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

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Testimony
of
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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 Committee. 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), Hospices, 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 2013-14 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 a skilled nursing facility 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 on the receiving end of relentless cuts to reimbursement and ever more burdensome regulatory requirements and unfunded mandates. This proposed budget continues the cuts to home care and threatens to further destabilize providers that are undergoing massive system changes.

In addition, for the past several years, New York State's home and community-based care providers have been in the midst of an unprecedented, intense state of change and uncertainty in the long term care system in New York. The recommendations of the Medicaid Redesign Team

(MRT), and the enactment and implementation of such changes beginning in 2011, have resulted in a massive restructuring of how Medicaid home care services are delivered, with the entire structure of the Medicaid long term care system transitioning within an ultra condensed period of time.

New State policies have changed patient referral processes, dramatically altered reimbursement for services, and imposed employee compensation requirements that far exceed State and Federal minimum wage rules. These policies are being phased in by programs and geographic areas, resulting in an enormous collision of conflicting agendas, and causing the home care industry to teeter on the edge of viability.

Specifically, home care providers are facing, among other issues:

- The swift transition from operating in a fee-for-service health care delivery environment to managed care models;
- Hundreds of millions of dollars in Medicaid cuts, including six years of a zero percent trend factor and four years of a 2% across-the-board cut;
- The financial impact of the recoupment of over $250 million in Medicaid funds over the past year and the harsh penalties imposed by the Department of Health;
- An unfunded enhanced wage mandate that singles out the home care industry with a wage and benefit package that far exceeds State and Federal requirements;
- A proposed increase in the minimum wage that threatens patients' continuity of care and the overall earning power of home care workers;
- Cash flow crises stemming from delayed or non-existent payments from managed care organizations;
- Business-stifling administrative and general cost caps;
- Aftermath of Hurricane Sandy;
- Federal Medicare reductions and further proposed cuts; 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 stay in business 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 this major transformation, 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 consider any legislation or policies that affect home care and/or small businesses in the context of the challenges that these job creators face daily.

Cuts and Caps Continue to Jeopardize Patient Care, Jobs, and Agencies

Global Cap and 2% Across the Board Cuts

The global spending cap under Medicaid has given the State Department of Health the unilateral authority to impose utilization controls, provider cuts or other spending reductions if State spending in Medicaid exceeds 4% in annual growth. An extension of the 2% across-the-board (ATB) cut is being proposed for the period April 1, 2013 to March 31, 2015, and is being represented as necessary to keep the growth of Medicaid under 3.9% in the next year. These spending provisions were originally part of the 2011-12 State Budget, but their impact will be felt throughout 2012 and beyond.

While the Global Spending Cap has proven that it can change the Medicaid program in New York and could in the future, HCP is opposed to the "super powers" that continue to reside with the Executive to levy any additional provider cuts as needed to ensure the cap is not breached. This puts providers at an ongoing risk for unanticipated cuts in the system, which could see increases by virtue of increased enrollment due to an aging population rather than excessive provider expenditures. HCP strongly urges that such unilateral options to reduce expenditures be eliminated and become part of broader stakeholder discussions.

HCP also strongly opposes the continuation of the 2% ATB. Payment cuts strike 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 have been forced to reduce services, programs, staff or, most troublesome, close their doors entirely. Home care providers have struggled through the first two years of the 2% payment reduction on services they deliver to Medicaid recipients and thought there was a light at the end of the proverbial tunnel when the 2% ATB cut would sunset this March. They are now being confronted with the proposal to continue such a hardship for another two years. Many providers will not be able to maintain operations with such ongoing payment reductions, especially as their expenses continue to increase.

Trend Factor Elimination

The 2013-14 State Budget continues the elimination of Trend Factor adjustments in Medicaid provider reimbursement rates permanently. HCP continues to oppose this elimination, which, along with the ATB cut, 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 will shrink.

By eliminating Trend Factor adjustments, agencies will continue to be challenged to deliver services in a 2013 economy with reimbursement levels based on expenses incurred in 2011. A two-year lag exists in home care rates and thus, an agency's 2013 Medicaid rate is based on 2011 data, reported in 2012 to DOH and then paid in 2013. The trend factor is the way to attempt to bring rates, that are based on two year old data, in line with today's costs of doing business and make agencies closer to whole for the time period being reimbursed. In order for agencies to

continue to provide these essential services, they must receive a rate that is in line with today's costs.

