Testimony of the
Home Care Association of New York State

Before the
Assembly Committee on Health

Public Hearing on Rural Health

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Hearing Room C
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Introduction

Chairman Gottfried and members of the Assembly Health Committee.
I'm Al Cardillo, President and CEO of the Home Care Association of New York State (HCA). Thank you for convening this important public hearing on rural health care.

Today I will present information and recommendations focusing on home care and its core role in rural health. Today's hearing provides an opportunity to explore the challenges that abound in rural health, and importantly, what we can do together to harness and maximize solutions for rural communities and residents. It is an opportunity to target gaps, offer recommendations to support what currently works, identify new and needed initiatives, and consider the further enlightened allocation of public, private, provider and health plan resources.

About HCA and Home Care. HCA is the statewide association comprised of approximately 300 organizations and individuals representing home and community based care programs, including but not limited to: certified home health agencies (CHHAs), licensed home care services agencies (LHCSAs), managed long term care plans (MLTCs), long term home health care programs (LTHHCP), hospices, consumer directed/fiscal intermediary (FI) programs, waiver programs, and other. Our providers and organizations, which substantially serve all rural areas across the state, serve over 500,000 individuals plus families: from maternal and newborn care to end of life; from public health to primary to post-acute to chronic care; and from highly complex to daily, supportive care.

Home care, hospice and managed long term care plan services are ordered by physicians and provided by federal and/or state approved licensed entities based on

assessments and person-centered care planning and delivery. Services include care management, nursing, physical therapy, social work, occupational therapy, speech pathology, respiratory therapy, home health aide, personal care, telehealth, nutritional counseling, personal emergency response systems, home and environmental adaptations, home delivered meals, home maintenance, care transition, and other vital services.

Home care is a vital, indispensable part of the entire continuum of care for individuals, health systems and communities, on which constituents' health and life depend.

I would like to underscore home care's current role as a core and vital health care provider and partner in rural health care systems. In all communities, home care serves in multiple capacities as a provider, coordinator and manager of services; especially in rural communities, it leads in establishing innovative ways of creating services and solutions for rural residents where such would otherwise be inaccessible or left to the costliest alternatives. It is important also to highlight that home care is not just the "direct care" that is provided in the home; but it is also the accompanying work of the home care agency, hospice or MLTC to bring together and synchronize the wide span of support that an individual needs for health recovery, support and care outside of a hospital or congregate facility.

Leveraging Home Care as an Asset to Rural Health Challenges

Rural health is greatly challenged by factors inherent in communities and regions where population density, topography, economies and other elements create limitations and/or risks and barriers to services. Challenges include: limitation in core resources in

health and related services that are critical determinants of personal and population health; geographic distances; outward migration associated with education and career mobility; transportation needs and constraints; funding limitations; gaps in communication, including broadband; particular occupational injury risks; and other.

While home care faces great challenges in these areas, it also functions as a vital strength and asset. It fills service gaps, provides one of the top growth areas of employment, creatively innovates solutions where no formal services exist, keeps individuals and families together in the community (when otherwise they might face relocation/transfer to other areas for needed service), bridges distances by delivering in-person and telehealth care to the patient's location, and helps contain otherwise exorbitant costs in the health care system.

In addition to helping meet direct medical and personal care needs, home care is one of the most effective vehicles for patient health education leading to better personal health management and prevention. Home care promotes patients' recovery, independence, and necessary engagement with the overall medical system to ensure medical stability and health. It is vital for patient transition from hospitals and nursing homes, and vital to avoid hospitalizations, emergency episodes, physical and mental deterioration, and long term institutionalization.

Compare for example the minimal dollars-per-day cost to help a rural citizen medically manage congestive heart failure, COPD or diabetes through home care telehealth, versus the cost and impact of a multi-thousand dollar hospital stay, repeat emergency room episodes, or long term confinement to a nursing home. Compare the cost of a reduced hospital stay – and perhaps no stay at all – following a surgical procedure or for

rehabilitation from injury, or for end of life palliative care because home care and hospice are provided, versus prolonged stay in a facility. There ***is no comparison*** to the value in cost and quality of life that home care renders.

So as the committee considers rural health needs and solutions, HCA urges you to look to home care in leveraging effective service and policy responses.

