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HCP | NYS Association of Health Care Providers
Representing Home & Community-Based Care

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Testimony
of
The New York State Association of Health Care Providers, Inc.
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of the
Senate Finance and Assembly Ways and Means Committees
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Good afternoon Senator DeFrancisco, Assembly Member Farrell, distinguished members of the Senate Finance, Assembly Ways & Means, and Senate and Assembly Health and Aging Committees. My name is Christine Johnston, and I am President of the New York State Association of Health Care Providers, Inc. (HCP), a trade association representing approximately 400 offices of Licensed Home Care Services Providers (LHCSAs), Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), and related health organizations throughout New York State. On behalf of the HCP Board of Directors and members, thank you for the opportunity to comment on Governor Cuomo's 2014-15 Executive Budget proposal and its impact on home and community-based care providers.

Home and community-based care is preferred by patients and their families. It allows those facing illness, disability and aging to maintain their dignity, independence and privacy in the comfort of their own homes. Home care also delivers extreme value to the State and taxpayers. On average, home care services are half the cost of care provided in an institutional setting and are a critical part of slowing or preventing the need for institutional care.

For decades, New York State has been a leader in developing innovative programs and policies designed to keep families together through the use of home and community-based care. Despite evidence that greater investment in home and community-based care saves money, home care programs in New York continue to be plagued by inadequate levels of reimbursement, burdensome and costly regulatory requirements, unfunded mandates and systems-altering policy changes. While this proposed budget, unlike previous years, recognizes some of the challenges that home care providers are facing, and is inclusive of initiatives meant to support providers and alleviate some of the financial pressure they are experiencing, it does not go far enough. There remain many longstanding and new issues which threaten to further destabilize an industry that is still undergoing massive system changes.

New York's home and community-based care providers remain in the midst of a massive transition of the State's long term care delivery system from Fee-for-Service to managed care models. This complete restructuring of the entire Medicaid long term care system, which stemmed from recommendations of the Medicaid Redesign Team (MRT) enacted and implemented in 2011, has taken its toll on home care providers. Those that have made, or are currently undergoing, the transition struggle to secure adequate and prompt reimbursement from many Medicaid managed care/managed long term care (MLTC) plans while continuing to provide the same level of services and meet payroll each week. Those in areas of the State that have started the transition are doing so while addressing fee-for-service challenges and attempting to prepare for what is to come.

No matter where in the managed care transition process home care providers find themselves, there are a great deal of challenges that must be addressed, including more specifically:

- Delayed and inadequate Medicaid fee-for-service reimbursement rates;
- Unfunded wage and benefit mandates that threaten patient continuity of care, home care worker jobs and businesses, including wage parity, living wage, minimum wage increases, and the Affordable Care Act;
- Cash flow crises stemming from inadequate reimbursement rates and delayed or non-existent payments from Medicaid managed care/MLTC plans;
- A new Department of Health (DOH) policy that will again alter the structure of the home care delivery system, undermine the State's transition to managed care, and diminish the role that LHCSAs play in the delivery of care;
- Federal Medicare reductions, costly unfunded mandates and additional costs stemming from the Federal Affordable Care Act and elimination of the Companionship Exemption; and
- A regulatory environment that is hostile to cost-effective home and community-based care.

Despite the uncertainty, uneasiness, and in many cases exasperation at the changes underway, home care providers are doing everything possible to operate effectively and efficiently and continue to help New Yorkers remain in the comfort and security of their own homes. Home care providers are working extremely hard to adapt to new ways of doing business amid the introduction of policies and regulations that put their viability at risk, showing again the remarkable tenacity and dedication of this industry.

Home and community-based care is the centerpiece of the nation's long-term care strategy. Without a strong network of providers, the prospects for maintaining a professional system of caregiving is bleak. HCP and home care providers appreciate the need to control the cost of Medicaid and providers are all too familiar

with having to do more with less. State Medicaid policies, however, must not destroy Medicaid home and community-based care services, which ultimately reduce the need for more costly care.

