcing agencies to make decisions about whether to reduce services, programs and staff, or to close their doors entirely.

By eliminating Trend Factor adjustments, agencies continue to be challenged to deliver services in a 2015 economy with reimbursement levels based on expenses incurred in 2013. A two-year lag

exists in home care rates and thus, an agency's 2015 Medicaid rate is based on 2013 data, reported in 2014 to DOH and then paid in 2015. The trend factor is the way to attempt to bring rates, which are based on two year old data, more in line with today's costs of doing business and make agencies closer to whole for the time period being reimbursed.

HCP strongly urges the reinstatement of Trend Factor adjustments in order to bring reimbursement rates in line with today's costs, and help ensure that home care agencies operating under the fee-for-service reimbursement structure may continue to provide essential, high quality services.

Additional Reimbursement Changes

The Executive Budget proposes the following reimbursement provisions for home care. While many are continuations of prior budget actions or modifications of such, there continues to be a need for additional clarification as they are applied in the context of new reimbursement systems and structures, such as in the managed care context or under value-based payment methodologies:

- **CHHA Episodic Payment System:** The authorization of episodic payment per sixty day period of care for CHHAs is permanently extended.
- **CHHA Bad Debt and Charity Care:** The authorization for bad debt and charity care costs as reported by CHHAs is permanently extended.
- **Medicare Maximization:** The requirement that CHHAs and LTHHCPs maximize Medicare revenues as was originally established in 1995 is permanently extended.
- **CHHA/LTHHCP A&G Cap Reconciliation:** The $1.5 million reconciliation limit for the CHHA and LTHHCP administrative and general cap is permanently removed.
- **LTHHCP A&G Cap:** The limitation on the reimbursement of the LTHHCP administrative and general costs to a Statewide average is permanently extended.

Home Care Funding Challenges Exist Statewide

Minimum Wage Increase will Impact Consumer Continuity and Access to Care

Home care providers throughout the State are struggling financially in response to unfunded wage and benefit mandates combined with insufficient reimbursement methodologies. The entire State has been impacted by the increase in the State minimum wage to $8.75 per hour, which became effective December 31, 2014, and will increase again to $9.00 per hour at the end of this year. The Executive Budget proposes to further increase the minimum wage to $10.50 per hour, effective December 31, 2016, in all areas of the State except New York City, where an increase to $11.50 per hour has been proposed.

The home care industry is significantly impacted by increases to the minimum wage, as multi-year limits on reimbursement under outdated fee-for-service (FFS) Medicaid and inadequate managed

care rates further compromise provider stability by limiting their ability to meet the growing costs of doing business. In particular, as a result of competitive hiring practices, local living wage and wage parity requirements, home care providers are most likely to take a hit in the calculation of overtime wages for personal care and home health aides, who are currently paid overtime wages at time and a half of the minimum wage (pending the outcome of the Federal court case challenging US Department of Labor's new overtime rule, which could potentially increase overtime costs even more drastically). Home care agencies will be forced to limit overtime hours, which will create significant continuity of care challenges for patients and limit the overall earning potential for home care workers.

Further, increasing the minimum wage has a domino effect which necessitates increases for other workers with wages already above the minimum wage, making the overall financial impact of an increase much higher.

Home care services are overwhelmingly funded by Medicaid in New York State, and it is critical that Medicaid reimbursement, whether through a managed care contract or fee-for-service Medicaid, match the State wage mandates being imposed. Traditionally, such funding has not consistently followed unfunded wage mandate policies at either the State or local level.

MLTC Transition Leaves Many Providers Caught Between Two Worlds

As the transition to mandatory MLTC continues its progression into upstate counties, home care providers are slowly beginning to shift away from fee-for-service Medicaid reimbursement and are instead negotiating payment rates through contracts with managed care plans. At this stage, however, the vast majority of cases served by home care agencies in these upstate regions remain under the fee-for-service structure and continue to be challenged by government rates that do not reflect the real-time costs of providing services in the current business climate.

HCP strongly urges the Legislature to expedite the payment of costs incurred by eliminating the Medicaid personal care payment lag and rebasing personal care rates to increase the ceilings on wage and aide training caps. HCP further urges that funding be allocated to support providers in all areas of the State to help address the ongoing fiscal challenges related to the managed care transition. While other health care provider types have been able to access funding to support this transition, similar support has not been provided for State's home and community-based care industry.