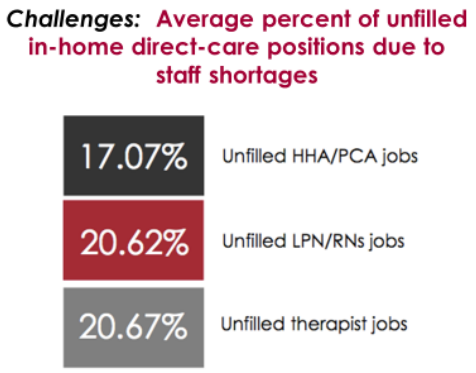
To sustain home care's capabilities in rural health, and moreover, to optimize its ability to meet the population's and the system's growing demand, home care requires investment and support in meeting the serious challenges presented in service to rural communities.

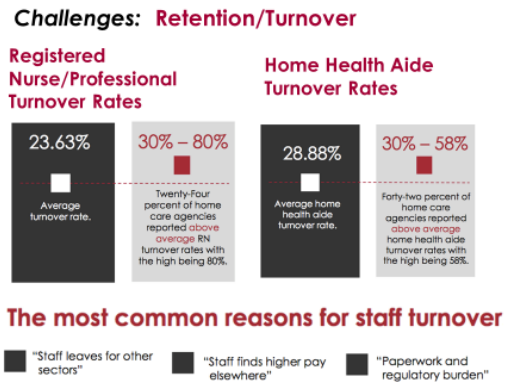
Priority Home Care Needs in Rural Areas

Workforce. Health workforce shortages across disciplines plague virtually all regions of the state, but are especially severe in rural areas. The problem is a combination of multiple factors, including: the absolute (limited) numbers of individuals who are credentialed and available in the needed positions in rural communities; the competition for workforce among sectors of the labor market in the rural region; ability for home care, hospice and MLTC to compensate at competitive levels commensurate with workforce supply needs and the indispensable value of the worker; staff turnover; and the burgeoning demand for care at home that is being driven by demographics, urgency for less costly care, and state, federal, industry and consumer trends shifting the focus of care to primary and community based care wherever possible.

As constituents, government and the health industry depend ever-more on home care, the capacity of the home care system to deliver must be supported commensurate with this demand.

HCA's 2019 state of the industry analysis revealed major needs in home health workforce. The graphs on the next page show average unfilled direct care positions and turnover rates from HCA's provider survey.





Unaddressed, these shortages pose challenges for patient access to care and functioning of the community health system. They highlight to this Assembly Committee the need for targeted support for recruitment and retention of essential home care personnel in these areas.

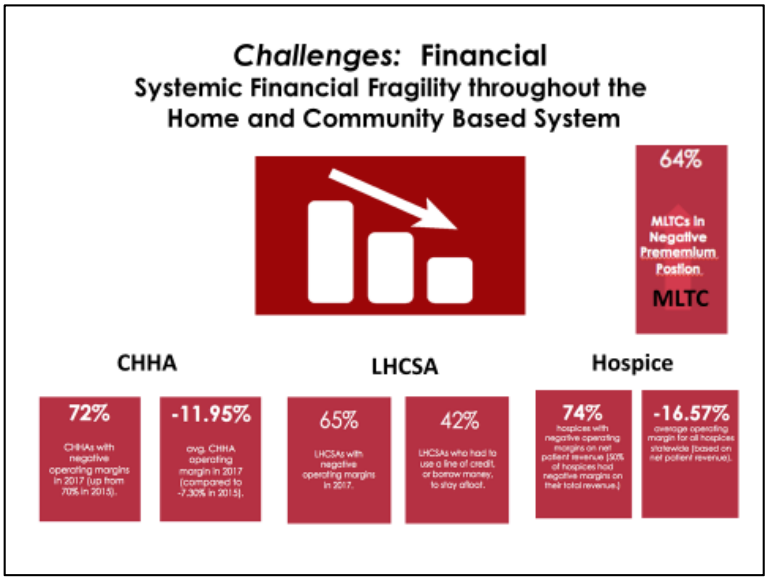
Proposed Responses. HCA has advanced and urges your support for proposals to help address fiscal and structural issues contributing to the workforce shortage. They include:

- Establishment of a new rate adjustment for CHHAs, LHCSAs, Hospices and MLTCs, targeted to shortage disciplines and geographic areas, and to allow funds to be used to pilot critical supports for personnel, such as transportation, child care, education, peer support, etc. (A.6768 by Assemblymember Bronson). The adjustment would be funded at up to $30 million annually, and authorized from funds as available from unspent and unencumbered allocations from the same public health law source as the existing recruitment and retention adjustments for health providers.

