Testimony To The
Joint Legislative Budget Committee
On Health and Medicaid

On The
2019-20 Executive Budget

Home Care Association of
New York State

Introduction and Testimony Overview

Good afternoon Honorable Chairs and Members of the Joint Committee.

I am Al Cardillo, President and CEO of the Home Care Association of New York State (HCA). HCA appreciates the opportunity to offer comment and recommendations on the 2019-20 Executive Budget Proposal. We stand ready to assist you, fellow legislators and the Executive in shaping the budget's provisions to meet New Yorkers' health care needs.

The Home Care Association (HCA). HCA is the statewide association representative of home and community based care, comprised of approximately 300 members that include home care agencies, managed long term care (MLTC) plans, hospices, waiver programs, allied organizations and individuals involved in the provision of health care and support at home. Over 500,000 New Yorkers are served in home and community based care across the state, and specifically by thousands of dedicated home care aides, practitioners and organizations.

Background on Home Care. Home care organizations provide supportive, preventive, post-acute, rehabilitative, long term, and medically complex care. Home care has critical roles across the patient and service spectrum, from maternal and infant care, to care of medically needy children and adults, to post-surgical care, rehabilitation and recovery services, public health services and education, chronic care to the elderly, palliative and advanced-illness care, partnering with hospitals, physicians, mental health and other providers for collaborative care, and more. Home care helps individuals maintain and/or restore health, keeps individuals from avoidable hospitalizations and institutional placement, promotes the independence of persons with disabilities, prevents emergency episodes, and enables major efficiencies that sustain the Medicaid budget.

Home care services for patients can include: clinical and service management, skilled professional nursing, home health aide/personal care aide, physical therapy, occupational therapy, respiratory therapy, medical social work, telehealth, medical supplies and equipment, nutritional counseling, preventive health, community supports and services like home adaptations, home delivered meals, social day care, care transitions, patient advocacy for other needed health and social/environmental services, and other supports.

Status of the Industry. Through these services and interventions, home care is providing for increasingly medically complex patients at home; many are individuals who even just a few years ago would be hospitalized or in intensive long term care facility placements.

This major and growing role of home care, combined with the increasingly competitive staff compensation needed to achieve workforce sufficiency, while continuing to face the huge underfunding of its services, makes the need for dedicated support in ***this*** budget an imperative.

This section provides you with some of the very latest data profiling the financial status of the industry. A separate report has been compiled by HCA and will be provided to you imminently.

The data for this profile is derived from official home care agency, hospice provider and MLTC cost and statistical reports to the State Department of Health, and supplemented by an HCA provider survey. Also provided is payment data that is annually compiled by Simione Consultants for NYS Certified Home Health Agencies (CHHAs) participating in their *Financial Monitor* tool. The Simione data, in conjunction with the HCA-compiled data, reveals the **alarming reimbursement shortfalls across payors** that are contributing to steep reimbursement losses compromising NY CHHAs.

The data reveals urgent vulnerabilities and needs in the vital in-home safety-net. Nearly three-fourths of Medicare-certified home health agencies and two-thirds of licensed home care agencies are operating with rates that are sinking them into red margins and worsening trends, and two-thirds of the state's MLTCs are in negative premium income positions.

<u>Data from the HCA analyses shows:</u>

- **72%** of Certified Home Health Agencies (CHHAs) have negative operating margins in 2017 (up from 70% in 2015).
- **Minus -11.95%** is the average CHHA operating margin in 2017 (a worsening trend from an already serious -7.30% in 2015).
- **$107 million** in total CHHA agency operating losses in 2016.
- **65%** of Licensed Home Care Services Agencies (LHCSAs) with negative margins in 2017.
- **42%** of LHCSAs in the survey sample reported having had to use a line of credit, or borrow money, to stay afloat.
- **64%** of MLTCs had Negative Premium Income, a worsening trend from 42% in 2012, when the state's enrollment mandate was instituted. (A negative premium income is the difference between a plan's premium receipts from the state and its expenses for services and other functions.)
- **74%** of hospices show negative operating margins on net patient revenue (50% of hospices had negative margins on their total revenue).
- **Minus -16.57%** average operating margin for all hospices statewide (based on net patient revenue).
- **$79 million** in total operating loss for all hospices (based on net patient revenue).

