



Testimony of the Home Care Association of New York State

Before the

**Assembly Committees On Health
Assembly Committee On Aging
Assembly Committee On Labor
Assembly Task Force On
People With Disabilities**

**Joint Public Hearing on the
Home Care Workforce
& Sufficient Capacity to Meet Need**

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The Home Care Association of New York State (HCA) is the statewide health care association representative of all levels and models of home care including Certified Home Health Agencies, Licensed Home Care Services Agencies, Long Term Home Health Care Programs, Hospice agencies, Managed Long Term Care Plans, Waiver Programs, and Allied Agencies and Organizations. HCA providers and programs are sponsored by health systems, hospitals, nursing homes, free-standing agencies and health plans.

HCA members serve over a half million home care cases annually, as well as families and communities.



Summary of Major Points and Recommendations

1. Home care need is acute throughout the state; driven by state and federal policy reforms, major reconfiguration of the health care system shifting care to home and community, demographics, and patient need/preference/patient health care right. The home care shortage is evidenced statistically, and in reported difficulties in consumer access and overall health system functioning.
2. Home care capacity, worker shortage and investment needs are evidenced in all regions of the state, and are particularly acute in certain disciplines and regions. Supporting data are presented.
3. Regional and discipline-specific responses are needed, as is a comprehensive state action plan.
4. Contributing factors to access, capacity and personnel shortages are multifactorial. Some of the many factors discussed in the testimony involve:
 - a. Inadequate premiums, rates and other resources for managed care and home care providers to sufficiently cover supportive operations, staffing, wages, training, and direct worker supports.
 - b. Difficulty providing compensation sufficient to attract and retain qualified health personnel, especially home health and personal care aides.
 - c. Shortages in the sheer numbers of personnel trained and available for work in the field.
 - d. Unique aspects of the home care field, mission and populations; difficult working environment (e.g., excessive documentation) stretches limited capacities and detracts from entry/retention.
 - e. Need to support personnel in employment capability and in practice, including professional development, skill and practice progression.
5. Actions proposed:
 - a. Adopt the proposed \$242 million appropriation in the state budget for increased minimum wage, and add language ensuring a workable distribution method for managed care plans, providers and workers.
 - b. Adopt HCA Article VII proposal amending PHL Articles 44 and 36, and SSL 364-j to strengthen state reimbursement methodologies to ensure sound managed care/home care payment for state/federal law compliance, wages/benefits, staff support, services to meet need, operations.
 - c. Examine coverage options beyond Medicaid/Medicare. Modernize antiquated state statutes (unchanged since 1972) for private and commercial coverage for home care; this statutory framework bears no resemblance to 2017's health system. (HCA offers legislative and administrative proposals)
 - d. Implement comprehensive worker supports, including support for transportation, day care, documentation/admin relief, and professional development/advancement opportunities.
 - e. Engage state agencies, SUNY/CUNY/BOCES, HCA and applicable stakeholders to promote home care as a career/practice interest and building a pipeline for entrance into the field.
 - f. Adopt HCRA renewal in the state budget with: (i) amendment to the HCRA Health Care Worker Retraining Program to further target retraining of the downsizing institutional workforce to serve in home care; (ii) tap other applicable HCRA initiatives (e.g., home care workforce monies) or funds to support the purposes identified through these public hearings.
 - g. Amend PHL Article 28 to strengthen DSRIP support for home care and the purposes identified through these public hearings.
 - h. Adopt HCA Article VII language proposal to establish and implement a comprehensive state policy and plan to examine and ensure home care capacity and health personnel to meet statewide and regional patient, worker, community and overall health system needs.

Honorable Committee Chairs and Members. The Home Care Association of New York State (HCA) thanks you and applauds your leadership for conducting these critical public hearings on the home care workforce and capacity-need in New York State. We appreciate this important opportunity to testify to you.

The issues and challenges surrounding home care personnel recruitment, retention and supply sufficient to meet community need are multi-factorial. The actions needed to respond to these issues and challenges – in order to ensure quality and sufficient home care staffing, service capacity and access for New York residents and New York’s health system – are likewise multidimensional.