- Direct the State Labor and Health Departments to conduct a Competitive Labor Market Analysis for home care and hospice, yielding recommendations for rate and rate methodological changes necessary to support home care and hospice workforce commensurate with need. (A.6902 by Assemblymember Bronson)
- Establish a state-interagency initiative to actively promote value and interest in home care and hospice occupations, and to promote entrance into the field including from pipeline, professional schools and practice settings. (A.6902 by Assemblymember Bronson)
- Promote cross training collaboratives between hospitals and home care/hospice. Include within the existing Health Care Reform Act (HCRA) supported "Health Care Worker Retraining Program" provisions to allow hospital-homecare-hospice collaboratives to cross train workers (including nurses, therapist, social workers, aides) to provide services in community based settings, in addition to the hospital setting. (Reintroduce S.8613 of 2018, by Senator Hannon)
- Establish Tracking of Home Health Aide Annual In-service Training using the state home care worker registry, which will increase efficiency and ease administrative work across agencies in fulfilling these important requirements. (A.7854 by Assemblymember Gottfried/S.5605 by Senator Rivera)
- Amend state law to promote finance and rate stabilization in home and community based care that will better enable staff compensation and workforce adequacy. (described in the next section)

Home Care Rate Stabilization and Adequacy Needs. A major factor in the home care workforce shortage, and the ability to compete in salary, benefits and favorable working conditions in the field and in rural areas, is the current underpayment for services. HCA analysis of official state cost reports shows these underpayments to be systemic in the home and community based system. Underpayments combined with methodologies and provisions for funding higher compensation levels in other sectors, creates enormous competitive disadvantage in home care recruitment and retention. In addition to the impact on workforce, this underpayment has eroded working capital for fundamental home care infrastructure and operations, like the infrastructure and cost of clinical integration with partners, expansion of sites into underserved regions, educational support and specialization, initiation and operation of new aide training, staff transportation to patient homes, clinical technology, and other.

The following graphic from the 2019 HCA state of home care report shows the financial status of core home and community based organizations – home health agencies, licensed home care services agencies, managed long term care plans and hospices- in New York State. The graphic below shows the result of severe underpayment for services rendered and the impact across program types.



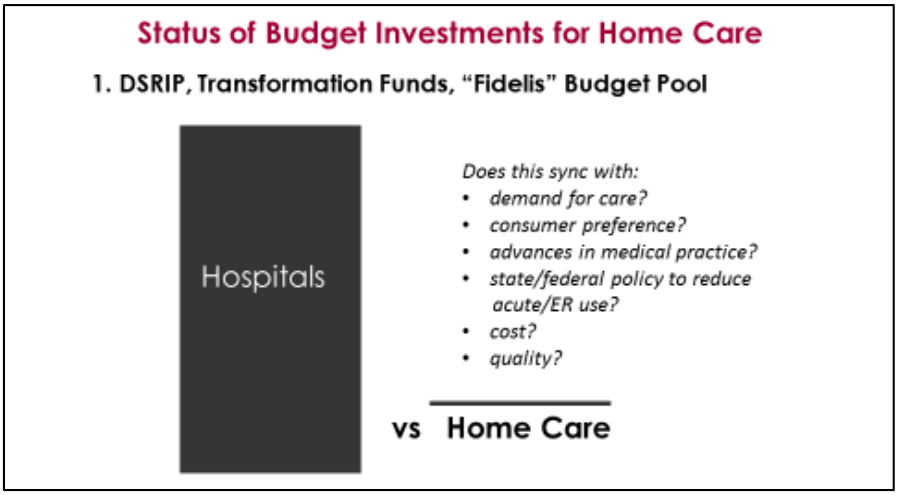
HCA thanks Assemblyman Gottfried and Senate Health Chair Rivera for sponsoring the following urgently needed legislation to stabilize the rate and reimbursement system for CHHAs, MLTCs and LHCSAs. (A.7798 by Assemblymember Gottfried/ S.5915 by Senator Rivera; additional rate adequacy and transparency amendments are being separately considered for introduction) We urge the Committee and both houses of the Legislature to advance and pass this critical legislation.

In this year's budget, a series of reimbursement and program changes were adopted affecting the Consumer Directed Personal Assistance Program, and the FI's who manage aspects of local administration and personal assistant compensation. A state workgroup has been formed to provide input and guidance to the State Department of Health on the implementation of these changes. The changes include a targeted reduction of $150 million (state/federal) from the FI's for program's administration, and a potential reduction in the FI's across the state who administer the program.