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

Elimination of 2% ATB Cuts, Distribution of Medicaid Global Cap Savings

HCP supports the Executive's proposal to eliminate the 2% across-the-board (ATB) reductions in Medicaid fee-for-service (FFS) reimbursement as of April 1, 2014. These spending provisions, which were originally part of the 2011-12 State Budget, have struck directly at funding needed to provide direct patient care. Patients and workers have experienced the brunt of such deep cuts the past couple of years as agencies reduced services, programs, staff or, most troublesome, close entirely. While the elimination of these spending reductions will make a difference for home care providers still operating under Medicaid FFS, the impact of past years' reductions will continue to be felt in the years ahead.

The Executive Budget extends the Medicaid Global Spending Cap for another year, through March 31, 2016. Since 2011, the Global Cap has given the State Department of Health unilateral authority to impose utilization controls, provider cuts or other spending reductions if State Medicaid spending exceeds 4%. While there has not been a need to exercise such powers, the specter of cuts is always there and the limitations on the ability to address other funding issues within these limits is difficult. If policies imposed by the State, such as wage parity, are unable to be funded adequately because of global cap limitations, providers and patients suffer as a result of conflicting State policies.

With greater clarification and parameters, HCP is supportive of a proposal put forth this year which authorizes the Commissioner of Health to distribute savings achieved under the Global Cap to certain eligible Medicaid providers. Under this proposal, up to 50% of distributions would be allocated to providers that are financially distressed. The budget language does not indicate what types of Medicaid providers would be deemed eligible for these funds, and HCP strongly recommends the inclusion of all types of home care agencies in this definition. HCP also urges the Legislature to ensure that they are involved in such decisions.

Reimbursement Changes Extended from 2013-14 State Budget

<u>Trend Factor Elimination</u>

The 2013-14 State Budget continued the elimination of Trend Factor adjustments in Medicaid provider reimbursement rates through March 31, 2015. HCP continues to oppose this elimination, which will squarely impact patients and workers by forcing agencies to make decisions about whether to reduce services, programs and staff, or to close their doors entirely. Demand for home care services is only anticipated to grow, but in this environment, access to home care services is shrinking.

By eliminating Trend Factor adjustments, agencies continue to be challenged to deliver services in a 2014 economy with reimbursement levels based on expenses incurred in 2012. A two-year lag exists in home care rates and thus, an agency's 2014 Medicaid rate is based on 2012 data, reported in 2013 to DOH and then paid in 2014. The trend factor is the way to attempt to bring rates, which are based on two year old data, more in line with today's costs of doing business and make agencies closer to whole for the time period being reimbursed.

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

Additional Reimbursement Changes

In addition, the following reimbursement provisions were extended in the 2013-14 State Budget into 2015. While many are continuations of prior budget actions or modifications of such, there continues to be a need for additional clarification as they are applied in the managed care context:

- **CHHA Bad Debt and Charity Care:** The authorization for bad debt and charity care costs as reported by CHHAs is extended through June 30, 2015.
- **Medicare Maximization:** The requirement that CHHAs and LTHHCPs maximize Medicare revenues as was originally established in 1995 is extended through 2015.
- **CHHA A&G Cap Reconciliation:** The $1.5 million reconciliation limit for the CHHA administrative and general cap is removed through March 31, 2015.
- **LTHHCP A&G Cap:** The limitation on the reimbursement of the LTHHCP administrative and general costs to a Statewide average is extended through March 31, 2015.

Level of Funding Proposed for Wage Parity is Insufficient

HCP is very supportive of the Executive's proposal to adjust Medicaid premiums for managed long term care and payment rates for services provided by CHHAs and LTHHCPs to address the cost increases of the Home Care Worker Wage Parity Law. The Law, which was enacted in 2011 at the same time as all of the long term care delivery system restructuring, has created serious challenges for providers complying with confusing rules and interpretations, and seeking to secure adequate funding from Medicaid managed care/MLTC plans and other contractors.

HCP has always maintained that home care workers should be compensated for their hard work with fair and adequate wages and benefits, but commensurate levels of reimbursement for such services must also be made available by the Medicaid and Medicare programs and any private contracts with managed care

organizations or other entities. Traditionally, such funding has not consistently followed unfunded wage mandate policies at either the State or local level.