<u>Data from the Simione *Financial Monitor* shows:</u>

- A median Medicare Advantage plan rate for NYS CHHAs at 54% lower than Medicare prospective payment system (PPS) rates for CHHAs.
- A median Medicaid mainstream managed care rate for CHHAs at 75% lower than Medicare PPS rates.
- A median Medicare Advantage rate for NYS CHHAs at 90% lower than their costs.
- A median Medicaid mainstream managed care rate for NY CHHAs at 213% lower than their costs.

Urgent need for adjustments. The severity of the financial need in the home care system is definitive; adjustments ***must*** be made. NY's home care providers, MLTCs and hospices ***must*** have sustainable reimbursement for the essential services they and their workforce provides for NY's patients, health system and health policies.

Home care and MLTC partners together have the major responsibility for noninstitutional long term care provided in New York State. The federal and state governments certify CHHAs as the entities for providing skilled home health care directly under Medicare and Medicaid. State policy and Federal waivers further require all long term care dual-eligible recipients to enroll in MLTCs for services through partnering home care providers, which are predominately LHCSAs and CHHAs. NY's policies stake the long term care system, and the care of our citizens, on the viability of these organizations.

Yet, home care has received no reimbursement adjustments (like "COLAs" or trend factors") or methodology corrections across payors, necessary for sustainability, while being constantly asked to innovate and "do more with less" via state mandates.

The home health investment gap. Meanwhile major investments, including rate increases, continue to be made for the institutional providers; and, while we fully support our hospital and nursing home partners, home care remains less than visible in the financial rearview mirror. The lack of proactive investment and reimbursement correction for home care not only continues to overlook the needs (and opportunities) in home and community care, but it serves to widen and worsen the worker compensation gap between community care and institutions.

In the past month, two MLTCs have closed due to inadequate state premiums to match their enrollees' risk. These health plan closures are leaving outstanding debt and default

payments to providers further adding to their financial struggles, while the 2019-20 Executive budget proposal contains still-further cuts to MLTCs. These providers, and the ongoing MLTCs, must be supported. **Additionally, one of NYS's CHHAs serving among the largest number of patients in NYC last week announced over 100 layoffs in planned scale-back of patient caseload** to a fraction of its current service capacity.

Meanwhile, new OMIG mandates in the Executive budget proposal (impacting workforce and discussed in the next section) will further burden providers and plans with new costs.

HCA appreciates the Executive's proposed addition of budgeted funds to support the increased minimum wage levels; but, for the past three years, the funding levels have not matched the need.

HCA Core Budget Requests and Recommendations

We recognize the Executive's challenge to construct a budget seeking to close a major deficit, provide core Medicaid funding and target new dollars to key areas of need. Within the Executive proposal there are items we support. However there are ill-advised cuts and proposals seeking reforms or new mandates that we strenuously urge the Legislature to modify or reject, and the Executive to reconsider and withdraw. And, there are urgent needs in the system not addressed in this budget that we urge be addressed in Article VII Health and Mental Hygiene (HMH) amendments and in related budget action.

Our recommendations are provided in **five key areas**, summarize below, with details to follow:

I. *Sustainable Financing:* *Provide urgently needed support for home care reimbursement. Provide for essential home care rate adjustments in fee-for-service and managed care, and modify the rate setting laws and methods to sustainably fund managed care*

plans and providers for essential home care services and workers; address funding for further targeted areas, including providers left vulnerable to default payments from the referenced MLTC plan closures.

II. Modification/Rejection of Certain Executive Long Term Care Budget Actions: *Rework the proposed Consumer Directed Assistance Program proposals; reject the MLTC transportation carve-out and other MLTC cuts; withdraw/table the overlays of new administrative burdens and costs proposed by new OMIG audits*.

