



November 16, 2011

Members of the Codes Committee
Members of the Public Health & Health Planning Council

Dear Committee and Council Members:

The Home Care Association of New York State (HCA) **strongly opposes and urges your disapproval** of the State Department of Health's (DOH) proposed emergency adoption of amendments to **section 760.5 of Title 10 NYCRR**. This proposal radically undermines the rules, market and level playing-field for the establishment of Certified Home Health Agencies (CHHAs) in the state.

HCA is the statewide association comprised of nearly 400 health care providers, organizations and individuals involved in the provision of home care services to several hundred thousand cases annually. HCA's provider membership includes CHHAs, Long Term Home Health Care Programs (LTHHCPs), Licensed Home Care Services Agencies (LHCSAs), Managed Long Term Care (MLTC) plans and Hospices. HCA's member home care programs are provided by hospitals, nursing homes, and public and private agencies, like Visiting Nurse Associations (VNAs).

DOH's proposal effectively guts the public need process for CHHA establishment, allowing a bypass of public need for certain entities (MLTCs or other care coordination models*) to establish CHHAs to ostensibly facilitate patient enrollment into managed care plans, or for CHHA development in counties with less than two (excluding county-sponsored) CHHAs, ostensibly for purposes of access. CHHA establishment for either purpose is permitted under the proposal; but, neither justifies the proposed waiver of public need or potential consequences to the delivery system.

(*For ease of reference in this letter, MLTCs and other integrated/care coordination models are grouped as care management organizations, or "CMOs.")

HCA urges the Committee's and Council's **disapproval** of this proposal for the following reasons.

- 1. Circumvents Public Need.** The proposal completely circumvents the CHHA public need process in a manner that defies justification, and defies the consideration of the existing infrastructure or efficiency of the system, including impact on local resources and workforce. The proposal allows for the establishment of new CHHAs: (i) without regard to public need whatsoever; (ii) without regard to whether public need in the community has been deemed to be met, or would best be met, by the existing agencies; (iii) without regard to the longstanding public need methodology with which existing entities have had to comply; and (iv) without regard to impact on the existing home care agency infrastructure.
- 2. Further Destabilizes Home Care.** DOH seeks to rush this proposal through the Council at a time when there is a cascade of profound and destabilizing changes affecting the home care system, including the unprecedented MRT cuts and programmatic actions. By disregarding public need as well as the role, capacity, and functioning of the existing community providers, only to establish new CMO-owned

CHHAs, the proposal will further exacerbate the existing system's instability, the disruption of the workforce and disruption of continuity of care. It is an imprudent and unnecessary proposal that will facilitate, and, in some cases cause, the closure and elimination of the existing home care service delivery structure provided by CHHAs, LTHHCPS and LHCSAs.

In the case of the stability of rural home care specifically, HCA has been working intensely with both the Senate and Assembly chairs of the Legislative Commission on Rural Resources on legislative and other solutions to support access to home care in rural communities. Our mutual work has resulted in the introduction of four Commission bills, one of which was signed into law this August, as well as other initiatives and concerns we continue to pursue together. This is a far more constructive route upon which to build for rural home care stability and access than is the DOH proposal.

3. Unnecessary and Duplicative - Need Already Being Met and Patients Being Served. There is no valid reason for DOH to petition the emergency adoption of this proposal to create new agencies – which according to the state's own methodology are “not needed” – especially given that there are agencies which right now meet the defined need and are delivering the care. There is no useful purpose served by transferring patients from the care of their current, longstanding agencies to newly created, and by definition “duplicative,” CMO-owned agencies. Instead, the existing plan should be pursued whereby CMOs without CHHAs establish contracts or seek other affiliation with existing agencies for the required services – which is contemplated in the state budget's home care continuity of care language.