This testimony addresses many of the core need and challenge areas, and offers recommendations for both immediate and ongoing action. The testimony is by no means exhaustive, as this issue and the needed actions are indeed comprehensive, and go well beyond the space and time allotted here. We look forward to working with you on comprehensive solutions and supports for this vital need.

The Home Care Imperative

Home care has ceased being just an “option” or an “alternative” in the health system; home care and access to it are a fundamental need.

The public health system has been reconfigured to require and rely on ready access to timely, capable and person-centered home care. Current governmental policies and reforms are rapidly and substantially deepening this reliance. For citizens, families, hospitals, physicians, payors and other system partners who

depend on home care access, it is imperative that New York's home care resource matches the need.

Home care-need is also upwardly trending due to core demographics greatly driving demand, cost control policies directing patients and services to the home and community, medical advances migrating highly complex care into ambulatory and in-home settings, care regimes using home care to avoid preventable hospitalizations, and patients' preference on where they'd like to receive their care. A clear measure of this ever-building need is the fact that home care workers are the largest area of anticipated health care employee growth in our state (figures subsequently cited in testimony).

Ultimately, the Americans with Disabilities Act and decisions of the United States Supreme Court (esp *Olmstead v. LC, 1999*) create the right for individuals to receive care in the least restrictive, most integrated setting, which most of the time means an individual's *home*. Home care is not only *right*, it is a person's *right* in health care.

These and others are among the more reasons why the home care need is only growing, and why it is imperative that New York's home care resource matches the need.

State and Federal Policy Driving a Growing Need

The new models of care and coverage, like managed care, accountable care organizations, value based payment, Delivery System Reform Incentive Payment

(DSRIP) programs, comprehensive joint replacement, and other integrated models depend on readily accessible, nimble, efficiently delivered, and high-performing home care services. Billions are being invested in these models.

For these policies and models to succeed, New York's home care resource must match the need.

Home Care Need Spans the Continuum; Workforce & Access Must Too

Home care agency services span the continuum of care – from maternal and child health, and pre- and peri-natal care, to primary and preventive care, to post-acute recovery and rehabilitation, to complex chronic care and disease management, to long term care and support, to palliative and end-of-life care.

Across this continuum, home care encompasses: the direct care provided in a person's home, as well as care and service in community settings; the transition of persons from setting-to-setting, especially from hospital-to-home or nursing home-to-home; and managing the navigation of complex service planning and delivery, including medications, appointments, personal and environmental supports, transport to and from physicians and outpatient services, and other.

Home care supports the holistic aspects of the patient in his/her environment and community, thus home care must employ personnel that are capable and in sufficient supply to meet this mission. The home care resource must match the need.

Adequacy of Personnel and Access is About More than Numbers

The question of adequate home care personnel and access is therefore not just about the *number* of workers. Adequacy requires personnel of the right *kinds, right credentials, right amounts, and right duration* able to deliver services that match the needs of diverse patients and a diverse health care system.

Individual case needs may include a range of:

- highly specific, one or two-time visits,
- episodic, multi-visit plans,
- highly complex multi-level care regimens that combine multi-hour/multi-day support of activities of living (dressing, bathing, eating, transferring), therapy and skilled care,
- 24-hour constant care and support.

These and all other diverse case types must be accommodated, and likewise require the needed personnel.

Among the core personnel in home care needed to deliver these services are: nurses, physical therapists, occupational therapists, medical social workers, respiratory therapists, home health and personal care aides, nutritionists, and other direct care staff. Critical to meeting needs are also specialized staff such as pediatric and psychiatric nurses, nurse practitioners, behavioral health specialists, and staff trained in clinical competencies like palliative care and cultural and language competencies critical to patient care. The home care resource must match the need.