The trend factor elimination further complicates operations for providers in counties with local living wage mandates—and now, the phase-in of the unfunded home care worker wage parity law. These mandates impact State Medicaid programs, but increased reimbursement from the State is not available to providers that are subject to State and local living wage laws. The two-year lag between incurred costs and reimbursement leaves them without funding for living wage increases for two years. Elimination of the trend factor exacerbates this reimbursement discrepancy.

Direct Care and Training Regional Ceiling

While much of the Medicaid Personal Care Program is transitioning to managed care, there are many areas of the State that remain Fee for Service and under the traditional cost based reimbursement methodology. An ongoing challenge that is faced by these providers and exacerbated by trend factor eliminations is the Personal Care aide/nurse direct care and training regional ceiling. As established by Department of Health regulations, portions of the Medicaid Personal Care rate are subject to a regional ceiling, including the direct care and training cost component. Personal Care providers are not reimbursed by the Medicaid program for components of the rate that exceed the regional cap. Included in the aide/nurse direct care and training component are all wages and benefits for Personal Care Aides. As wages and benefits for workers increase as mandated by the living wage law and market forces, so too do the direct wage components of the Medicaid Personal Care rate.

If the direct care component of the regional ceiling is surpassed as a result of Healthcare Workforce Recruitment & Retention (HWRR) initiatives or other market-driven forces (e.g., living wage requirements), providers will incur Medicaid costs that will not be reimbursed under the current Medicaid reimbursement structure. In fact, many providers are already at or near the regional ceiling and more will surpass that mark as time goes on. The elimination of the trend factor also serves to lower the ceilings, resulting in even less reimbursement for wages and benefits.

These cuts, in addition to the 2% ATB cut, result in home care providers attempting to operate at a reimbursement level that barely covers the level of expenses incurred before 2010, and this is a best case scenario. While many home care services are rapidly transitioning away from Fee-for-Service Medicaid to managed care, and related reimbursement is transitioning from Medicaid cost report rates to negotiated contract rates, these proposed cuts will still impact home care. Any provider that is not in a mandatory managed long term care enrollment area and/or continues to provide any Fee-for-Service Medicaid, will be directly impacted by these Medicaid reimbursement and payment reductions. Overall cuts and the global cap on Medicaid spending also impact providers indirectly when passed down through managed care/ managed long term care plans as part of negotiations of private contracts for the delivery of home care services.

Additional Reimbursement Changes

In addition to these extended cuts and caps, the Executive Budget proposes the following changes for home care. While many are continuations of prior budget actions or modifications of such, they require additional clarification as they are applied in the context of new reimbursement systems and structures:

- **CHHA Recruitment & Retention Add-On:** The budget would limit recruitment and retention add-ons for CHHAs to services delivered to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the Department. It also removes reference to services provided through contracts with LHCSAs. It also continues the add-on for LTHHCPs, Hospice and others. The change is described as being consistent with the overall transition to managed long term care.

- **CHHA Bad Debt and Charity Care:** This proposal would extend the authorization for bad debt and charity care costs as reported by CHHAs through June 30, 2018.

- **Medicare Maximization:** This proposal would make permanent the requirement that CHHAs and LTHHCPs providers maximize Medicare revenues as was originally established in 1995 and extended thereafter.

- **CHHA A&G Cap Reconciliation:** This proposal would remove the $1.5 million reconciliation limit for the CHHA administrative and general cap through March 31, 2018.

- **LTHHCP A&G Cap:** This proposal would permanently extend a limitation on the reimbursement of the LTHHCP administrative and general costs to a statewide average.

Funding for Wage Parity Remains a Paramount Concern

HCP has always maintained that home care workers should be compensated for their hard work with fair and adequate wages and benefits, but that 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. To date, such funding has not consistently followed these unfunded wage mandate policies at either the State or local level. HCP remains opposed to this unfunded mandate and continues to implore the Legislature and Executive to provide the funding necessary to implement and maintain the Wage Parity law.

The Wage Parity law, which was enacted at the same time as all of the long term care delivery system restructuring, has created serious challenges for providers that are attempting to comply with confusing rules and interpretations, and secure adequate funding from managed care organizations/managed long term care (MLTC) plans. As a result of various implementation dates for wage parity amounts, conflicting local living wage laws, and inconsistent direction to managed care organizations and MLTCs as to how much they must reimburse providers for services, providers have the extremely difficult task of trying to secure rates of payments that are adequate

to meet their wage parity obligations and ensure adequate and consistent wages for their workers.

