

Testimony to the NYS Joint Legislative Hearing on Workforce – Challenges and Solutions

Van Buren Hearing Room A
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Executive Summary of Recommendations

The following is a summary of our workforce recommendations that will be further explained in this testimony:

- **Workforce Compensation and Support:** Allocate new Federal Medical Assistance Percentage (FMAP) funds to increases for direct home care, hospice and MLTC support for workers and service capacity, including:

 - Enhanced worker salary and benefit compensation.
 - Offering of signing and longevity incentives.
 - Provision of professional and personal supports (peer supports, transportation, child care, wellness).

Refrain from wage mandates as a means to allocate FMAP funds or otherwise enhance worker compensation.
- **Support for Training:** Enable agencies to use FMAP to create, expand or support training (basic, advanced, cross-training, specialized, cultural/linguistic). Incorporate funding of training in basic provider rates and MLTC premiums. Fund preceptor and mentoring programs for recruitment and training of new entrants into home care (nurses, home health aides, therapists, social workers). Fund compensation of aides in training.
- **Stop/repeal/modify regressive measures that will impair workforce, access, service capacity and efficiency:**

Repeal the pending DOH Request for Offers “RFO” through which DOH will unilaterally limit LHCSAs in NYS, which risks massive workforce dislocation and service dislocation (S.6640/A.7304).

Modify the DOH RFO for Consumer Directed Personal Assistance Plan Fiscal Intermediaries (FIs) to preserve current, quality FIs that are supporting workers and patients, but being cutout by the DOH RFO.

Repeal/stop implementation of several pre-pandemic Medicaid Redesign items (e.g., Independent Assessor, high hour review panels) that are counterproductive to workforce efficiency without viable benefit.
- **Regulatory Flexibility:** Continue critical areas of regulatory flexibility allowed in the pandemic that support workforce efficiencies, and expand flexibility into areas of efficiency, such as long overdue DOH permission to use nurse practitioners and physician assistants to order home care services, as is now federally permitted. Allow flexibility in state DOH criteria for a worker’s eligibility to serve in home care and hospice. Allow completion of annual home health aide in-service to be trackable via the DOH aide registry.
- **Rate/Reimbursement Responsiveness:** Enforce DOH updates to home health agency rates as required by the Public Health Law, and pass S.2117 /A.293 to improve financial stability, including capacity to support workforce.

Amend DOH reimbursement methodologies to recognize key home care costs and needs for worker recruitment, training and retention.

Conduct a state-agency-led competitive labor market analysis to determine home care and hospice worker (nurses, aides, therapists, social workers) compensation levels and reimbursement rates necessary competitively to recruit and retain workforce capacity in home care and hospice to meet community need.

Examine coverages under NY’s insurance law and other state coverage policies as it relates to (or that excludes) home care and determine the need and potential cost-benefit of coverage improvements.
- **Technology/Telehealth Investment:** Support funding/reimbursement for point-of-service technology and telehealth through home care, hospice and MLTC.
- **Campaign for Entrance into Home Care Occupations:** Establish a statewide, inter-state-agency and stakeholder campaign to promote value and entry into home care and hospice occupations, including interest pathways for individuals in secondary schools, colleges and professional nursing, therapy and social work schools to learn about and consider entrance into the occupation. Offer aide compensation during training. Provide for nurse loan forgiveness for service dedicated to home care and hospice.
- **COVID Relief and Pandemic Costs:** Provide agencies fiscal relief with COVID impacts and prospective emergency response costs for PPE, testing and agency restorations.
- **Adopt the New York Home Care First Policy:** Ensure prioritization of home care services by adopting the NY *Home Care First* state policy. Proposed by HCA, the policy would align state laws and procedures to ensuring home care is an accessible option across the continuum of need, and a first option prior to institutionalization.

Opening Remarks

Thank you, honorable committee chairs and members, for conducting this hearing on workforce challenges in home care and long term care. I'm Al Cardillo, President and CEO of the Home Care Association of New York State (HCA). The decades-long and growing challenges in the home care workforce are now at unprecedented levels, as greatly worsened by the consequences of the COVID-19 pandemic. The pandemic has left home care in a dire worker-shortage. Immediate support is needed to ensure service capacity and access for our patients, while simultaneously, a broader, multitiered and bold plan must be assembled for long term workforce support and sufficiency in home care.

