

2017-18 State Budget Testimony HCA Concerns and Recommendations

Joint Legislative Hearing
of the Senate and Assembly on the
Health and Medicaid Budget

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New York State (HCA)



Introductory Remarks

The Home Care Association of New York State (HCA) appreciates the opportunity to testify before the Legislature today on the Health and Medicaid aspects of the proposed 2017-18 state budget.

I am Al Cardillo, Executive Vice President at HCA. My organization represents home care and hospice providers, as well as Managed Long Term Care (MLTC) plans, throughout every region of New York State. This vital system of home-and-community-based entities serves 375,000 Medicaid recipients annually, as well as 180,000 Medicare beneficiaries and other patients receiving cost-effective services at home.

HCA's membership encompasses the full continuum of home-based services. This includes post-acute, long-term, preventive, end-of-life, and managed care-directed programs, each of which have their own core licensing features, payment and billing structures, clinical and human-resource capabilities, as well as distinct roles in the system.

Collectively, these providers and plans keep patients out of costlier settings (like hospitals and nursing homes); provide maternity-newborn care to assist mothers and children; help aging New Yorkers live independently and safely at home; support patients recuperating from surgery (so individuals aren't readmitted to the hospital due to complications); address clinical risk areas like asthma mitigation, cardiovascular health management and infection control; provide public health services like immunizations; and execute additional functions that are not explicitly health-related but are unique to in-home service delivery, such as emergency-preparedness activities.

I point your attention to all of these features because I think you will see that home care delivers squarely on priority areas that have commanded attention from the state in all of its major policy initiatives intended to reduce costs and provide better care.

As you know, the state has invested billions of dollars into the Delivery System Reform Incentive Payment (DSRIP) program to reduce unnecessary hospital use by 25%. The state has also invested enormous financial and planning resources in an effort to reorient the entire Medicaid system toward value-based payments (VBP). These new risk-sharing and highly integrated system models seek to reduce costs and incentivize outcomes in manners that have long resided in home care's domain of expertise.

If you were to examine any of the specific DSRIP or VBP projects targeted by the state – whether its post-acute joint-replacement care, asthma mitigation, or managing chronic obstructive pulmonary disease, congestive heart failure and diabetes – home care has been addressing these needs in

focused and intensive ways for decades. A robust home care system is requisite for the success of every state Medicaid waiver project and system redesign activity currently in operation, especially those models aimed at the overarching goal of a 25% reduction in hospital use.

I will focus on four areas critical to the support of the community-based sector in which we ask for your help and action in this new state budget.

Payment Adequacy Needed for Home Care Stability in Achieving State Outcome Goals

Home care providers and the MLTC plans they partner with are collectively shouldering operating losses due to long-standing Medicaid rate-setting inadequacies. Our just published financial condition report, attached to my testimony, profiles the data.

The state's premium and rate methodologies are failing to cover the *real* cost of delivering services, particularly with the increasing need for care and constant layering of new provider/health plan mandates. We ask the Legislature to build on last year's budget language requiring actuarially sound payments by further strengthening the methodology language to ensure that critical managed care and provider operating and service expenses are duly covered in the premiums and rates as statutorily intended.

HCA has provided requisite Article VII language for your consideration.

We further ask that cuts to MLTCs that have been proposed by the Executive in this budget, and referenced further in this testimony, be rejected and that this necessary MLTC funding is restored.

Our financial condition report, derived from certified cost reports to the state, finds that state Medicaid underpayments result in 61% of MLTC plans having negative premium incomes in 2015 and 72% of Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs) having negative operating margins for 2014, with similar CHHA/LTHHCP financial results in 2015.

Thirty-one percent of all home care agencies (CHHAs, LTHHCPs and Licensed Home Care Services Agencies, or LHCSAs) have had to use a line of credit or borrow money to pay for operating expenses over the past two years, and another 6% of agencies were unable to establish a line of credit or financing due to various financial factors.

Funding pressures on MLTCs also contribute to a downstream effect on providers experiencing authorization and payment delays, the accumulation

of bad-debt, and constricted revenue flow. I point you to our report, *NYS Home Care Program and Financial Trends 2017*, for further details and elaboration on these financial matters.