III. Critical Assistance with Workforce: *Adopt HCA's legislative language (bills later referenced) to initiate assistance for urgently needed workforce for patient care; also* ***importantly, reject OMIG proposal to require home care worker NPI*** *(National Practitioner Identification) numbers.*

IV. Balanced Funding for Home Care Infrastructure: *Ensure that funds in the budget for health Infrastructure (typically weighted toward institutions) are proportionally allocated for home care, hospice and community health.*

V. Leverage and Reinvest Health Savings through Home Care and Hospice: *Adopt HCA's legislative language (bills later referenced) to strategically leverage home care and hospice roles to save costs and improve health in the state's prevention, primary care and public health programming.*

These recommendations are further detailed in the balance of this testimony, and HCA will be following today's hearing with data, Article VII language amendments and additional materials in support of the recommendations.

This testimony, and these asks, are against the backdrop of a state health care system, a state budget, and most importantly hundreds of thousands of medically needy individuals, all dependent upon this home and community health care system. The state's core health policies for delivering care, making the system affordable, and advancing state of the art health care practices are predicated on a quality home and community based care system that is continuously accessible and clinically and culturally aligned to the citizens needing care.

Details for on recommendations in each priority area, I – V, follows.

I. Sustainable Financing

HCA proposes the following urgently needed rate adjustments and modifications.

1. Include home care and hospice in rate adjustments that that the Executive is otherwise planning for the institutional sectors. In November 2018, funds from the Fidelis-Centene transaction were directed for rate increase for institutional providers; it is our understanding that 2019 institutional rate adjustments are planed using these same funds or other budget sources. **We ask that these or other available sources be used to support urgent increases for home care providers.** We project that increases from 2% to 10% would drive a total allocation of between $4.5 to $20 million in state share Medicaid funds; potentially able to be offset by system savings from improved home care access for patients who would otherwise require higher cost services. Such rate increases should also be able to yield much needed increases in Medicare funding to home care agencies (explained further below).

2. The Executive's HMH Article VII bill proposes renewal of the state's CHHA Episodic Payment System (EPS) methodology under Medicaid through March 2024. **HCA recommends amending the EPS language to authorize Medicaid rate adjustments under EPS and individual fee-for-service rates necessary for wages, services and operations; and, as necessary, the increase or elimination of the cap preventing adequate payment.** (Moreover, rate adjustments overdue by the state to CHHAs and their contract LHCSAs for minimum wage have still not been made for the 2018 and 2019 MW levels, and the Department of Health and Budget Division should be directed to make these adjustments.)

3. Undertake NYS Actions that Support Medicare Payment. The Medicaid rates are typically also used by Medicare Advantage payers as their benchmark for payments to providers. Therefore the adjusted EPS and FFS Medicaid rates recommended in # 1 and #2 above can also

provide a basis for adjusted Medicare payments by Advantage plans. This would help address some of the critical underfunding to NY home care agencies cited in the data provided earlier. Because the use of these rates as Medicare benchmarks reflects the "practice" but not a requirement, and with payor shortfalls to home care occurring broadly across payors, as shown in the earlier data, we recommend further action to assist home care (next recommended).

4. Adequacy of Rates in Fee-for-Service and Managed Care. Insert Article VII language addressing home care rate adequacy by all payors – fee-for-service and managed care. **The Article VII should establish a basic standard across payors that rates at a minimum be at levels for sustainable home care in NYS, and that these rates capture the full and necessary cost of worker wages, operation, and service delivery. It should also require that these costs be fully and properly reflected in actuarially sound premiums provided by the state to Medicaid managed care plans for the rates paid to home care providers**. State law currently provides such standards as benchmarks for payor reimbursement of nursing homes and other providers in fee-for-service and managed care, with the costs required to be reflected in state premium payments to Medicaid managed care plans.