The Need to Respond to Patient Diversity & Home Care's Unique Aspects

The health, situational and personal diversity of patients seen by home care agencies and home care staff present and accentuate the unique and extraordinary challenges in home care. As noted, the home care population includes the full array of conditions and service needs. Moreover, in home care, each and every case is a unique circumstance because the patient, the entire social and familial milieu, and the physical environment, are different, and require customization by the agency and the workforce. This means matching home care staff to work within each individual and unique case/setting in order to deliver and manage effective care.

A 300 pound bariatric patient who needs transfer assistance, or a 90 year old patient who needs maximum assistance to toilet or bathe, will not have access unless an agency has direct care staff physically matched to such a patient and matched to the timeslots required for the care. A patient entering home care with serious wounds or ostomies needs a specialty wound-care/ostomy nurse. If such a nurse isn't available, the access is not available either. It's not about the numbers; it's about the *right* type of staff for the person and condition in need.

The same matching requirement holds for cultural competencies, which are similarly critical to both access and quality. This requires the correct matching of the practitioner to the language and, overall, the cultural, religious and ethnic needs of the patient.

So when we talk about adequacy needs and shortages in the home care workforce and in the capacity of agencies, it's about sufficient capacity for timely and

properly matched, and patient centered services. The home care resource must match the need.

Evidence of Need/Shortage Across All Regions, Including Geography Driven

These service and personnel needs are significant in all geographic regions – rural, urban and suburban. Additionally, each region creates a unique set of challenges to the delivery of services in home and community, and to the personnel responsible to deliver and manage them. In rural areas for example there are large travel distances, low population density, limited community and health/social resources, remote living, etc. Urban and suburban areas likewise present geographic-specific, sometimes neighborhood-specific, needs and challenges.

Data from an HCA statewide provider analysis (*NYS Home Care Program and Financial Trends 2017, HCA 2017*) and from the Center for Health Workforce Studies of the State School of Public Health at the University at Albany (*The Health Care Workforce in New York, 2015-2016: Trends in the Supply of and Demand for Health Workers, CHWS 2017*) provide a window into the health workforce needs and gaps. We regard these as illustrative, and provide sample data below from these studies. However, a formal and comprehensive assessment is needed to drill more thoroughly into actual home care personnel and service need projections and remedies by region and statewide. HCA has provided Article VII language to the Legislature and Executive for such an assessment, discussed subsequently in this testimony, and we commend that again to your attention.

HCA's Financial Condition Report finds:

- **High staff turnover rates** – home care agencies reported an average 24% turnover rate for aides and a 21% turnover rate for nurses and other professional staff.
- Unfilled Positions – home care agencies reported 14% of home health aide positions, 17% of personal care aide positions, 13.51% of registered nurse positions, and 10.6% of therapist positions are unfilled due to shortages. (Note that these statistics report “*unfilled positions*,” this is not necessarily reflective of the total breadth of the need, only the capacity of positions that an agency can afford or manage at the time of reporting.)
- Inability to Accept Cases - On average, agencies responding to the HCA survey report inability to accept cases due to staff shortages, with at least three agencies in the survey reporting over 100 cases unable to be accepted because of shortages, and one agency separately reports having to turn down 350 patients in just one county due to the shortage of aides.

Center for Health Workforce Studies Survey & Report

The CHWS home care agency survey responses aggregated in the aforementioned CHWS report indicate:

- Most difficulty experienced by home care agencies is in recruiting: aides, nurses/experienced nurses, speech-language pathologists, physical and occupational therapists and social workers, including difficulty recruiting part-time, bi-lingual and off-shift (evenings/nights/weekends)

- Most retention difficulty reported by home care agencies is in retention of: aides, nurses, speech and respiratory therapists
- The majority of home care agencies report expansion planning in order to meet need.
- Reasons surveyed for recruitment and retention difficulties included: shortage, non-competitive salaries/benefits, lack of specialized training, and location.

(Charts with survey results by region are contained in the CHWS report)

CHWS Analysis of Health Sector Employment

The CHWS also report documents New York State Labor Department statistics illustrative of the growing need for home care workforce:

- Between 2000 and 2014, employment in New York’s health sector increased by nearly 24%.
 - Home health care settings (136%) had the largest increase in employment, more than doubling during this period.