The Department of Health maintains that there is adequate reimbursement to managed care/MLTC plans to ensure proper payment of workers, but that does not always translate into an adequate contract rate for the provider of services who employs the home care worker. The actual cost of employing a home care worker is more than the base wage and required benefits, and home care providers are not consistently being reimbursed at a level that covers their costs. This creates the untenable situation for providers as to whether or not they can continue to provide services to patients depending on the managed care/MLTC plan they choose.

There are two additional immediate concerns relative to the impact of the Wage Parity law during this transition. First, the amounts that are to be paid to workers in New York City are increasing in the coming year and the wage parity mandate will then apply to the surrounding counties of Nassau, Suffolk and Westchester. This financial strain on the system is of great concern and its impact on a successful transition of long term care to managed care could be significant. This policy dramatically increases the cost of delivering home and community-based care at a time when the State is trying to reduce Medicaid spending. It was passed with little regard for the ability of providers to pay for it and has generated significant instability in the home care industry.

The second issue is the intersection of the mandatory managed long term care transition into counties with local living wage laws outside of New York City (Nassau, Suffolk and Westchester). Currently, personal care workers on Medicaid cases in these counties 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 guarantee of wages. This change has the potential to disrupt the workforce in these counties significantly. 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.

HCP also anticipates that there will be costly conflicts between the New York State Wage Parity law and the Federal health care reform insurance coverage requirements. It will be important for the Legislature to entertain adjustments to the Wage Parity law to ensure that providers that are complying with both mandates are not penalized.

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. Agencies provide a variety of worker benefits, including flexible scheduling, paid time off, insurances, employee recognition programs, and educational opportunities. These benefits help retain a well-trained, compassionate workforce, which translates into better patient care.

Minimum Wage Increase will Affect Continuity of Care for Consumers

Further taxing home care reimbursement and putting patient continuity of care at risk is the proposed increase to the State's minimum wage. The Executive Budget proposes to increase the minimum wage by $1.50, from $7.25 to $8.75 per hour, effective July 1, 2013. An increase in the minimum wage will impact many home care providers throughout the State, but as a result of competitive hiring practices, local living wage mandates and the Wage Parity law, fewer are impacted by the minimum wage for the base wage. Home care providers are more likely to take an enormous financial hit by such an increase in the calculation of overtime wages for personal care and home health aides, who are paid overtime at time and a half of the minimum wage. Should the increase occur, less and less overtime will be authorized, which will create continuity of care challenges for patients and overall earning potential for home care workers.

This is another area in which the reimbursement must match the mandate. Home care services are overwhelmingly funded by Medicaid in New York State, and Medicaid reimbursement, whether through a managed care contract or Fee-for-Service Medicaid, should match the mandates being imposed.

Supporting and Investing in Home and Community-Based Care

In addition to the proposed cuts, there are some continued funding opportunities included in the Budget proposal, which HCP supports and recommends that the Legislature approve:

- **Health Care Workforce Recruitment and Retention:** $22.4 for the continuation of the Homecare Workforce Recruitment and Retention funding for Upstate New York; $272 million for continuation of the Homecare Workforce Recruitment and Retention funding for New York City; and, $100 million for Certified Home Health Agency, Long Term Home Health Care Program, AIDS home care programs, hospice, managed long term care plans workforce recruitment and retention.

- **LTHHCP Spousal Budgeting:** This proposal would extend authorization for spousal budgeting in LTHHCPs for five years through December 31, 2018.

- **Spousal Impoverishment Provisions for MLTC:** This proposal would apply spousal protections to all MLTC enrollees and provides for the Commissioner to apply for any Federal waiver or approval necessary to effectuate the provision.

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

Success in Managed Care Requires a Slow-Down, Focus on Challenges

The home care industry understands well that change is difficult, but often necessary. HCP and providers have been working cooperatively with the Administration, New York State Department of Health, and other stakeholders to move forward with the implementation of MRT's proposal for "Care Management for All," which calls for shifting the majority of the State's Medicaid

recipients away from a Fee-for-Service delivery structure to managed care models.

All parties involved have been working tirelessly to make the changes that are being required and will continue to do so as new provisions from this year's State budget are ultimately incorporated into this transition as well. It does, however, take time to become familiar with new rules, new operations, new stakeholders, new everything! At this point, the speed with which home care providers, patients, and others in the long term system are being forced to adapt to the changes is among the biggest concerns that HCP has.