HCA thanks the Legislature for its efforts in the final budget outcome to circumscribe these changes to help provide for consumer and access protections, and we look forward to our continued input on the state workgroup. However, we remain extremely concerned about the potential impact especially on rural health, as many consumers, agencies and MLTCs servicing rural areas currently work through this program for essential personal care support. While the Executive is attempting to provide for new efficiencies and address concerns with regard to the growth in the consumer directed/FI program, we assert that the level dependence on and growth in this program especially in rural areas is also a function of the gaps in funding for workforce recruitment, training and

retention that should otherwise be provided to CHHAs, LHCSAs, LTHHCPs, MLTCs and Hospice.

Working Capital for Infrastructure. The graphic below illustrates and emphasizes the disparity in funds provided for home care/hospice infrastructure versus that which continues to be provided substantially for institutional facility support. HCA strongly supports needed funding for hospital and nursing home partners; but state and federal official must recognize the simultaneous need for vital and balanced investment for the home care infrastructure. The graphic below includes only these limited examples of investment imbalance; the problem of imbalance extends far beyond these. The major health care shift and need is toward community care is ongoing; yet the investment financing is not following the shift in services.



HCA applauds Assemblyman Gottfried for your introduction of A.7977 advocated by a coalition of home and community based provider associations, including HCA, that would ensure that budgeted funds for health provider capital and infrastructure support be

apportioned to the home and community based sector in an amount no less than 25% of the statewide total pool. HCA urges the Committee and both houses of the Legislature to advance and pass this legislation.

Telehealth and Clinical Technology. New York's home care system has been the national leader in telehealth and in clinical applications the enable real-time remote monitoring, assessment and management of care across distances, and between provider partners. HCA applauds the Legislature's enactment of the home telehealth law in 2007.

Building on the capability of this law, and including support for related clinical technology that supports the patient, facilitates communication to and from caregivers in the field, enhances quality and outcome tracking and eases the documentation/reporting burden of personnel, would be a major support for the system. HCA urges the Legislature to build upon this effort with the rate stabilization legislation previously referenced (A.7798 Gottfried/ S.5915 Rivera), key amendments to the telehealth coverage act (S.888 by former Senator Young), and enactment of the Home Health Information and Clinical Technology Act, S.1791 by Senator Rivera, and which you, Assemblymember Gottfried have also sponsored in prior sessions.

EHR-HIE and Broadband. Interoperability, connectivity and analytical capability of clinical information is critical to quality, access, efficiency and integration of health are services. As noted, the current reimbursement rates and methodologies for home care need to be modified to support electronic health information infrastructure and exchange among provider and health plan partners. State policies aimed at achieving value, improved outcomes and "triple-aim" goals are thwarted by the lack of this infrastructure and investment. Enacted a decade ago, the Federal American Recovery and Reinvestment

Act provided funds for electronic health records and technology in institutional and physician settings, but no funds were provided for home care and hospice. Moreover, many rural areas of the state continue to suffer from lack of broadband access and pockets where basic cell phone access are highly challenged. We urge the Committee's support for the aforementioned legislation, state reimbursement methodology fixes and dedication of existing and new state budget funding to address these critical needs.

Transportation. The dependency on transportation for delivery of in home care is self-evident. Reliable and readily accessible transportation in rural areas is especially critical for getting health care workers to patients, and patients to and from key medical appointments and services. The limitation of public transportation in rural regions compounds this challenge, as do topography issues, including mountains, rivers, islands, backroads and seasonally-affected roads, homesteads on vast farmland, the impact of severe weather, and more. Legislation referenced in this testimony that would amend the existing reimbursement methodologies to better recognize provider costs, including transportation expenses, and that would authorize new pilot programs to target transportation assistance, would be extremely helpful with this challenge. Meanwhile, HCA and providers serving rural communities continue to explore tapping additional asset options, such as Uber. Legislative support in this area would be vitally healpful.