March 1, 2014, marks the beginning of the third phase of the Wage Parity law in New York City. At this time, the minimum rate of total compensation will jump from $10.93 to $14.09 per hour, an increase of more than $3. The direct hourly cost for employers will jump to $16.35 per hour according to the Department of Labor. For many home care providers, this cost exceeds their current rate of reimbursement from Medicaid managed care/MLTC plans or other providers.

HCP appreciates that the 2014-15 Budget for calls for $308.7 million in funding to support the Wage Parity increase effective March 1, 2014 for New York City; however, this amount is not sufficient. DOH has indicated that the cost of funding the increase is at least $400 million, and in fact may be greater. Additional appropriations are necessary to ensure the mandate is adequately funded.

HCP also urges the Legislature to include a mechanism or requirement that funding for Wage Parity be passed on to the employers of the impacted workers, which is most often a licensed home care services agency (LHCSA). Without assurances that the funding is going to reach the employer, there will continue to be disastrous financial consequences as these unfunded mandates continue to grow.

Outside of New York City, the second phase of the Wage Parity law will also become effective in Nassau, Suffolk and Westchester counties. In these areas, there continue to be challenges stemming from the intersection of the mandatory MLTC transition and local living wage laws. Under the fee-for-service reimbursement structure, personal care workers on Medicaid cases are guaranteed wages and benefits that far exceed the State minimum wage and even the Wage Parity law. As these personal care cases transition to MLTC, there is no longer a long-term guarantee of wages.

A Department of Health policy requiring that home care providers be reimbursed at their FFS Medicaid rate on transitioning MLTC cases is scheduled to sunset on March 31, 2014, with no plans for an extension. The expiration of this policy has the potential to disrupt the workforce in these counties. Providers have been attempting to negotiate rates of payment from MLTCs that accommodate the current local living wage laws, but have been unsuccessful. In order to maintain such wages, providers need to have higher levels of reimbursement from plans, otherwise wages for certain home care workers will be impacted.

Looking ahead, the Wage Parity requirement for Westchester and Long Island home care providers will continue to rise in the years ahead. Beginning March 1, 2016, home care providers will be mandated to provide rates at 115% the minimum amount of total compensation in New York City. It is essential that this impending increase be addressed sooner rather than later to ensure that affected home care providers are adequately prepared, and are in receipt of adequate reimbursement rates, to meet the cost increase.

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

Unfunded Wage Parity Law			
County	**March 1, 2012-Feb. 28, 2013**	**March 1, 2013-Feb. 28, 2014**	**March 1, 2014-Feb. 28, 2015**
New York City	$9.00 plus $1.35 supplemental benefit rate ($10.35)	$9.50 plus $1.43 supplemental benefit rate ($10.93)	$10.00 plus $2.40 supplemental benefit rate plus $1.69 additional wages ($14.09)
Nassau	n/a	$9.00 plus $1.35 supplemental benefit rate ($10.35)	$9.50 plus $1.43 supplemental benefit rate ($10.93)
Suffolk	n/a	$9.00 plus $1.35 supplemental benefit rate ($10.35)	$9.50 plus $1.43 supplemental benefit rate ($10.93)
Westchester	n/a	$9.00 plus $1.35 supplemental benefit rate ($10.35)	$9.50 plus $1.43 supplemental benefit rate ($10.93)
Local County Living Wage Laws (Medicaid Personal Care Fee for Service)			
August 1, 2013			
Nassau	$13.35 w/ benefits or $15.21 w/out medical benefits, plus additional 12 compensated days off		
Suffolk	$11.52 w/ benefits or $13.12 w/out medical benefits, plus additional 12 compensated days off		
Westchester	$11.50 w/ benefits or $13.00 w/out medical benefits, plus additional 12 compensated days off		
Statewide Minimum Wage Increases			
On/after Dec. 31, 2013	$8.00 per hour		
On/after Dec. 31, 2014	$8.75 per hour		
On/after Dec. 31, 2015	$9.00 per hour		

Funding Challenges Exist Statewide

Outside of New York City and its surrounding counties, home care providers throughout upstate New York are also struggling financially in response to unfunded wage and benefit mandates combined with insufficient reimbursement methodologies. The entire State has been impacted by the increase in the State minimum wage to $8 per hour, which became effective December 31, 2013, and will continue to increase annually for the next two years. The home care industry is significantly impacted by this increase, as multi-year limits on reimbursement under outdated FFS Medicaid and managed care rates further compromise provider stability by limiting their ability to meet the growing costs of doing business.