What is needed to provide for home care capacity and Workforce?

1. Adequate rates and coverage for agency operations and services, especially staff wages.

Home care agencies, whether paid under the episodic payment system (EPS), or through managed care, are struggling to support operational costs and staffing that meet the system’s and community needs. The challenge likewise applies to managed-care plans, which are not being adequately reimbursed for the requirements and demands placed upon them, and the expectations placed upon

them for reimbursement of their home care service delivery providers and personnel.

Most immediate to the state budget, HCA supports and urges adoption of the currently proposed state budget allocation to cover significant portions of the impact to providers and managed care plans of the state minimum wage increase for services provided to Medicaid beneficiaries. HCA urges that the appropriation be accompanied by language for clear and equitable distribution to managed care plans and home care providers to meet their minimum wage and related funding obligations. The distribution of the 2016-17 adjustment was a major challenge for providers and managed care plans.

It is also important to note that, since the minimum wage increase applies to all of a qualifying employee's service hours, not just to service hours to Medicaid beneficiaries, home care agencies are impacted by the minimum wage law well beyond Medicaid and the current proposed budget funding. Home care agencies have no place to turn to make up this gap. The gap and funding squeeze will only further increase recruitment and retention pressures on agencies.

In addition, to date, the minimum wage budget assistance is limited solely to meeting minimum wage costs for bringing wage earners who are below minimum wage, up to the new wage levels; no funding is provided to support the deserved-adjustments to employees (particularly longer tenure individuals) earning above these levels but meriting adjustment in face of the wage increase to agency colleagues. An adjustment for these employees is not only fair and worthy, it is

critical to retention. HCA urges the Legislature and Executive to allocate funding to support this critical fair wage and retention purpose related to the state's minimum wage increase.

With regard to overall payment adequacy for essential direct care staffing, HCA has submitted Article VII language for consideration by the Legislature and Executive that builds on the last two Article VII chapters to ensure that state premium and reimbursement methodologies for managed care and home care soundly account for statutory and other fundamental workforce support.

HCA's language would ensure actuarial soundness and premium adequacy for:

(i) Costs to the managed care plan and home care network providers to comply with all applicable laws and regulations, state and federal, including wage and compensation benefits, workers' compensation, overtime and other labor mandates.

(ii) Costs necessary for recruitment, training and retention of a qualified and sufficient direct care workforce, and in the case of training, would ensure support for both basic personal care and home health aide training, and advanced in-service training of aide-level and professional direct care staff. This latter training would be in areas and skills supportive of meeting the access and quality of care needs of patients in the changing health system, including interdisciplinary, high complex/high risk populations, special populations including pediatric, palliative and others with unique needs, and populations evidencing health care disparity.

(ii) Essential technology infrastructure, including health information technology, interoperability and exchange, clinical technology, and connectivity to network, regional and statewide health information systems, and the capital and staffing necessary therefor.

(iii) Quality improvement programing, including essential data production, benchmarking and performance assessment, and support for innovations in quality and value.

(iv) Community public health services, including immunization, emergency preparedness and response, public health screening, and other population health services.

Further evidence is next presented demonstrating why this strengthening of the statute and of the payment methodologies is necessary for financial stability and adequacy for home health care services and home care workers.

Statistics from HCA's analysis of certified home care and managed-care plans, derived from certified cost reports to the state (see *NYS Home Care Program and Financial Trends 2017, HCA 2017*), show a deeply concerning picture of financial erosion affecting plans and providers, reflecting payment inadequacies. The analysis finds that state Medicaid underpayments result in:

- 61% of MLTC plans having negative premium incomes in 2015.

- 72% of Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs) having negative operating margins for 2014, with similar CHHA/LTHHCP financial results in 2015.
- Thirty-one percent (31%) of all home care agencies (CHHAs, LTHHCPs and Licensed Home Care Services Agencies, or LHCSAs) have had to use a line of credit or borrow money to pay for operating expenses over the past two years
- 6% of agencies were unable to establish a line of credit or financing due to various financial factors

Funding pressures on managed care plans are also felt downstream by providers and workers. Providers report experiencing authorization and payment delays, the accumulation of bad-debt, and constricted revenue flow.