We ask your urgent action to help these agencies and workers who provide for New York's medically needy and vulnerable individuals every day.

About HCA

HCA is a statewide nonprofit association of home and community-based service organizations.

HCA's membership spans the array of home care programs and organizations in the state, including: certified home health agencies (CHHAs); licensed home care services agencies (LHCSAs); managed long term care plans (MLTCs); hospices; Programs of All-Inclusive Care for the Elderly (PACE); long term home health care programs (LTHHCPs); consumer directed personal assistance program fiscal intermediaries (CDPAP FIs); waiver programs; allied community support service organizations; and individuals throughout the field.

HCA's mission is to promote the quality and accessibility of health care and support at home. HCA has continuously worked to assist agencies and advocate policy solutions prioritizing home care workforce development and worker needs.

This year, the Legislature and Federal government have taken an extraordinary step in channeling major Federal Medical Assistance matching dollars to New York for the state's home and community based services and workers. We are extremely appreciative and encouraged by the prospects of these funds for both immediate aid and for launching critically needed structural solutions.

Year after year, HCA has advanced initiatives and policy/budget proposals aimed at this goal, but over time, decisive state and federal actions have not followed. Moreover, at times, state and federal cuts to reimbursement, incompatible reforms and mandates, and the all-too-frequent omission or marginalization of home care and hospice in government programming (as in the case of the Affordable Care Act, the federal HITECH Act, DSRIP, Health Care Transformation Pool, and innumerable others) have worsened already challenging conditions for this sector.

Indeed, in the state's current filing for the enhanced federal Medicaid matching funds booked in the new 2021-22 state budget, ***certified home health agencies are mentioned but one time***, and ***we do not see hospices mentioned whatsoever***. This is an obvious and first correction that we ask to be made!

We look forward to a full and collaborative effort to address the workforce and service capacity needs boldly and creatively, and to this newest opportunity with his hearing and with the new federal and state funding.

Home Care Need

Home care is a core service in the health care system and it serves as one of the pivotal footings that supports the system's entire foundation.

Hundreds of thousands of New Yorkers depend upon home care each and every day -- from maternal/infant patients, to adults, to elders; from primary care to pre- and post-op, from medically complex to chronic, to end-of-life. The health system in its entirety depends on accessible, quality home care to function.

State, federal and health system trends and policies, together with aging demographics, advancements in medical practice and patient preferences, create a trajectory of ever-growing home care need. Home care is looked to for prevention, public health, hospital and emergency room avoidance, post-hospital care, management of major conditions, long term care, end-of-life care, and more. Meeting this need rests upon the agencies and especially the workers. Home care's corpus is its workers – its nurses, therapists, home health aides, social workers, transporters, case managers, and all who “bring the care” to the patient, neighborhood and community.

While there is an estimated home care workforce of 250,000-400,000 in the state, the need for workers and services in this sector greatly exceed this current supply. HCA has for years called for priority action to address the gap between need and supply. Agencies, workers, continuum partners like hospitals and doctors, and most of all, patients and families, all have had to make do within supply limits to make the services and the system work – but the gaps are consequential and are in dire need of remedy.

Data from national and state labor sources (US Bureau of Labor Statistics and NYS Department of Labor) show that employment need for in-home care exceeds nearly all other occupations. Each year, HCA surveys of the home care sector show vacancy rates and recruitment and retention challenges impacting access. While, for all of the aforementioned reasons, the gap between workforce capacity and need grows wider and wider, the pandemic has raised this to a fully acute and emergent level.

Pandemic Impact on Workforce Capacity

The already-growing gap between need/demand for home care services and the trended increases in the available workforce supply was enlarged by COVID-19 as workers in large numbers either left active practice due to COVID-related parental/family responsibilities, or their own COVID-19 illness or exposure and isolation requirements or left the field entirely. Many have not returned due to conditions in the labor market, extension of government unemployment and COVID-related benefits especially, and other factors triggered in COVID-19.

Simultaneous with the onset of the COVID-19 surge, COVID-19 physical distancing requirements reduced training certification programs to a fraction, which reduced the ability to recruit and replace those lost to the workforce as well as the ability to otherwise add needed home health staffing.