Changes at the Federal level will further impact providers by increasing costs. As a consequence of changes last year to the Federal Companionship Exemption, for instance, providers will be required to reimburse

overtime hours at time and a half of an aide's current rate of pay, as opposed to time and a half of the minimum wage beginning January 1, 2015. Additionally, home care providers will face additional costs as a result of changes that will require them to pay workers for travel time.

As the transition to mandatory MLTC progresses into upstate counties this year, home care providers will begin shifting away from FFS Medicaid reimbursement and will instead be required to negotiate payment rates through contracts with managed care plans. At this stage, however, the vast majority of home care agencies in these regions remain under the FFS structure and continue to be challenged by government rates that do not reflect the real-time costs of providing services in the current business climate.

HCP urges the Legislature to expedite the payment of costs incurred by eliminating the Medicaid personal care payment lag and rebasing the personal care rates to increase the ceilings on wage and aide training caps.

The Budget does not address the fiscal challenges home care providers outside of New York City are facing. HCP strongly urges that funding be allocated to support providers in these areas as well as New York City. While the proposed elimination of the 2% ATB reduction in Medicaid reimbursement will make a difference, it does not go far enough.

Transition Funding for LHCSAs

HCP strongly supports language in the Budget that calls for lump-sum Medicaid payments to licensed home care services agencies (LHCSAs). Under this proposal, financially distressed licensed agencies can apply to receive temporary lump-sum Medicaid payments under the Vital Access Provider (VAP) program. LHCSAs have not had access to this funding stream in the past and HCP applauds the effort to support this essential provider. Concerns exist, however, about ensuring that these funds are made available to providers with regional and size equity. HCP is also concerned about ensuring that the appropriation is clearly defined and is made readily accessible to home care providers in a timely manner.

There is also language that calls for the establishment of a Capital Restructuring Financing Program, which would provide capital grants for the purpose of enhancing the quality, financial viability and efficiency of New York's health care delivery system by transforming the system into a more rational patient-centered care system that promotes population health and improved well-being of New Yorkers. Home care is currently not included in the list of health care providers eligible for the capital grants, and HCP strongly encourages that these grants also be made available to the home care industry.

Supporting and Investing in Home and Community-Based Care

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

- **Health Care Workforce Recruitment and Retention:** Funding for the Upstate Personal Care Workforce Recruitment and Retention (R&R) program is extended through March 31, 2017, with annual appropriations up to $28.5 million annually.

  The Budget includes a proposal to repeal provisions that authorize the Recruitment, Training & Retention Medicaid payment rate enhancements for CHHAs, LTHHCPs, AIDS home care programs, hospice programs and for MLTC plans and MLTC demonstrations and associated attestations. Annual appropriations under this provision have been consistently set at $100 million and were used for purposes of improving recruitment, training and retention of home health aides and other personnel with direct patient care responsibility. The Budget support memo indicates that the existing funding levels will be maintained, but shifted to the providers' base rates. This is an area that requires additional clarification.

- **Lump-Sum Medicaid Payments to LHCSAs:** This proposal would authorize the Commissioner of Health to make temporary lump-sum Medicaid payments under the Vital Access Provider (VAP) program to financially distressed licensed providers. More information is needed on the funding that will be targeted under this initiative.

- **Elimination of LTHHCP Slot Limits:** In accordance with the transition of LTHHCP service recipients to managed care, this proposal would essentially remove the slot limitations for LTHHCPs.

- **Funding for Waiver Programs:** The Budget contains appropriation and reappropriation of funds for the Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) waiver programs and services.

- **Expansion of MMCARP:** This proposal would expand the existing Medicaid Managed Care Advisory Review Panel (MMCARP) from 12 to 16 members by adding consumer representatives for individuals with behavioral health needs and dually eligible individuals, as well as representatives of providers that serve both populations.