Lack of Wage Parity Funding a Paramount Concern

HCP is alarmed that the Executive Budget proposal does not include adjustments to Medicaid premiums for MLTC and fee-for-service payment rates to address cost increases stemming from the Home Care Worker Wage Parity Law. The Law, which was enacted in 2011 at the same time as the long term care delivery system restructuring, has created serious challenges for providers working to comply with confusing rules and interpretations, and seeking to secure adequate funding from managed care plans and other contractors.

HCP has always maintained that home care workers should be compensated for their hard work with fair and adequate wages and benefits; however, similar to other unfunded wage and benefit mandates imposed by the State, it is critical that reimbursement rates match the mandate. Commensurate levels of reimbursement for such services must be made available by the Medicaid and Medicare programs and any private contracts with managed care organizations or other entities.

March 1, 2015, marks the beginning of the next phase of the Wage Parity law in New York City and Nassau, Suffolk and Westchester counties. In New York City, the rate will remain at the same level as in 2014-15; the minimum rate of total compensation will be $14.09 per hour, an increase of more than $3.00 per hour over 2013-14 levels. According to the State Department of Health (DOH), the total average hourly cost (prevailing wage, taxes, workers compensation, overtime, etc.) plus administration costs for the employers of impacted workers, which are most often licensed home care services agencies (LHCSAs), was identified at $19.64 per hour. For the majority of New York City home care providers, this cost is not adequately supported by current rates of reimbursement from managed care plans or other contracts.

Outside of New York City, the counties of Nassau, Suffolk and Westchester will see an increase in the wage parity rate this year from $10.93 to $11.50 per hour. Beginning March 1, 2016, providers will be mandated to provide rates at 115% the minimum amount of total compensation in New York City, a wage of at least $13.15 per hour.

In these areas, there continue to be challenges stemming from the intersection of the mandatory MLTC transition and local living wage laws. Under the fee-for-service reimbursement structure, personal care workers on Medicaid cases are guaranteed wages and benefits that far exceed the State minimum wage and even the Wage Parity law. As personal care cases continue to transition to MLTC, workers are no longer guaranteed the living wage rate and their overall earning potential is many instances is lessened.

While providers have been attempting to negotiate rates of payments from plans to accommodate the current local living wage, they have been largely unsuccessful to this point. In order to maintain such wages, home care providers need higher reimbursement from managed care plans. Further, as the phase-in of wage parity progresses, it is essential that impacted providers are adequately prepared, and in receipt of adequate reimbursement rates, to meet the cost increases.

Last year, HCP applauded the Executive and Legislature for beginning to address the fiscal challenges stemming from wage parity rate increases by including an appropriation of $350 million in the FY 2014-15 State Budget. While the level of funding, which was earmarked for New York City, did not go far enough to cover the full cost of the increases and did not address the increases going into effect in areas outside of New York City, it was a critical step in the right direction.

Additional appropriations are necessary to ensure the mandate is adequately funded to address the current rates and future increases. This year, there are no such funds included in the Executive

Budget. Based on last year's appropriation, at least $300 million in funding is needed to meet this year's rate increase.

HCP also urges the Legislature to include a mechanism or requirement that funding for wage parity be passed on to the employers of impacted workers, which are most often licensed home care services agencies (LHCSAs). Without concrete assurances that the funding will reach the employer, there will continue to be disastrous financial consequences as this unfunded mandate continues to increase.

Home care workers are an essential component of keeping the elderly, disabled, and chronically ill in the safety and comfort of their own homes. The home care industry is extremely supportive of its workforce and strives to attract and retain valuable and committed caregivers. It is incumbent on the State, however, to ensure the funding to cover its own policy initiatives is made available.

The following chart outlines the various State-imposed unfunded wage and benefit mandates home care providers are subject to.