Meanwhile, referral of more complex, intensive and earlier discharges from hospitals has been on the rise, as well as overall public outcry for more access to home care services to avoid or minimize inpatient and long term facility care.

An October 2020 pandemic-status survey of home care and hospice providers conducted by HCA found that the overwhelming number of agencies (85%) said that structural workforce shortages — especially the limited numbers of nurses, home health aides and/or personal care aides — have been greatly amplified by COVID-19, and these shortages are a primary obstacle to admitting patients, including for persons needing to be discharged from the hospital. It found that approximately 43% to 45% of home care and hospice agencies experienced a decrease of 11% or more in home health aide and personal care aide workforce capacity since March 7, 2020 and decreases in nurse and therapist capacity were likewise experienced.

Sixty-five percent of home care agencies in New York State saw an increase in referrals to home care from hospitals and other settings and 76% of agencies reported challenges in accepting these new referrals, mostly because of reduced workforce availability.

COVID-related impacts on home care specifically, along with workforce impact and market adjustments (e.g., wage competition) across the economy as a whole, are exacting an unprecedented toll on home care shortages and recruitment challenges. Despite having faced decades of worker shortages, providers statewide are telling HCA that they have “never witnessed anything” like the shortages and challenges occurring now. A downstate NY agency administrator stated just today that only “one potential home care recruit in the past four months has walked into their office for interest in training and service.”

Needed Actions

The need for both immediate and progressive structural solutions is critical. This will not be a “one-and-done proposition,” but will require a multitiered action plan that must be rooted in a firm, well-articulated policy for New York. It will require a commitment to develop and maintain the structural capacity of the system, and must span requisite areas of: funding; rates and compensation for worker salary, benefit and agency operations; recruitment and training; core personal, professional and operational supports for workers and agencies; mitigation of regulations and procedures that are counterproductive to the workforce and to worker and agency efficiency; technology innovation, authorization and reimbursement fostering staff and operational efficiency; and more.

2021-22 State Budget Opportunity for Workforce

How do we move forward with an operational plan?

The federal and state governments have taken a major step targeting \$1.6 billion in enhanced Federal Medicaid Assistance Percentage (FMAP) funds for New York State home and community based services approved in the 2021-22 state budget, to be broadly allocated across health, mental health, intellectual and developmental disabilities and substance abuse providers. We are aware that the state Department of Health’s implementation plan seeks to maximize federal matching of these funds to possibly as much \$5 billion.

Within CMS’s parameters for use of these FMAP funds, we recommend priority allocation of these funds focusing primarily on direct worker compensation and support. We also recommend a parallel series of actions – legislative, regulatory, collaborative and

other – to further assist with immediate relief, as well as for consideration in a multitiered plan for long term structural support.

A summary of HCA’s recommendations follows.

HCA Recommendations

I. Workforce Compensation and Support

HCA urges that the new FMAP funds be used substantially to address the very urgent workforce recruitment, compensation and retention needs in home care and hospice.

These should include:

- A. Supporting agency capability to provide increases in compensation and benefits *as are able to be carried over and maintained in sustainable reimbursement/funding to home care agencies, hospices, MLTCs and FIs at the conclusion of the FMAP period.* Improved funding to providers and MLTCs in order to substantially improve worker compensation must be a priority. HCA advocates for this in every state and federal budget cycle. However, sustained increases in wage and benefit levels must be contingent on commensurate funding, including funding that is applicable to **all patients** that workers serve, regardless of payor.

Background

- Since the FMAP monies are one-time funds, unless the funding commitment is continued by the state and federal payors, these FMAP funds have to be applied in ways to promote as much structural improvement as possible, but short of measures that would necessitate long term reliance and commensurate increases by the other major payors like Medicare and private, over which