Challenges Remain in Transition to Mandatory Managed Care

The mandatory transition to managed long term care (MLTC) is now well underway in New York City, Nassau, Suffolk, Westchester, Orange and Rockland counties. As of January 2014, the transition has also been initiated in Albany, Erie Monroe and Onondaga counties. A recently released transition timeline from

DOH, shows plans to initiate the transition in the remaining upstate counties over the course of 2014, subject to Federal approval. While home care providers have worked aggressively to adapt to the new system and new way of doing business, there remain significant challenges that are jeopardizing the stability of home care agencies, home care worker jobs and patient access to care.

As anticipated and raised by HCP in the past few years, an issue that has grown increasingly challenging as the shift to managed care has progressed is the ability of home care providers to maintain an adequate cash flow to cover their weekly expenses. Home care providers have frequently been unable to secure adequate rates of payment in their contacts with managed care plans, and there are ongoing reports that plans do not make claims payments in a timely manner. In a survey HCP conducted in September 2013, nearly half of respondents cited outstanding claims payments from MLTC plans, with the majority of claims 61 - 180 days past due, far beyond prompt pay laws.

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

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

Under the Medicaid program, while it may not always pay at a level that covers providers' costs, agencies can trust that they will receive reimbursement on a timely basis each week. Because the cash flow needed to meet weekly payroll is significant, the instability of managed care payments has been particularly difficult for providers to manage. As the mandatory transition expands to more counties this year, it is critical that resolutions to the fundamental issues of managed care billing and payment are identified.

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

Pre-Claim Review of Medicaid Claims: The Executive Budget proposes that the requirement for Medicaid participating providers with Medicaid reimbursements exceeding $15 million per calendar year to have their claims reviewed and verified by a verification organization (VO) prior to submission be amended to include Medicaid reimbursements from managed care plans, and to require review of claims and encounters by a VO prior to submission to a managed care plan. It is also proposed that DOH and Office of the Medicaid Inspector General (OMIG) jointly develop requirements for pre-claim review.

This initiative was included in the 2011-12 State Budget and this modification seeks to roll-in the revenue that providers now receive from managed care organizations as part of the overall system transition to managed care. The shift is another frustrating example of the State's consideration of the revenue providers receive from managed care as being Medicaid funding, while the contracts between home care providers and managed care plans are considered private when home care seeks assistance or intervention from the State.

New DOH Policy Threatens MRT Goals, Reduces Role of Licensed Agencies

Managed care models are touted across the country as a way to streamline the delivery of health care services while also increasing its effectiveness and efficiency. The recommendations of the State's Medicaid Redesign Team (MRT), which have led to a complete restructuring of the long term care delivery system in New York State over the past few years, were built on this premise. As the transition to managed care has moved forward, home care providers of all types have invested a great deal of time, money and resources to adapt to the new system and ensure that home care consumers continue to receive high quality services and maintain continuity of care.

On January 28, 2014, DOH issued a Dear Administrator Letter (DAL), HCBS 14-01, entitled "Home Health Care Services in Managed Care Plans." The DAL signifies a massive policy change which again alters the structure of the home care delivery system, undermine the State's transition to managed care, and diminishes the role that LHCSAs play in the delivery of care.

The letter cites Federal regulation indicating that licensed home care services agencies may not provide home health aides services, skilled nursing services or therapies (including occupational therapy, physical therapy and speech pathology) to Medicaid and Medicare beneficiaries under a direct contract with a Medicaid managed care or managed long term care plan. Instead, the letter states that these services must be provided by an entity that meets the Federal Conditions of Participation for a home health agency (CHHA).

The directive represents a major policy change in New York State, as licensed agencies have been providing the indicated services through direct contracts with managed care plans since the inception of managed care in the State nearly two decades ago. This practice has increased greatly since the transition to mandatory managed care was initiated in 2011. In a survey of licensed agencies that HCP completed in January, nearly 95% reported that they provide some level of home health aide services under a direct contract with

managed care; while 70% and 30% reported that they provide some level of skilled nursing or therapy services, respectively.

The DAL was issued by the Department of Health without any additional clarification and guidance; however, it has raised many critical questions and concerns among the home care industry and other stakeholders which require immediate answers. HCP is working with agencies to sort through the confusion and frustration, but additional support and guidance is needed to help home care providers move forward and ensure they are able to maintain compliance with State policy and Federal regulation.