Unfunded NYS Home Care Worker Wage Parity Law				
County	**3/1/2013 – 2/28/2014**	**3/1/2014 – 2/28/2015**	**3/1/2015 – 2/28/2016**	**3/1/2016 – 2/28/2017**
New York City	\$9.50 + \$1.43 supplemental benefit rate **(\$10.93/hr)**	\$10.00 + \$2.40 supplemental benefit rate + \$1.69 additional wages **(\$14.09/hr)**	\$10.00 + \$2.40 supplemental benefit rate + \$1.69 additional wages **(\$14.09/hr)**	TBD
Nassau, Suffolk & Westchester	\$9.00 + \$1.35 supplemental benefit rate **(\$10.35/hr)**	\$9.50 + \$1.43 supplemental benefit rate **(\$10.93/hr)**	\$10.00 + \$1.50 supplemental benefit rate **(\$11.50/hr)**	\$11.50 + \$1.65 supplemental benefit rate **(\$13.15/hr)**
Local County Living Wage Laws (Medicaid Personal Care Fee for Service) *As of January 2015*				
Nassau	\$13.58/hr with benefits or **\$15.50** w/out, plus an additional 12 compensated days off, annually			
Suffolk	\$11.91/hr with benefits or **\$13.56** w/out, plus an additional 12 compensated days off, annually			
Westchester	\$11.50/hr with benefits or **\$13.00** w/out, plus an additional 12 compensated days off, annually			

Statewide Minimum Wage Increase		
On/after Dec. 31, 2014	**On/after Dec. 31, 2015**	**Executive Proposal: On/after Dec. 31, 2016**
\$8.75/hr	\$9.00/hr	Statewide: \$10.50/hr New York City: \$11.50/hr

Establishment of an Advanced Home Health Aide Designation

The Executive Budget proposes to establish a new advanced home health aide (AHHA) designation, which would require amending the Education law and providing an exemption from the Nurse Practice Act to permit AHHAs to perform "advanced tasks" in home care and hospice settings with the appropriate training and RN supervision. The proposal calls for:

- Regulations to establish the qualifications, training and competency requirements of AHHAs would be promulgated by the State Education Commissioner, in consultation with the Commissioner of Health.
- Information on AHHA trainings, certifications, re-certifications, limitations and/or revocations would be added to the Home Care Worker Registry (HCR).
- The Education Commissioner, in developing the related regulations, would be required to consider the recommendations of the Department of Health-convened AHHA stakeholder workgroup.
- AHHA provisions to take effect October 1, 2015, provided the State Education Department has adopted the associated regulations.

In the past, HCP has been opposed to an unrestricted nurse delegation approach to enhancing the role of home care paraprofessionals, primarily due to concerns related to quality of care, liability, and lack of standardization, uniformity and oversight. Similar to proposals put forth by the Executive during the 2014-15 budget process and then toward the end of the 2014 State Legislative Session, however, this proposal takes a more cautious and prescribed approach, and HCP continues to be supportive of moving the initiative forward.

Over the past several months, HCP has been an active participant on the Department of Health's AHHA stakeholder Workgroup. To date, the Workgroup has focused largely on identifying tasks that could be recommended for designation as an "advanced task," permissible for an HHA to perform under the direction and supervision of an RN, as well as identifying the level of training and the number of training hours that should be associated with such tasks.

Concerns exist, however, regarding the broader funding and policy issues that have yet to be adequately addressed in the Workgroup context, including issues related to funding and reimbursement, program scope, aide eligibility, training program eligibility, and provider liability. In particular, it does not appear that any funding allocation has been identified to support the initiative moving forward.

Providers that employ AHHAs will experience increased costs related to higher hourly pay rates, staff development and on-the-job training for aides, as well as higher costs associated with the provision of more intensive oversight and supervision by RNs. These additional costs will be difficult to absorb without commensurate increases in Medicaid fee-for-service (FFS) and managed care/managed long term care reimbursement rates, and HCP urges the Legislature to address the need for adequate reimbursement to support the utilization of a new class level of home health aide. In addition, home health aide training programs (HHATP) that provide AHHA training will also experience higher costs related to the development of new curriculums, additional training hours, etc., and HCP strongly recommends that funding be allocated to offset the increased costs that HHATPs that provide an AHHA curriculum will incur.

HCP looks forward to its continued involvement in the Workgroup, and participating in efforts to ensure the development of the program and associated regulations governing the program progress in a thoughtful way that adequately addresses the issues raised by the provider community.

DSRIP Implementation and the Development of Value-Based Payment Methodologies

Along with the majority of the State's health care delivery system, home care providers across New York have signed on to participate in one or more of the twenty-five (25) performing provider systems (PPSs) emerging under the State's massive $6.42 billion Delivery System Reform Incentive Payment (DSRIP) program. The home care industry has an essential role to play in supporting the success of DSRIP, which has an overall goal of reducing avoidable hospitalizations and re-hospitalizations by 25% over the next five years.