5. MLTC-Provider Rate Adequacy. Amend Public Health Law (PHL) §4403-f in the HMH Article VII bill to **provide transparency in the state's calculation of the cost and provision of funding to MLTCs and providers for minimum wage and other statutory wage mandates**. **Specify that any new mandate on MLTC must require the state Department of Health to demonstrate adequate and timely funding** for such to MLTCs and providers. Further, require transparency and clarity in the state's distribution to MLTCs and providers of the funds that are intended to cover their cost of meeting these mandates. These statutory changes would help address major and

recurring concerns by providers and MLTCs over funding inadequacy and uncertainty of the payment process plaguing the minimum wage increases since they began in 2015.

6. Good Faith Support for Providers Owed Service Payments in MLTC Closures. We ask the Legislature and Executive to ensure that outstanding Medicaid payment to providers' resulting from the recent closure of two MLTC plans in the past two months be responsibly paid and covered in the Medicaid budget. The funds should be provided to sustain the affected providers that rendered services in good faith to these state-funded MLTCs and are now facing losses due to the plans' insolvencies. Moreover, a mechanism should be established in the Article VII to help prevent provider and plans from being so affected should future insolvencies arise.

II. Modification/Rejection of the Executive's Long Term Care Budget Actions

1. Modify the Executive's Proposals on the Consumer Directed Personal Assistance Program (CDPAP) and Fiscal Intermediaries (FIs). The proposed budget contains several proposals aimed at cost and performance controls in CDPAP and the FIs administering this program. **HCA supports program improvements; but the new provisions must be modified from the Executive's language to be workable for the conusmers and for the administering FIs and MLTCs.**

The Executive proposes "repeal and replace" of the entire CDPAP statute, and repeal of the FI authorization statute. The latter repeal would eliminate the current FI authorization process and potentially the FI operating and/or approval status all of several hundred providers and other entities operating or awaiting authorization as FI administrators for CDPAP. The Executive language proposes a new DOH discretionary authority to determine the number and

sponsor of FIs based on a request-for-proposals process. The proposal carries a fiscal that seeks a more than 64% reduction in state reimbursement to FIs to administer CDPAP, and projects a $75 million state share attributable to the reduction.

HCA urges that the Article VII be amended to reject the repeal and replace approach, and instead to transparently amend the existing CDPAP and FI statutes to institute responsible and workable improvements into the programs and its administrative costs. Changes to increase program controls and efficiency should ensure that patient access to care is not diminished, and that any changes to the FI authorization process or approved FI numbers ensure an appropriate distribution of FIs in the state to administer the program without impact on access or the viability of LHCSAs or CHHAs currently serving as FIs. Any changes to the administrative payment levels or methods must ensure levels that adequately cover the agency's cost of administration.

Any state savings derived from these reforms should be reinvested into home care to assist with desperately needed worker recruitment, training and retention.

2. Reject Carve out of MLTC Transportation from the service package, or at least retain as a plan-option. Patient transportation is a critical service to the long term care population. It is central to patient health, safety and overall coordination of care that the ability be retained to provide this service through MLTCs in a timely manner, tailored to the patients' needs, aligned with his/her functional abilities and conditions in arranging the appropriate transport assets and personal assistance in transport, and to have the asset responsive to MLTC case managers and communications. Transportation resources are especially challenged in the upstate and rural areas, and MLTCs in these areas in particular have invested time, funds and staff to institute transportation services for the enrollees in this geography. **The proposed**

carve-out has been repeatedly rejected by the Legislature and HCA urges that it again be rejected, or least retained as a plan-specific option for those MLTCs who request it as needed for their service package and care management.

3. Reject other hidden cuts to MLTC premiums that have been tucked into various budget proposals to pay for other initiatives by reducing MLTC funding for services, providers and workers. Executive briefings reveal the intention to fund or backstop certain new program initiatives with offsets to MLTC premium or related funding. An example is the Executive proposal to fund new long term care initiatives outside of Medicaid. HCA greatly welcomes and supports efforts to expand non-Medicaid sources of long term care support, and these should be tested and funded in their own right. The State Fiscal Plan should not use MLTC funding reductions as a bankroll for such other programming, particularly as there is no advance assurance that MLTC costs would actually be reduced by the creation of these other long term care efforts, thereby absorbing the premium offset. MLTCs and their service partners who are already struggling financially cannot withstand such further erosion of funds.