As noted earlier, agencies report the inability to fill referrals, and this is exacerbated by worker shortages and payment inadequacies which contribute to insufficient recruitment and retention. Agencies indeed report substantial turnover rates of across key personnel. Underpayments, and resulting under-compensation for wages and benefits, not only compromise recruitment and near-term retention, but undermine longevity. The payment system must support and reinforce longevity, which leads to seasoned expertise, continuous quality advancement, and effective practice. Turnover is a costly and adverse proposition from many angles.

The underpayment of rates for wages, lack of training factor adjustments and other cited worker supports in the state's reimbursement methodology, run contrary

to the capability of plans and providers to recruit, support and retain staff, and in particular to support staff longevity.

In terms of wages in and market ability to compete for and recruit/retain staff, the CHWS report referenced earlier documents average wages per hour in selected health occupations for New York State, based on 2012-2015 survey data, adjusted to include the first quarter of 2016. The report documents personal care aides at \$12.22 and home health aides at \$11.46 as the lowest wage earners in health care. Adjustments, such as we have proposed in Article VII providing for rate adequacy for wages and benefits, are a must.

Adequacy must also include coverage of basic training to qualify and credential direct care staff to work in home care. This includes investment in home health aides, as well as in training and retraining nurses, social workers, therapists, and other professionals to work in the home care field. Clinicians often report the extensive time, cost and effort involved in training personnel practicing in institutional settings to work in the community; and very often, individuals attempting to make this transition, are said to be of limited stay in home care because of the challenges associated with work in home and in community.

Funds must be adequate to also support the *specialized* training of staff, both professional and paraprofessional, to meet the specialized needs of community populations. These include needs associated with major public health priority areas, such as sepsis, asthma, HIV, pediatrics, behavioral health and other. It also includes proper investment for in-service education, to ensure that home care staff are at the

forefront of state of the art changes in the field, such as infection control, pressure ulcer management, use of clinical technology in the care of patients, and other.

2. Examine Ways to Expand coverage beyond Medicare/Medicaid, Including Modernization of NYS's Antiquated Insurance Law Coverage of Home Care (40+ years old)

Adequate payment and coverage of home care worker services need to go beyond Medicaid, Medicare and other government payors; it's long overdue that today's medical standard integrating home care and home care roles into the mainstream also become part of mainstream health coverage. One short-term/immediate step is to address the antiquated coverage of home care services for New Yorkers under their private and commercial policies.

Currently, New York's insurance law coverage provisions are based on a statute enacted over 40 years ago, when home care was a comparably niche service, and before Article 36 even existed. The coverage was (and remains) indexed to the health system in place at that time, which juxtaposed home care to the hospital and nursing home use patterns of the early 1970's that bear no resemblance to the systems, or need of home care, today.

Forty years ago, patients stayed in hospitals until they left recovered; and, in the absence of family, entered nursing homes the near sole source of long term care.

Today however, patients are discharged from hospitals quickly, and often with complex and major recovery needs intended to be met through home care.

Accentuating this pattern, current reform policies are seeking to reduce hospital use

by 25 percent (over already reduced use levels). On top of these, is the overarching emphasis on providing care at home in community to prevent hospitalizations in the first place, along with preventing avoidable emergency room use and rehospitalizations.

Without a change in how mainstream coverage reimburses for home care services, neither the agencies, the workforce nor the patients will be accorded the necessary tools to access services for based on need.

HCA has presented both legislation and administrative proposals to synchronize private and commercial home care coverage to the current real needs of individuals and the medical practice standards of today, and we ask your consideration in furtherance of the goals of this hearing.