At this time, as the DSRIP application review process moves ahead, home care providers that have partnered with a PPS are working to better understand the process and what the specific roles, responsibilities and expectations of their agency will be in helping a PPS meet its project goals and overall DSRIP program goals. Depending upon the projects that a particular PPS has chosen to pursue, the level of home care provider involvement will likely vary. As the DSRIP program moves forward, it is critical that PPSs fully utilize and engage their home care provider partners, who have a plethora of experience and expertise in caring for, understanding, and meeting the needs of disabled, chronically-ill and aging individuals residing in the community.

Providers are further struggling to understand how funding will flow through the PPSs. The Executive Budget proposes to implement value-based payment reimbursement methodologies to meet the terms of the State's 1115 Medicaid Waiver, which requires that 90% of payments made by managed care plans be value-based by the conclusion of the five-year DSRIP program. The move to value-based payments will signify another massive systems change for home care, and the health care delivery and reimbursement system overall, and providers seek to ensure they are adequately prepared to make the shift from the fee-for-service payment system that continues in the managed care setting, to the successful implementation of value-based payment methodologies.

Moving ahead, HCP urges the Legislature to monitor closely the progress of the DSRIP program, as well as the development of value-based payment methodologies, to ensure that home care providers, who are at the heart of this massive State initiative to further reform, restructure and reinvest in the health care delivery system, are adequately supported throughout the span of the program, and beyond.

Supporting and Investing in Home and Community-Based Care

HCP supports and recommends that the Legislature approve the following Budget proposals:

- **Health Care Workforce Recruitment and Retention:** $22.4 million for the continuation of the Homecare Workforce Recruitment and Retention funding for Upstate New York; $272 million for the continuation of the Homecare Workforce Recruitment and Retention funding for New York City; and, $100 million for the continuation of Homecare Workforce funding for certified home health agencies, long term home health care programs, AIDS home care programs, hospice, and managed long term care plans.

- **Funding for Waiver Programs:** The Budget contains an additional appropriation of funds to increase rates for services provided under the Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) waiver programs.

- **Spousal Support:** This proposal would require spousal support for the costs of community-based long term care, but must be accompanied by the approval of provisions that ensure spousal impoverishments provision.

Significant, Ongoing Challenges Remain in the Transition to Mandatory Managed Care

The mandatory transition to managed long term care (MLTC) is now well underway in the majority of New York State counties, with the State Department of Health (DOH) aiming to commence the transition in remaining fee-for-service counties by the end of February 2015, pending Federal approval. While home care providers have worked aggressively to adapt to the new system and new way of doing business, there remain significant challenges that are jeopardizing the stability of home care agencies, home care worker jobs and patient access to care.

As anticipated and raised by HCP over the past several years, an issue that has grown increasingly challenging as the shift to managed care has progressed is the ability of home care providers to maintain an adequate cash flow to cover their weekly expenses. Home care providers have frequently been unable to secure adequate rates of payment in their contacts with managed care plans, and there are ongoing reports that plans do not make claims payments in a timely manner. In a survey conducted by HCP, nearly half of respondents cited outstanding claims payments from MLTC plans, with the majority of claims 61 - 180 days past due, far beyond prompt pay laws.

Reconciling claims issues is a time-consuming process that also uses the dwindling resources of providers. Additionally, providers report service payment gaps stemming from client transfers, loss of eligibility, and retroactive discharges. In these instances, the home care provider is not informed that a change has occurred and is left with no payer source to cover services that have been provided in good faith.

Another issue that home care providers face within the managed care paradigm is the lack of standardization in the system, which is draining home care resources and contributing to delays in payments. Providers must contract with multiple managed care plans for the provision of services, all of which have different processes and procedures with which home care providers must adhere. Agencies struggle to keep track of the different billing codes, modifiers and requirements of each managed care plan with which they contract. Meanwhile, poor communication makes it difficult for providers to secure the information necessary to bill properly for services or to resolve conflicts in a timely manner.

Under the Medicaid program, while it may not always pay at a level that covers providers' costs, agencies can trust that they will receive reimbursement on a timely basis each week. Because the cash flow needed to meet weekly payroll is significant, the instability of managed care payments has been particularly difficult for providers to manage. As the mandatory transition continues to

expand, it is critical that resolutions to the fundamental issues of managed care billing and payment are identified.