Most urgently, as you know, last year's budget adopted a minimum wage hike that disproportionately affects home care providers and MLTC plans. This wage hike alone will have a \$2.19 billion cost impact for home care across the full, multi-year implementation of the mandate. It is essential that state-set managed care premiums and provider rates be increased to fully cover these wage requirements, and that the requisite appropriation level be included in the budget for this purpose. We urge the Legislature and Executive to ensure the necessary budget funding.

The Governor's budget includes some allocations for home care minimum wage impacts, starting in April. However, both the final adopted funding amount and the distribution methods must be adequate to meet the huge need created by both the wage increase and the growing number of elderly and medically-fragile patients requiring care at home. Home care providers and MLTC plans agree that the state's year-to-date efforts to fund minimum wage costs in the first quarter of 2017 have been uneven, disproportionate, inadequate and, frankly, confusing in regards to the required flow of payments across the continuum of services.

As earlier noted, we also call on the Legislature to reject the Executive's proposed MLTC cuts and adverse actions proposed in the Executive budget. These include the proposed carve-out of patient medical transportation, cuts in the MLTC quality incentive payment, and MLTC eligibility changes that would further compromise MLTC service capability and stability.

HCA also asks that the Legislature reject the budget proposal that precludes MLTCs from marketing. This prohibition creates an un-level playing field for provider-based MLTCs in the market with commercial health plans, whose portfolio of plan services includes MLTCs. By disallowing marketing across the entire field of MLTCs, provider-based plans will be at a disadvantage with commercial plans who can continue to market their other non-MLTC health plans to consumers.

Home Care Regulatory Flexibility for Participation in the State's New Care and Coverage Models, and Strengthened Enforcement of Unlicensed Entities Providing Sanctioned Home Care & Hospice Services

As previously noted, billions of dollars have flowed to other sectors through new models of care, like DSRIP and the Performing Provider Systems (PPSs) functioning under DSRIP. Key to the success of these and other new

integrated models (e.g., advanced primary care, ACOs, value based payment, hospital-physician-home care collaborative) models is available, accessible and well-designed and integrated home care participation.

Home care participation in – and its benefits produced through – these new models can be substantially advanced by a well-matched regulatory structure that would align more specifically to these models. This is particularly so in the case of focused roles and tasks that home care can expertly perform as partners in these models, distinct from home care's more encompassing role in traditional cases where home care is the only or the primary provider. Examples include partnering with physicians in: asthma mitigation through home assessment and recommended remediation; immunization; support in high-risk/high-need maternal and post-partum care; sepsis screening and others. I have attached a background document that provides further explanation and detail.

HCA has submitted Article VII language to create a specific section within Article 36 of the public health law (the governing statute for home care) that would authorize a more flexible and lean regulatory approach, providing a more quickly accessible and efficient structure specifically for home care's participation in the new models.

Meanwhile, DSRIP is witnessing an increase in potential "scoff-law" practices by which non-home-care providers are incentivized to enter the home care field of practice, but through 'unregulated' channels, contrary to state laws and standards.

HCA's members report that hospitals, group practices and others throughout the state are seeking to bypass licensed Article 36 home care providers (as well as Article 40 hospice providers) in an effort to deploy their own nurses or staff to the homes of patients as a way of fulfilling the goals of DSRIP and other system reform projects. These activities escape the strict state and federal laws and regulations that Article 36 home care agencies and hospices must abide as part of their basic state/federal certification and licensure, and participation in the Medicaid program, including patient safety and quality protections specific to in-home providers, such as assessments, documentation, and other requirements.

The Governor's budget proposes a Health Care Regulation Modernization Team to examine regulations, with an intensive focus on community care. Our concern is that such a venue could exacerbate already problematic jurisdictional crossovers occurring in the field, and we urge the Legislature to guard against this "free-for-all" outcome. HCA wholly supports regulatory relief throughout the continuum, and specifically within home care, as we have proposed in our own language provided to you. But we do not support the construction of a process which could violate the basic integrity of

provider/practitioner licensure and the fundamental organization of the system. We ask the Legislature to ensure strict parameters targeting regulatory flexibility within licensed sectors, and not across sectors; and if such a Modernization Team is authorized, stakeholder representation (including home care), safeguards, and legislative control must be incorporated. Further, specific to home care, such a process must take care to recognize the important provider relationships that exist in Article 36 for meeting very specific competencies and roles, be it: recruitment, training and retention activities; workforce supply and oversight of various disciplines of care care-management; and more.