- neither the state, the providers nor plans have control. Doing otherwise would not be survivable for providers, plans or workers.
- Use of these funds to provide and promote pay and benefit increases should ***NOT be implemented as, or translated into, new wage mandates***, because there is no practical and reliable way under state, federal and private reimbursement methodologies for providers to cover costs commensurate with the mandates, or for patients/families who are out-of-pocket payors to absorb the increases. To date, providers and managed care plans have struggled mightily with wage mandates adopted under the Medicaid Redesign Team (MRT) actions. Moreover, in the case of the MRT, state “promises,” and even new statutes held out as “guarantees” for compensating for those mandates, have not lived up to the commitment. HCA fully endorses and is strongly advocating additional funding for home care worker compensation, benefit and support, as further enumerated here and throughout this testimony. However, we urge the Legislature in the strongest possible terms **NOT** to enact wage and benefit mandates as have been contemplated in the Senate Article VII Medicaid budget bill (S.2507-B), and in the Fair Pay Act (S.5374/A.6329).
 - B. Use of funds to enable agencies to offer hiring incentives, longevity bonuses, and COVID service recognition through worker payment enhancements.
 - C. Enabling agencies to provide for workers’ essential professional/occupational supports such as transportation, child care, peer support in the provision of services, team-based

approaches to care, career ladder development, and related supports to increase the abilities of agencies to recruit and retain staff in the competitive labor market.

- D. Enabling use of funds to support aide compensation during initial training.
- E. Enabling RN and LPN “Nurse Loan Forgiveness” for service rendered in home care and hospice for defined minimum periods in the state.

II. Repeal/Stop/Modify Implementation of Pre-pandemic 2020 MRT-II program actions adverse to workforce, including the pending LHCSA RFO, FI RFO, Independent Assessor, and

Other

- A. Repeal the 2020 budget item, Request for Offers “RFO,” that if implemented would allow DOH to unilaterally limit Medicaid contracting capabilities for NYS LHCSAs, which risks massive workforce and service dislocation.
- B. Amend the RFO parameters for FIs set forth by DOH and ensure that already-operating, quality FIs may continue to provide services for personal assistants and consumers under the Consumer Directed Personal Assistance Program (CDPAP).
- C. Repeal/stop implementation of several 2020 pre-pandemic DOH/MRT items (such as the “Independent Assessor,” and high hour review panels) that are counterproductive to workforce efficiency and workers without viable benefit.

III. Support for Training

- A. Enable agencies to use funds to create/operate training programs. Training funds should be allocated both as direct funding to agencies with training programs, or for expanding or developing these programs. Funds should also be provided and methodologically

incorporated in rates provided to MLTCs, CHHAs, LHCSAs and LTHHCPs for their sponsored training programs and those of their LHCSA contractors.

- B. Enable funds for agencies to compensate aides in training.
- C. Support home care and hospice agency preceptor and mentoring programs for recruitment and training of nurses, home health and personal care aides, therapists and social workers.
- D. Enable agencies to use funds to support or establish online/hybrid home health aide and personal care aide training programs, and require DOH to streamline procedures to approve or expand the programs. The current length of this DOH process and the wait for approvals do not reflect the staffing/training urgency in the field.
- E. Enable agencies to use funds to establish or expand specialized training programs to support worker skills and capabilities in caring for complex, comorbid, culturally and linguistically diverse, and underserved populations.

IV. Regulatory Flexibility

- A. Ensure that critical areas of regulatory flexibility begun in the pandemic through the emergency waivers may continue post-pandemic to support operational efficiency. Also provide opportunities for new areas of regulatory and procedural flexibility that may further help to promote efficiency for workers and agencies.
- B. Expedite DOH issuance of its long overdue approval of a regulatory revision recognizing federal authorization of nurse practitioners and physician assistants to order home care services.

- C. Allow flexibility in current requirements for worker eligibility for positions in home care and hospice.
- D. Allow agencies to track completion of annual aide in-service via the DOH aide registry.

V. Technology/Telehealth Investment

- A. Support home care and hospice agency with direct funding/reimbursement for development and provision of telehealth services.
- B. Increase MLTC premiums to allow for MLTC rate support to home care agencies (CHHAs, LTHHCPs and LHCSAs) for telehealth, and restore distinct reimbursement for home telehealth under Public Health Law 3614.3(c) as delivered by CHHAs, LTHHCPs and contracted-LHCSAs. (These distinct payment methods were lost in the DOH transition to the episodic payment system for CHHAs in 2012 and in the transition to managed care).
- C. Allow home care, hospice agencies and MLTCs to receive funds to support critical point-of-service and health information exchange technologies for patient care, including technologies that support clinical integration, timeliness and management of care, administrative/documentation relief for nurses, therapists and aides, and other point-of-service technology supports.