3. Support for personnel in home care work environment.

The physical and social environment - Home care personnel work in environments which are substantially different from all others in health care. The nurse, therapist, and home health aide work in peoples' homes, streets, neighborhoods and communities. They travel to high-rises, across farms and to islands, through inner-city neighborhoods and along isolated rural routes to their patients. They must fit into home, familial, social and other environmental situations to provide the needed care. This not an easy task, and affects those who are willing to work and/or stay in the field.

This is made more challenging in that these environments are not always optimal conditions for the care of the patient, or for a comfortable work setting for the worker. Additionally, work in home environments is distinct from most other settings because, unlike in facilities or clinics or offices, workers are usually on their own, apart from clinical peer support which is often a key resource in the health care field. There is no parallel to a “hospital nurse’s station” just a room or hallway away from a worker and the home care worker’s patients.

Operational support for agencies to support home care staff to serve in this practice environment is crucial.

Requirements for staff backup - Another critical areas in home care is that regulations and practice standards require that backup services must always be ready in case a regularly assigned home care worker is ill or unable to fill the assignment. This means the agency must maintain both primary and backup capacity, both of which must be matched to the patient’s specific health and schedule needs. Especially for complex and/or intensive cases, this is a major challenge without a plentiful workforce, and in its absence, greatly affects access to home care for the often most needy cases. This is another area where resources to support home care recruitment and retention are vital.

The documentation load - The documentation and procedural environment in home care is often described as overwhelming by agency staff. Staff express concern that the documentation load competes for workers’ critical direct care time with patients, and ultimately drives practitioners from the field. There must be

attention to providing relief and streamlining of these requirements in favor of the overall quality of the working conditions of the home care professional and their ability to instead channel the time and resources into accessible, quality care.

Chapter 444 of 2011 (Young/Gunther) restarted for home care providers a health occupation and workplace flexibility statute that was originally enacted as part of the 1990 hospital reimbursement law (NYPHRM) and the next year expanded to home care. This chapter, though signed, has yet to be implemented by the Department of Health, and if implemented could support flexibility to address the documentation load and other workplace needs. HCA and DOH have recently engaged in discussions to implement.

Professional development opportunities - The practice environment in particular for home health aides and personal care aides, needs a supported professional development mechanism and strategy, including in-service, specialty training, a career-ladder opportunity and more.

Key to creating such is investment in home care- and collegiate-sponsored specialty education, and support for progression to more advanced practice levels, including care specialization (in areas like pediatric, HIV, behavioral, palliative care, high risks conditions/populations for hospital admission, and other), skill development aligned to new models of care (including integrated care and management teams, value based payment), public and population health skills, training for the new Advanced Home Health Aide level, and progression to new practitioner levels like therapy assistants, LPNs, RNs, and the other.

Support of this type not only increases the attractiveness of entry into the home care field, but importantly, supports retention, quality and worker satisfaction.

Support for these purposes is included in the HCA Article VII proposals provided to the Legislature and Executive.

4. Unique Home care worker supports.

This testimony has repeatedly identified the unique aspects in providing and managing care in the home. Many of those aspects create unique pressures on home care staff. Home care agencies and workers need support in these critical areas. These areas include: transportation, assistance with child care, safety escorts, field-level technology, and other. Support for these purposes is included in the HCA Article VII proposals provided to the Legislature and Executive.

5. Support for Practice/Job Entry into the Home Care Field

Collaborative effort to build pipeline into home care - The state should lead a comprehensive and collaborative effort among the applicable state agencies, HCA, professional societies, and others to examine and implement approaches for promoting interest and entry into the home care field. This should be targeted to practitioners and direct care workers already in the health field, those in or entering education or training curricula, and to the state labor force in general.

The projected growth in the need for home care direct care personnel, combined with the existing reports of vacancy, unfilled cases and turnover, warrants

an aggressive campaign to build and promote an active pipeline of quality individuals into home care.

Some immediate steps could include specific engagement of the Area Health Education Centers, incentives to SUNY (universities, colleges and community colleges), CUNY and BOCES.