4. Contradictory to Federal Action, National Experience, Current Reform. This proposal is contrary to federal actions and current national experiences with home care in relation to public need and CON. Other states that do not apply or that bypass public need for CHHAs have been the focal point for fraud, abuse, saturation and cost concerns. As a consequence, they are also the focal point for national efforts to *impose* limitations, including a national moratorium, on CHHA development outside of public need. The imposition of a moratorium tied to home care public need is in fact in current discussion in proposals before the Congressional “Supercommittee.” DOH's proposal is in contradiction to these efforts.

5. Undermines the Council's CON Reform Effort Integrity. Though dramatically affecting CHHA CON, DOH has advanced this proposal in isolation from the Council's current, public outreach initiative on CON reforms needed for the evolving system. Instead of its submission and debate with these broader, competing ideas, this proposal was sent straight for Council adoption on a purported emergency basis, but without true emergency, without industry discussion, or a gauge of impact from the existing agencies.

HCA recognizes and supports streamlining, fast-tracking and related CON reforms. HCA has previously provided an array of meaningful home care CON reforms to the former, SHRPC. In the spirit of the Council's current efforts, HCA has engaged its Policy Council in formulating updated proposals to feed (the state) Council's reform initiative as well as address major policy changes like the shift from fee-for-service to managed care coverage. HCA urges the Council's continued engagement with the public and the home care community on meaningful CON reforms, and the rejection of DOH's end-run proposal.

6. The Proposed Departure from Specific Regulation to RFA Circumvents Regulatory and Public Accountability. The proposal circumvents the regulatory and public accountability for CHHA CON. It shifts the current regulated process for determining CHHA need and establishment to a non-regulatory,

DOH-developed “request for applications.” The proposed RFA process accords none of the protections, accountability or input of the regulatory process.

7. Unfair Leverage/Playing Field in Negotiations. Because CMOs will have a captive base for referral and authorization of services, this proposal gives the CMO hugely unfair and inappropriate leverage in any contact negotiations with existing CHHAs, LTHHCPs and LHCSAs. Regardless of whether the CMO actually proceeds to establish its own CHHA, the CMO will be given an unfair playing field to be able to advance “take-it-or-leave-it” positions with home care agencies who are already at a major negotiating disadvantage with regard to network participation, rates and other contract terms.

8. Dilution of Agency Staffing/Workforce. Throughout the state, there are critical shortages in health care staffing, and significant competition for personnel. The approval of new agencies, particularly outside the need process, will further dilute the workforce and an agency’s ability to maintain adequate staffing for operations. This can be ill-afforded on top of the extreme challenges the system already faces in staffing.

In addition to all of the aforementioned concerns and objections with regard to the proposed rule itself, HCA takes major issue with assertions made throughout the regulatory impact statement claiming that there will be: (i) no small business impact; (ii) no rural impact; (iii) no impact on workforce; and (iv) an improvement in quality and efficiency from CMO-provided home care. The impact statement provides façade justification and ignores the clear consequences of the proposal in an attempt to avoid scrutiny.

The regulatory impact statement also makes repeated assertions about the necessity of CHHAs for the coordination of patient care. We certainly agree with CHHAs’ expertise and role in coordinating care. It is ironic and troubling however that throughout the MRT process, budget negotiations, and subsequent MRT discussions, CHHAs were specifically excluded as recognized care coordination entities by the Administration. Despite HCA’s and the Legislature’s efforts to the contrary, DOH opposed even the mention of CHHAs among care coordination models cited in the final budget language. Now, ironically, the Administration seeks to use an opposite argument – CHHAs’ care coordination value – to justify its proposal to disregard public need for CHHAs so that new CMO CHHAs can be established.

HCA appeals to the Council, for all of the stated reasons, to reject this regressive, highly unfair and unsound policy proposal, and instead to continue to work on meaningful CON changes in the context of the Council’s own, transparent, CON reform initiative.

HCA is pleased to answer any questions or provide further information as you may require.

Thank you for your consideration.

Sincerely,

Al Cardillo

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Executive Vice President