VI. Rates, Financing and Methodological Needs for Agency Stability and Workforce

- A. The state is legally obligated (long overdue) to update the Medicaid rate base CHHAs, as well as the minimum wage and wage parity funding levels (which likewise extend to the workers of the CHHAs and their subcontracting LHCSAs). HCA urges that the FMAP enhancement funds be applied to help fund this state obligation to the agencies and workers. The updates are urgently needed to help stabilize the unsustainable fiscal

trend for CHHAs due to underpayments, which affects operations and workforce support capabilities.

Background

- The most recent cost-report information available to HCA (2019) shows over 65% of CHHAs operating far below margin, with an average margin of negative 14%.
 - PHL Section 3614.13 requires DOH to update CHHA base year costs “no less frequently” than every three years. The last DOH update was implemented in 2015, meaning that the last six years of new CHHA costs have not been reflected in the CHHA rates.
 - Updates are critical for both CHHAs, subcontracting LHCSAs and workers. They are also critical in the case of individual service fee-for-service rates approved for CHHAs by DOH. Importantly, these rates are often used as benchmarks for negotiation with health plans, including Medicare plans, and to the extent that the state-issued Medicaid rates are substantially below margin, they lead to underpayment in negotiated Medicare and commercial rates.
- B. Amend state rate and premium methodologies to recognize key home care cost and support needs relative to worker recruitment, training and retention.
- C. Examine coverages under NY’s insurance law and other state coverage policies as it relates to (or excludes or limits) home care and determine the need and potential cost-benefit of modifications.

- D. Conduct a state agency-led competitive labor market analysis (with input from a stakeholder advisory group) to determine the salary and benefit levels that are necessary in the market to recruit, compensate and maintain staffing capacity for home care and hospice. Based on the analysis, recommendations could be made for the requisite funding, premium levels and provider rates to meet this threshold.

VII. Promote Entrance into Home Care Occupations

Establish a statewide, inter-state-agency-led campaign to promote entry into home care and hospice occupations and public value of this workforce. Promote “pipeline development” of career/interest pathways for individuals in secondary schools, colleges and professional (nursing, therapy and social work) schools to learn about and consider entrance into a home care/hospice occupation. Provide loan forgiveness for nurse entry into home care and hospice, with defined service periods and, as previously recommended, compensate aides during training.

VIII. COVID Relief

- A. Home care agencies and hospices have borne a huge financial impact associated with COVID, with uncompensated costs such as for PPE, COVID-19 testing, reduced capacity for staff/procedural efficiency, lost operating revenue and unfunded COVID mandate costs. We projected 2020 COVID losses in the range of \$200 million statewide.
- B. HCA urges that a portion incoming federal funds be made available directly to agencies to help provide relief from these losses, as well as for new and ongoing PPE, COVID testing requirements, and restoration of agency operation.

IX. Use Direct Methods of Funding Wherever Possible

It is critical that funds be allocated wherever possible via direct funding to CHHAs, LCHSAs, hospices, MLTCs and LTHHCPs for the costs of these supports. This direct funding process is essential to avoiding the situation where funds are foisted onto the plan-provider negotiation process, with plans and providers left to sort out allocations.

X. Adopt the “New York Home Care *First*” Policy

Solidify the commitment to home care services under in an established “Home Care *First*” state policy that has been proposed by HCA. Under this policy, state laws and procedures related to home care workforce, rates, operations, consumer access to care, coverages and other elements would be aligned to a “home care first” goal, to ensure home care is an accessible option across the continuum of need, and a first option prior to institutionalization; and ultimately to ensure that home care is *a reality* and not an elusive chase for consumers and the health care system.

Conclusion

HCA is committed to working with the Legislature, Executive, our providers and plans, and all stakeholders to address the critical workforce need in home and community-based care for New Yorkers. We have a major, perhaps historic opportunity, along with a professional and moral obligation, before us to address this need truly and substantively. Thank you for this opportunity for HCA’s input and we look forward to working with you on the many next steps.