HCP fears that by implementing these changes in such an expedited fashion there will be significant unintended consequences, and it will be difficult to assess whether the ultimate goal of this new approach to care management and care coordination across medical, behavioral, social and personal care services to reduce waste and improve patient outcomes, is successful.

While everyone in the process is working hard and fast with good intentions, from a policy perspective, there is little time available to assess what is working and what is not working to make small course corrections as the transition moves forward. By the time the consequences of policy decisions become clear, there are concerns that the transition will have moved so far along—with systems, contracts, and other aspects established—that it will be difficult (if not impossible) to put the brakes on, make changes, or unravel major issues.

The lasting impact of the transition is difficult to determine at this point because of the speed of the implementation. By the time an issue has been identified, stakeholders are busy with the newest change or challenge that has arisen. It is also early in the implementation process. Mandatory enrollment has been in place for just over six months in the New York City area, and only for limited services, and is just now being rolled out in Nassau, Suffolk and Westchester counties.

Cash Flow Crisis for Home Care

One of the issues that HCP anticipates will grow as more care is shifted to managed care is cash flow for home care providers. Currently the Medicaid program, while it may not always pay at a level that covers providers' costs, it does pay on a timely basis every week. As the majority of Medicaid cases move to managed care and providers are receiving payment through multiple managed care contracts, each with different billing and payment procedures, cash flow will become increasingly challenging for home care providers. Because home care's cash flow needs to meet weekly payroll commitments are significant, any challenges in this area will be particularly difficult.

HCP has heard from providers that timely payment is increasingly becoming a concern. Ensuring that claims are clean is a difficult challenge when there is little guidance from the managed care organizations to help accomplish this goal. Limited cash flow for home care providers means workforce shortages and compromised access to patient care.

Upstate Providers Preparing for Implementation while Struggling with Cuts

The phase-in of managed long term care in regions outside of New York City and Westchester, Suffolk and Nassau counties is imminent; however, exact transition dates are anything but concrete as implementation of mandatory enrollment is dependent upon a county's service "capacity." As such, many home care providers are unclear as to exactly when they will be making the shift from Fee-for-Service to a managed care environment.

Throughout the State, consumers have the option to enroll voluntarily into managed long term care, and questions are on the rise as providers in these regions begin the process of contracting with managed long term care plans and working to ensure their aides can continue to serve the clients they have, in many cases, been working with for years. Many of the questions and concerns of these providers are similar to the questions that New York City providers posed at the beginning of their transition process and are just now beginning to work through.

Proceed with Caution

From a home care perspective, the managed care transition to date has been challenging, chaotic, and often nonsensical. Providers are concerned about their patients, their workers and their businesses. HCP members have shared that the changes, which are coupled with the normal challenges of running a business in this economy and a State that has routine reimbursement cuts, unfunded mandates and heavy regulation, are overwhelming. Patients are bombarded with information and are afraid of losing their aides, and managed care organizations/MLTCs must increase and maintain their enrollment.

HCP continues to recommend that the State institute a "slow-down" of the mandatory managed long term care transition process by delaying the phase-in of additional counties until major issues are identified and resolved in New York City. Additionally, slowing down on new program changes, such as the dually-eligible, Fully Integrated Dual Advantage (FIDA) waiver demonstration, should happen as well. The State and all stakeholders are working extremely hard to address issues and transition smoothly, but additional time to learn from the initial wave would be a prudent, reasonable step to take without compromising the forward motion of the overall policy objective of moving all care to a care managed environment.

Additional Initiatives Focus on Expanding Managed Care

Office of People with Developmental Disabilities (OPWDD): The Budget includes a proposal that would allow OPWDD to perform a FIDA program in order to provide comprehensive health services targeted to Medicare/Medicaid dually eligible persons. Up to three MLTCs could be authorized to exclusively enroll individuals with developmental disabilities.

There is also a detailed proposal related to the establishment of Developmental Disability Individual Support and Care Coordination Organizations (DISCO) and the authorization for managed care plans to provide services operated, certified, funded, authorized or approved through OPWDD with certain protections recognizing the unique needs of individuals with

developmental disabilities.

While managed care plans have been part of New York's health care system for decades, they have played only a modest role in the delivery of long term care services. The change to having these entities assume responsibility for the delivery of a majority of long term care services requires providers to learn the intricacies of an entirely new industry. It also requires managed care organizations to learn an entirely new industry and the intricacies of community-based care at the same time. These learning curves have collided and are creating numerous challenges for those currently transitioning.