HCRA Workforce Retraining Program/further target home care - Another immediate and concrete step can be incorporated into the Legislature and Governor's renewal of the Health Care Reform Act (HCRA) in this 2017-18 budget. A minor amendment could help further target HCRA funding under the Health Care Worker Retraining program to support the retraining of the downsizing institutional workforce for service in home care. Training and orienting institutional staff for work in home care can be a very lengthy, challenging and costly task; yet it is a critical step that would help support home workforce adequacy, public health and priority benefit from use of these funds.

The HCRA pools and HCRA renewal should also be examined for other ways in which one or more of the array of HCRA initiatives could help support home care worker needs and capacity in meeting patient and community needs. HCA would be pleased to submit Article VII language for this purpose.

Discrete DSRIP Support - HCA recommends that the Legislature and Executive incorporate an amendment in the Article VII Health and Medicaid bill to reflect the home care capacity and workforce imperative assessed in these public

hearings within the Delivery System Reform Incentive Program (DSRIP) enabling language in PHL Article 28.

The state's independently conducted mid-point assessment of DSRIP is showing minimal investment in home care; less than 4 percent of DSRIP funds thus far have gone to a category called "other" into which home care has been lumped. It should be inarguable that home care merits its own category and that DSRIP funds be meaningfully directed to the purposes elevated by this public hearing. HCA would be pleased to work with the Legislature and Executive to develop the requisite language.

6. Comprehensive Plan for Home Care Capacity & Workforce Adequacy

Upon its enactment by Chapter 895 of the Laws of 1977, the preamble to PHL Article 36 established as a fundamental purpose that the development and accessibility of home care for New York's citizens, including alternatives to institutionalization, be a priority focus of the state's actions. While major Medicaid and health reforms have been at center stage since the 2011 Medicaid Redesign Team (MRT) effort by the Administration, and while the MRT effort is heavily reliant upon home and community based care for success, it has yet to focus on how home care will indeed be supported to meet MRT goals, let alone the expanded home care service needs of citizens across this state.

The time for a comprehensive home care support plan and policy is now.

HCA has submitted Article VII language to the Legislature and Executive to direct the establishment and implementation of such a comprehensive home care

policy and plan, with the active involvement of all stakeholders, and the close oversight of the Legislature. The HCA proposal would charge this policy and plan to examine and ensure in all regions of the state:

a. Adequate number and location of home care services agencies, including licensed agencies, certified home health agencies and long term home health care program providers.

b. Adequate capacity of the direct care workforce in numbers, locations, hours of availability and necessary areas of training.

c. Adequate capacity and accessibility of both basic and specialty training programs for direct care staff, including specialty training in: care management; population health; palliative care; pediatrics; specialized screenings such as for sepsis and fall risk; behavioral health; areas of health disparity; use of point of service technology, and other.

d. New skills, scope of practice flexibility and/or changes needed to meet the needs of new populations and/or new models of care and coverage at home.

e. Identification of and incorporation of technologies which assist in service efficiency and meeting workforce capacity needs.

f. Provisions needed to support and incentivize direct care workers' employment in home care, including but not limited to support for transportation, peer support, worker escort, day care, and career ladder opportunities.

g. Strategies for collaboration with the departments of labor and education, the state university of new york, the area health education centers, the center for

health workforce studies, professional schools, state home care associations, and others on encouraging career/employment interest in home health.

h. Provisions for managed care and non-managed care financing to support agency, worker and training capacity, including compensation amounts necessary to recruit and retain sufficient, quality and diverse direct care workforce.

j. Recommendations to the Legislature and Governor for administrative and/or legislative modification of state insurance requirements for private and commercial policies' home care coverage to ensure that beneficiaries have access to home care services coverage consistent with prevailing standards of medical practice and state policies for health care delivery.

Concluding Remarks

HCA thanks the Committees for this opportunity to testify and stands ready to assist the Committees in developing and implementing policies and initiatives that effectively respond to supporting the home care system's capacity to fully meet the home care needs of New York's citizens, health personnel, agencies, overall health system, and state reform policies.

We are pleased to address any questions or assist in any way. Thank you.

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