Also, as MLTCs have developed approaches to directly make transportation assets available for patient medical appointments, it is also critical that the state continue to maintain transportation as a covered service under MLTC. HCA appreciates the Legislature's repeated rejection of Executive budget proposals to remove transportation as

a direct benefit of MLTCs, and we urge the Executive to withdraw this repeat proposal and maintain this direct coverage option for MLTCs and enrollees

Public health, Primary Care, Social Determinants. Home care agencies act as core service providers that are sponsored or contracted by county health departments to provide infrastructure for local public health services. At one time, nearly every county in the state sponsored a CHHA and a LTHHCP for public health, primary, post-acute and long term care services. Severe reductions in local county and public health aid have affected the county home care infrastructure and caused diminution of these services. It is critical for the state be aware of the importance of home care agencies roles in public health, and their financial support needs to provide counties with these services, which include high risk prenatal care, maternal and newborn care, immunizations, public health screenings, and more.

Home care also serves a critical role in primary and prevention services throughout the health system, and has had pronounced beneficial impact in rural areas where shortages of primary care physicians and transportation challenges impair residents' ability to access needed practitioners. HCA asks the Legislature to consider home care's further potential to cost-effectively benefit individual, public and population health in rural areas. Some specific examples follow.

Assemblymember McDondald and Senator Rivera have introduced legislation (A.3836/S.1816) to direct the State Department of Health to incorporate home care into the state's strategic plans, programs and policies for public health, primary care and prevention. This a wise, cost-effective and patient-centered policy. The bill would infuse

home care into cost-effective efforts to address such severe and costly public health problems as sepsis, asthma, diabetes, falls, health disparities, opioids, and more.

Another bill (A.3839/S.1817) by these same sponsors is exclusively aimed at combatting sepsis through home care. Sepsis is the number one cause of death in hospitals, number one national hospital health care expense across all payors, number one cause of 30 day Medicare hospital readmissions, and number one cause of avoidable Medicaid hospitalizations for the overall Medicaid population in New York. Of major relevance to home care, 80-90% of sepsis occurs in home and community, with the elderly, immunocompromised, disabled and others able to be reached by home care among the highest risks. HCA and partners have created and implemented statewide the nation's first sepsis intervention initiative launched through the home and community based system.

A further bill by Assemblymajority Leader Peoples-Stokes and Senator Sanders (A.6729/S4937) would specifically authorize collaborative models to address the problem of health disparities, a multibillion dollar national public health problem and a condition of unacceptable health care consequence.

HCA urges the Legislature to support rural public health and drive vital health savings by enacting these progressive bills.

Collaboration among Partners. HCA commends the legislature for enacting in 2015 the Hospital-HomeCare-Physician Collaboration Law, section 2805-x of the public health law. This law, developed as a result of ground level exploration with rural and small community providers, and advocated by in tandem by HCA and the Iroquois Healthcare Association, allows community health partners to come together to join assets, goals and

resources to address a wide array of patient and community health needs. One of the very recent programs approved by the State Department of Health under this program is enabling the establishment of a six-county complex care patient collaborative. HCA urges the legislature to further support and promote hospital, physician, home care and additional partner collaboration through this structure for rural health solutions. We urge the targeting of state funds to support this mechanism, and we further support legislative enhancement.

The aforementioned disparities collaboration legislation would extend from this same section of law.

Also of major potential, HCA urges support for A.1208 by Assemblymember Gottfried/S.1805 by Senator Rivera to authorize hospitals, physicians, home care, emergency medical services and other potential partners to come together to form Collaborative Models of Community Paramedicine. Under this concept, and pursuant to a collaborative plan by these partners, emergency medical services personnel could be brought into community health supportive services in ways that would promote health, safety, task need, care transition, and referral for individuals residing at home, and help avert emergencies, accidents, hospitalizations and other adverse events for vulnerable residents. HCA has worked extensively with EMS associations, the Iroquois Healthcare Association and other statewide associations to recommend the provisions of this legislation. This provision has previously passed the State Senate. We believe this program in collaborative form could have a very beneficial impact on resources and services available in rural, as well as urban, communities.

Conclusion

HCA thanks the Assembly Health Committee and Chairman Gottfried in particular for this critical opportunity to explore challenges, needs and improvements in rural health care in New York State.

To be sure, the needs and challenges are extensive, and HCA is ready to work with the Legislature and Executive on core strategies and solutions. We underscore and reinforce from our opening remarks that state officials, planners and health sector partners consider, leverage and help optimize the resources that home care brings to rural health care, and rural health solutions.

We thank you and the members of the Legislature for your sponsorship and support of the legislation and budget initiatives referenced in this testimony and look forward to working with you to pass and build upon these efforts.

I am pleased to answer any questions or provide you with further details.

Thank you.