4. Reject OMIG Proposals for more layers of OMIG audit. The Executive Budget includes several proposals that further layer audit burden upon MLTCs and providers. The system is inundated with audit activity that is already costly and adds to the direct care staff administrative burden that is actively driving practitioners from the field. These proposals should be rejected pending further analysis of merit, need and impact on MLTC and provider operations, costs and workforce.

III. Critical Assistance with Workforce

Data compiled from HCA's provider survey reveals major challenges in workforce need, vacancies, turnover rates, provider costs, and most importantly, consequences for patient

access to services. The updated data results below are conceptually consistent with other health personnel analyses, and underscore the urgency for multi-tiered intervention.

HCA's 2019 report of this survey will show:

- **28.88%** Average home health aide turnover rate.
- **23.63%** Average turnover rate of nurses.
- Unfilled positions consisting of **20.62%** RNs/LPNs vacancies; **20.67%** therapists; **17.07%** home health aides/personal care aides.
- Average percent of monthly home care patients unable to access services (delayed or at all) due to labor shortages: **38.95% due to aide shortages; 38.87% due to RN/LPN shortages; 28.25% due to therapist shortages**.

In meeting service costs, our survey of HCA members reveals that home care's biggest cost and access demands are related to workforce recruitment, retention, supervision and assignment.

As providers work to manage staff vacancies and shortages, patients face serious access-to-care burdens. This has been underscored in testimony at last year's legislative public hearings and related efforts of HCA, Statewide Senior Action Council, a home care worker shortage committee in the Adirondack region, and others. Workforce shortages create challenges that reverberate across the entire continuum, impacting hospitals, emergency departments, physician care, nursing home placement, family caregiver stress, state Medicaid costs, and quality of patient care and life.

As emphasized at the outset of this testimony, NYS rightfully continues to promote a system and policies seeking to increasingly shift and maximize the provision of health care to individuals in primarily home and community settings. This system, the policies and patients are in turn dependent on – ***and count on*** – the existence and accessibility of these services. Given the severity and consequences of the staffing shortages around the state, and especially

in certain areas, NYS must take serious policy and program action to help establish the resources in home care that can meet the great and increasing demand for care.

HCA is calling for a set of proposals to address workforce needs, including: competitive nurse, therapist and home health aide compensation; state initiatives to encourage occupational entry into the home care and hospice fields; targeted support to address specialty workforce needs and geographic shortages; plus cross-training of clinicians so that the current capacity of clinicians and paraprofessionals is equipped to transfer skills across settings. Administrative relief is also necessary, to help maximize the time direct care personnel can devote to patients, and to reduce the burnout rates from excessive administrative and documentation burden in home care.

HCA recommendations:

1. **Reject Executive's Proposed NPI Mandate.** First, HCA asks that the budget "do no harm." **We ask the Legislature to reject and the Executive to withdraw the OMIG's proposal that would require home care workers obtain national provider identification (NPI) numbers to provide services in New Yor**k. This proposal does not generate a state savings and could have very serious ramifications diminishing home care access that is already stressed by a severe workforce shortage. The logistics of this proposal have not been fully considered, and minimally include: how this requirement would be implemented by the thousands of agency employees accurately, timely and without disruption in service or payment; the ways that this new ID requirement could further disincentivize individuals from entering the field (particularly in the current climate of immigration and foreign worker access issues at play at the national level and relevant to this field where cultural/ethnic competency for worker-patient match is essential); how this process would work with already established systems to vet potential

employees providing home care services, such as the Home Care Worker Registry or Criminal History Record Check statute; how to account for NPI application by those employees whose native language is not English and who do not speak English as a first language; and other. **HCA appeals to the Executive to withdraw and the Legislature to reject this proposal.**