The Home and Community-Based Care Workgroup, which was established under the 2013-14 State Budget to address managed care transition issues, was extended under the 2014-15 State Budget. At that time, the charge of the Workgroup, which is representative of different types of home care providers, managed care plans, and consumer groups, was expanded to include an exploration of managed care payment and billing issues and identification of potential resolutions. To date, the Workgroup has not adequately addressed these issues; however, the need to identify collaborative resolutions to challenges related to billing and timely payment must remain a priority moving forward.

Overall, there is a critical need for New York State to ensure that the integrity of the Medicaid program is upheld as the transition progresses. All entities involved in the coordination and delivery of care to Medicaid beneficiaries, using State dollars, must be held to strict accountability standards and measures. Safeguards are needed to ensure that monies move through the system as intended, and that provisions are in place to address ongoing obstacles and assure patient continuity of high quality care.

HCP urges the Legislature to incorporate provisions in the Budget that will ensure home care providers receive prompt payment of clean claims by managed care plans. Additionally, the development of uniform billing codes for use across managed care programs for home care will help streamline billing and lessen administrative burden. A requirement for the use of electronic funds transfer, which currently exists in the State Medicaid program, will help guarantee that payments from managed care are received on a more timely basis.

Greater Home Care Efficiencies through Regulatory Reform

Home care in New York is heavily regulated and faces new and expanding statutory, regulatory and policy requirements despite an economic environment that demands streamlining. The fiscal and human resource costs of compliance greatly increase the challenges home care providers have in caring for their patients while dealing with inadequate reimbursement rates and changing health care system operating realities. At a time when all have been asked to be part of the solution to the fiscal challenges the State faces, regulatory flexibility, creative solutions, and streamlining are imperative.

Regulatory Requirements within the Managed Care System

Relative to the transition to managed care, an implementation issue that has still not been adequately addressed is clarifying how current home care minimum standard regulations and Medicaid program regulatory requirements intersect with the transition to a managed care environment and private contracts between providers and managed care. While the nexus among these regulations have existed for years, the fact that so many providers are now involved in this contracting, as well as managed care plans, greater confusion and questions continue to be raised.

Home care providers continue to cite that Medicaid managed care/MLTC plans do not fully understand the home and community-based care industry and the regulations with which home care must comply, which lead to challenges with contracting and operationalizing relationships between these entities. Home care providers have found themselves struggling to convince managed care organizations that there are certain things they are required to comply with under State licensure regulations, and there is confusion that exists regarding the roles and responsibilities of home care providers and managed care plans. Sorting through the issues and securing clarification is further complicated by the fact that oversight of the various managed care programs comes from the Office of Health Insurance Programs and two Divisions within that Office, and home care surveillance is conducted out of the Office of Primary Care and Health Systems Management.

The Home and Community-Based Care Workgroup was established to address these types of issues, among others. The Workgroup has worked to secure clarification on a number of regulatory issues, such as responsibility for Medical orders, and HCP and other stakeholder associations have worked to support the Workgroup in their efforts by helping to identify regulations and procedures in need of alignment, clarity or streamlining, along with suggested solutions. There are many questions and concerns that continue to exist, however, and it must be a priority to address these challenges.

Real People and Families Depend on Home Care

As New York moves ahead with multi-billion dollar initiatives to restructure and reinvest in the health care delivery system, HCP urges the Legislature to consider the tremendous value of home and community-based care in our State, the vital role that home care providers play in our communities, and overall, the desire of disabled, chronically ill and aging individuals to receive care in a manner that will permit them to remain in the comfort and safety of their own home as long as possible.

New York State's home care industry is comprised of agencies that go above and beyond to care for their clients and invest in their workforce. Their commitment and dedication to the work they do is unwavering. Home care providers recognize the fiscal challenges the State continues to face, but there now are more resources available and home care has already made significant sacrifices to help balance recent State budgets through hundreds of millions of dollars in cuts over the past several years.

We must not surrender the immense progress our State has made in increasing access to home care services that are both cost-effective and preferred by patients of all ages and their families. Home and community-based care is critical to reducing and preventing the use of care in more costly health care settings. So many New Yorkers depend on the State's home and community-based care system, which is why home care policy proposals must be carefully considered before being implemented.

In the coming weeks and months, as the Executive and Legislature work to agree on a budget for the upcoming fiscal year, HCP urges you to consider the devastating impact on patient access and continuity of care, the stability of home care worker jobs, and the financial viability of home care businesses if critically needed State support continues to allude the industry.

HCP looks forward to continue working with Governor Cuomo and the State Legislature to preserve access to home and community-based care for all New Yorkers.

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