In addition to ensuring that the experienced special needs providers that have been servicing the State's developmentally disabled population for years remain in that role, HCP stresses the importance of involving home care providers in the DISCO pilot program. HCP has encouraged OPWDD to consider how home care providers that serve the developmentally disabled might share their expertise through participation in DISCOs.

Overall, HCP encourages the State and OPWDD to take heed of the lessons that can be gleaned from the managed care transition currently underway, and ensure that the challenges and unintended consequences on the long term transition are not repeated as OPWDD transitions. It is also critical that the integration of home care is reflected in plans for transitioning the State's developmentally disabled population to managed care and in efforts to keep these patients out of institutionalized care settings.

Integration of Office of Mental Health and Office of Alcoholism and Substance Abuse (OASAS): The budget proposes greater integration of the services provided to beneficiaries from these Offices into care management programs and moving forward with caution and lessons learned from recent transitions is important.

As proposed in the Executive Budget, changes to managed care/managed long term care also include:

- A proposal to lift the current seventy-five certificate limit on the number of managed long term care plans that can be authorized by the Commissioner of Health.
- Permission granted to the Department of Health to set the cut-off date for monthly enrollment in MLTCs by removing language which stipulates that for purposes of reimbursement of the MLTC, if the enrollment application is submitted on or before the 20th day of the month, the enrollment begins on the 1st of the month following completion and submission and if the enrollment is completed and submitted after the 20th day of the month than enrollment commences on the 1st day of the second month following submission.

Greater Home Care Efficiencies through Regulatory Reform

The home care industry faces growing regulatory compliance costs that drain scarce fiscal and human resources. Home care in New York is heavily regulated by the State and is facing new and expanding statutory, regulatory and policy requirements despite an economic environment that

demands streamlining. The fiscal and human resource costs of compliance greatly exacerbate the challenges home care providers have in caring for their patients in the midst of budget cuts and changing health care system operating realities.

Many of these requirements, which impose unrealistic timeframes and burdensome data entry and paperwork, are not directly related to the health and safety of patients or workers. 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.

Relative to the transition to managed care, an implementation issue that could likely be adequately addressed with time and communication is clarifying how current home care minimum standard regulations and Medicaid program regulatory requirements intersect with the almost wholesale 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 organizations, greater confusion and more questions have been raised.

Home care providers have expressed concern that managed care organizations and MLTCs 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. 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. It must be a priority to address these challenges.

Advanced Aide Demonstration

The Executive Budget also proposes amendments to the Education Law that would:

- Authorize a demonstration program, developed in consultation with DOH, to permit home health aides to administer routine medications under the supervision of a nurse employed by a licensed or certified agency or hospice; and,

- Provide for the assignment of services to be delivered by a certified advanced home health aide to a self-directing individual performed under the supervision of a registered nurse employed by a home care agency or hospice and pursuant to an authorized practitioners' ordered care; provided the aide does not represent themselves as a licensed to practice nurse.

  Regulations to establish minimum training and qualifications of advanced home health aides would be developed and the Department of Health would certify advanced home health aides in accordance with such regulations.

In the past, HCP has been opposed to an unrestricted nurse delegation approach to enhancing the role of home care paraprofessionals, primarily because of concerns related to quality of care, liability, and lack of standardization, uniformity and oversight. The Executive Budget proposal does, however, take a more cautious and prescribed approach and HCP is supportive of moving forward with this process as described.

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. A.2482 (Gabryszak)/ S.2313 (DeFrancisco) 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 A.2482/S.2313 and repeal the burdensome annual employer notice requirement.

Real People and Families Depend on Home Care

The mission of HCP's members has not changed: home care providers are continuing to provide effective home care services in an environment of fiscal uncertainty, unfunded mandates and regulatory demands that are at many times duplicative and a strain on already strapped resources. 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 time and resources are needed. It would be prudent and reasonable to take these steps to maintain access to home care services without compromising the forward motion of the overall policy objective of moving all care to a care managed environment and slowing the growth of Medicaid.

Home care providers recognize the immense challenge that the State continues to face, and have 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. Any cuts must be put in the context of their impact on the entire health care continuum. The preservation of the State's home and community-based care system is depended on by so many New Yorkers, which is why home care policy proposals must be carefully considered before being implemented. Real people and real families will be hurt if the State enacts deeps cuts and dramatic and fast-paced policy shifts to home and community-based care.

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

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