2. Target shortage funding to critical areas, disciplines and key worker support needs. Incorporate into the HMH Article VII bill the provisions of S.1420 which provides for a $30M supplemental rate add-on for home care, hospice and MLTC, targeting the unique challenges direct care workers face daily, including transportation, child care costs and availability and in-service support, and targeting shortage disciplines and geographic regions. Funds for this initiative would come from the existing sources in PHL §2807-v as the current rate adds for home care staffing, and accumulated unspent balances in the §2807-v funding pool.

3. Address Structural Issues Affecting Worker Supply: Include the provisions of S.1359 in the Article VII, providing for a competitive labor market analysis for home care/hospice worker recruitment and retention, and yielding recommendations for compensation and rate levels needed to meet community need, and establish a state interagency effort to support, encourage and publicly emphasize the value of entry into the field, from pipeline, to professional schools, to attraction from existing workforce. Also, adopt Article VII provisions resurrecting PHL §2807-h (or comparable) that would allow DOH to approve providers for innovative relief measures.

4. Allow collaborative, cross-training for hospitals and home care/hospice. The Health Care Worker Retraining Program is an initiative provided for and funded under the Health Care Reform Act (HCRA). It was created to assist the alignment of health care worker training with the changing health care system. HCA asks that the provisions of S.8613 of 2018, which would

allow hospitals to engage with home care and hospice for collaborative cross-training via the Health Care Worker Retraining Program, be incorporated with the above bills and actions for this overall workforce package for the HMH Article VII bill.

IV. Balanced Funding for Home Care Infrastructure

HCA asks that the Legislature and Executive ensure that funds allocated in the budget to support health infrastructure, such as the Health Care Facility Transformation Program, and the new Charitable Health pools created by the Fidelis-Centene transaction, are proportionally allocated for home care and hospice. To date, distributions of budget funds for infrastructure have been heavily weighted toward institutions, and in the case of the Fidelis-Centene fund, exclusively provided to institutions. The state has leveraged billions of dollars in waiver funds (through DSRIP) that have almost exclusively flowed to institutional providers, with less than 1% going to home care, hospice and other community provider categories. Moreover, according to HCA's provider survey, 20% of home care providers participating in DRSIP collaborations have received no payments from DSRIP, with almost 30% stating that the DSRIP funding sources haven't involved them at all despite the fact that DSRIP's goal is to reduce hospitalizations by 25% – and home care is the backbone of that effort.

HCA Recommendations:

1. Amend the Health Care Facility Transformation Program (HCTP). In this budget, the Executive proposes to transfer $300M in funds from year 3 to year 2 HCTP projects. The shift would channel these prospective year 3 funds for health infrastructure to projects substantially for institutional sectors, while home and community health providers continue to receive comparatively minor support. Amend this proposal, directing that the remaining funds be further reapportioned in round 3 to support home care, hospice, MLTC and other community

health providers, making up for largely institutional benefit in the shift to round 2. Criteria should be included that better align the needs of home and community-based services.

2. Ensure proportionality in Fidelis/Centene Funding Pool Distributions - Require that home care and hospice be included in any Fidelis/Centene funding pool allocations in this and prospective funding periods.

3. **Ensure adequate electronic visit verification (EVV) funding for providers prior to implementation.** The OMIG has proposed mandating and implementing an EVV claims process by home care providers. OMIG has proposed, and the Executive Budget includes, $10 million to support the state's administration of the mandate; but no funds appear allocated for provider costs, especially difficult for smaller agencies that have minimal-to-no unencumbered assets to absorb these costs. **HCA asks that the full funding of this mandate be made available to providers *before* it is implemented and the EVV process is required to begin.**

V. Leverage and Reinvest Savings through Home Care and Hospice

Home care and hospice services play a major role in cost-effective care for Medicaid and the health system overall. However, there is much more that can be strategically done to create savings and better outcomes through state policies that further, and more deliberately, incorporate these services into the state's prevention, primary care and public health programming.