The Department of Health has indicated that licensed agencies should move forward with the understanding that patient care and safety are of the utmost importance, and have indicated that managed care plans are still receiving payments to deliver services. HCP has pressed strongly for guarantees that managed care plans will pay providers in spite of the recent policy change in contracting; however, HCP has been unable to secure any additional clarification or guarantees related to service delivery or payment. Under these unclear circumstances, it is crucial that licensed agencies, which are on the front lines and bear the responsibility of patient care and financial liability, are able to secure payment for the services they have provided.

This massive policy change also puts at risk the State's transition to managed care and goals to streamline service delivery by re-inserting another layer into the home care contracting process. In order to provide the identified services, licensed agencies will now be required to subcontract with a certified home health agency (CHHA) that contracts with a Medicaid managed care or managed long term care plan. The increase in administrative costs will be significant, and the implications for patient access and continuity of care could be disastrous.

For agencies that are already experiencing difficulty in securing adequate reimbursement rates from managed care plans, the addition of another layer in the contracting process will further complicate the process. With respect to the Wage Parity increase in New York City, any funding that is appropriated to help offset the increase in costs will now need to be raised even further. The budget includes $17 million to start to address the additional expenses, but is likely to be inadequate and certainly does not begin to address the administrative costs for LHCSAs and managed care organizations as they must quickly reconfigure the delivery system.

HCP implores the Legislature to support licensed agencies as they seek clarification on this massive policy change and work to identify solutions or points of flexibility that will permit them to continue providing the high quality home care services that their licenses permit, including engaging CMS in discussions about flexibility and changes.

Greater Home Care Efficiencies through Regulatory Reform

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

Regulatory Requirements within the Managed Care System

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

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

A Home and Community-Based Care Workgroup was established under the 2013-14 State Budget to address these types of issues, among others. The Workgroup, which is representative of different types of home care providers, managed care plans, and consumer groups, has worked to secure clarification on a number of issues, responsibility for Medical orders, for example, and will submit its recommendations report to the Legislature on March 1, 2014. There are many questions, however, that will remain and it must be a priority to address these challenges.

Redundant Reporting Relief—Wage Theft Prevention Act

This 2010 law, enacted in 2011, includes a costly and burdensome mandate that requires annual notices, including dual-language notices, new content requirements for paystubs, and extended timeframes for

recordkeeping. The law also exposes providers to new liabilities and penalties and increases the power of the Department of Labor.

This requirement is in addition to the requirement that employers give notice to employees of their wage rates at the time of hire. Businesses are incurring ongoing costs associated with education and legal guidance, training of human resources workers, updating recordkeeping and payroll systems, and securing additional space for record retention. As the majority of home care employees work in the homes of patients, it is incredibly difficult to obtain the necessary signed acknowledgement from each employee.

Currently there is legislation to address this issue. S.2313 (DeFrancisco)/A.8565 (Lupardo) would repeal the onerous and burdensome annual notice requirement from the Wage Theft Prevention Act. The proposed bill would not eliminate the notice for when an employee is first hired or when they have a change in wages, but rather eliminates the need to provide this notice each year of employment thereafter regardless of whether changes have occurred. In recognition of the regulatory relief it provides to home care agencies, HCP urges the Legislature to pass S.2313/A.8565 and repeal the burdensome annual employer notice requirement.

Real People and Families Depend on Home Care

Amid the fiscal uncertainty, unfunded mandates and regulatory demands that are at many times duplicative and a strain on already strapped resources, home care providers are continuing to provide high quality, effective home care services. Commitment and determination, however, can only support an industry for so long. The State and all stakeholders are working extremely hard to address issues and make a smooth and successful transition to managed care, meet fiscal challenges and ensure ongoing access to services, but additional support and resources are needed.

Home care providers recognize the fiscal challenges the State continues to face, but there now are more resources available and being made available and home care has already made significant sacrifices to help balance recent State budgets through hundreds of millions of dollars in cuts. We must not surrender the immense progress our State has made in increasing access to home care services that are both cost-effective and preferred by patients of all ages and their families. Home and community-based care is critical to reducing and preventing the use of care in more costly health care settings. So many New Yorkers depend on the State's home and community-based care system, which is why home care policy proposals must be carefully considered before being implemented.

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