For example, currently, HCA and NY home care providers are championing the nation's first initiative to screen for, educate, prevent, and intervene with doctors and hospitals to mitigate the severe and rapid effects of sepsis. Through the work of HCA, IPRO and our expert sepsis workgroup, home care providers across NYS have been trained in and adopted a unique

sepsis tool developed by HCA and the above experts for sepsis intervention through home care. The effort continues to train and initiate additional providers, including other community and ambulatory care providers, and has drawn national attention and growing replication in other states. Sepsis is the #1 cause of 30 day hospital readmissions, the #1 non-mental health related cause of Medicaid preventable hospitalizations, results in a hospitalization every 20 seconds and a death every 2 minutes, and begins 80-90% of the time in home and community, with the elderly and typical home care populations being among the highest risks and highest percentages of sepsis cases. Home care can make a game-changing impact on this enormously costly and devastating condition. Moreover, sepsis's 25% hospital readmission rate, and the often long-term physical and mental impairment afflicting sepsis survivors, makes it highly impactful to long term expenses – including Medicaid covered services. Further harnessing this initiative with the support of state policy and budget action can save even more lives and costs.

Another example of such health and cost saving potential through home care is in asthma management. It was estimated in the State Health Department's Value Based Steering Committee that upwards of 50% of all asthma cases are likely environmentally triggered, warranting home assessment; exactly what home care agencies could do if partnered for such purpose with primary care physicians and clinics. Additional triggers include compliance with medication and home management plans.

On this latter example, HCA has compiled data and outcome results on extremely significant asthma management through home care and will be providing such to the Legislature and Executive. The NY's Medicaid Redesign Team produced recommendations indicating the potential of millions in Medicaid savings through effective community based asthma management.

Legislation introduced by Senator Gustavo Rivera (S.1816 and S.1817) and Assemblyman John McDonald A.3836 and A.3839) would include home care in the state's policies and strategies for public health, primary care and prevention, focusing on such high cost/high risk areas as sepsis, falls, asthma, pressure injuries, health disparities, heart failure and other.

HCA recommends the adoption of the Rivera/McDonald legislation in the HMH Article VII bill. An additional bill, **A.2925 of 2018 by Assembly member Crystal Peoples-Stokes also addresses the dire need for intervention in health disparities.** "Health disparities" result in untold health impact, early death, avoidable health impairment, millions of avoidable health care dollars and adverse societal impact from disparate prevalence of health conditions, inequities in access, and other factors present with or affecting racial, ethnic, geographic and other population groups.

The existing HMH Article VII bill calls for an initiative to reduce avoidable hospitalizations through investments in maternity and ambulatory care.

The language should be modified to add home care and hospice, and would be further supported with the inclusion of Senator Rivera's and Assembly member McDonald's home health legislation as a primary vehicle.

HCA Recommendations:

1. Include "home care and hospice providers" to the list of "prevention providers" (currently maternal care and ambulatory care providers) in the Executive's proposed Hospitalization Prevention Reinvestment Program.

2. Adopt as part of the HMH Article VII HCA-developed language comprising Senator Rivera's bills (S.1816 and S.1817) and Assembly member McDonald's companion bills (A.3836 and A.3839), and the HCA language in A.2925 of 2018 by Assembly member Crystal Peoples-Stokes, to foster opportunities for improved health and savings through home care interventions in

conditions like sepsis, high risk maternal and neonatal care, asthma, diabetes, falls, pressure ulcers, palliative care and more, and include hospice along with home care in this initiative.

Concluding Remarks

HCA appreciates this opportunity to provide comments and recommendations. We are available to answer any questions or provide further information (acardillo@hcanys.org), and will be following up to offer our Article VII language and further backup documents for the data and proposals we have made.

HCA stands ready to work with the Legislature and Executive in any and all ways to support their adoption in the 2019-20 state budget.