As noted, HCA has already advanced proposed budget language for home care regulatory flexibility in ways that respect the intentions of agency licensure and jurisdiction on behalf of system integrity. HCA's proposal aims to allow home care to be a nimble participant in new models of service delivery that would optimize community providers in DSRIP models, which was a core goal and intention of DSRIP.

A related HCA proposal seeks to amend Article 28 of the public health law to ensure that DSRIP/PPS implementation optimizes the incorporation of community based network partners, rather than duplication by the PPS leads of services that community providers now already expertly provide. Findings from the state Health Department's Mid-point Assessment of DSRIP, by an independent evaluator, point to the lack of downstream funding by most PPS leads to community based partners and the need for more effective and robust incorporation of community providers and plans for the stability of these providers in the next DSRIP phase. HCA's proposal offers the Legislature with language to address these findings.

Infrastructure Investment Needed for Home Care's Participation in New Models

Home care is currently one of the only sectors without a dedicated working infrastructure fund, at the same time that other entities enjoy long-established working capital pools for clinical and Health Information Technology, and other infrastructure needs.

The Governor's budget includes a renewed commitment of \$500 million in infrastructure funding for all health care sectors, but a much greater funding apportionment is needed for community care, as well as a commitment for urgently needed infrastructure investment in home care specifically.

Home care providers have a wealth of clinical condition and encounter data on hundreds of thousands of patients. Better technological integration of home care would have a profound, game-changing impact on the system's operating intelligence and vital patient health information exchange with

partners (i.e., physicians, hospitals, managed care) when it comes to patient care conditions and transitions across the system. This is especially vital in connection with reforms such as DSRIP, Value Based Payments, and other Medicaid Redesign efforts.

HCA is urging the legislature to press for more robust home care infrastructure support in this year's budget, including a stronger commitment of investments in home care specifically. This commitment must go beyond the Governor's proposal of \$30 million in Health Facility Transformation funds as a floor for community care – which includes all (very needy) community health settings, not just home care – out of a total \$500 million allotment for all sectors.

HCA is specifically calling for a \$125 million minimum sub-allocation for community care and home care providers. This is consistent with the state's index goal of a 25% reduction in hospital services, which requires community care to shoulder a more substantial role in driving down costs, thus necessitating a more robust level of infrastructure investment. In addition, HCA asks that the program language in the Governor's proposal must also be made somewhat more flexible to ensure its responsiveness to home and community health system needs.

HCA has also provided separate Article VII language specifically related to home care infrastructure programming (described in the attached documents) and urges the Legislature's support.

Comprehensive Assessment and Action Plan Needed to Address Workforce Shortages, Recruitment and Retention in Home Care

I want to take a moment to commend Assembly Health Committee Chairman Richard Gottfried for sponsoring upcoming hearings on workforce issues in home care. The home care community appreciates this commitment to addressing what our partners in the senior advocacy community are calling a "crisis" in access, driven especially by issues in home care workforce retention, recruitment, and capacity to meet the needs of health reform broadly and the growing reliance on home care for our state's elderly and chronic-care population.

We hope these hearings, and the budget process, will culminate in a comprehensive plan to address home care workforce shortages, which affect access to services, create provider cost burdens, and limit the achievement of system goals to rebalance health care toward cost-effective community settings.

According to our provider survey and accompanying report on financial and program trends in the industry, home care agencies contend with high staff turnover rates, including a 24% turnover rate for aides and a 21% turnover rate for nurses and other professional staff.

Approximately 14% of home health aide positions, 17% of personal care aide positions, 13.51% of registered nurse positions, and 10.6% of therapist positions are unfilled due to shortages. On average, agencies are unable to accept 37.3 cases due to staff shortages, with at least three agencies reporting in our survey that over 100 cases can't be accepted because of shortages.

HCA has proposed legislative language to establish a comprehensive policy and set of initiatives to address these longstanding recruitment, retention and workforce shortage issues, as well as home care capacity needs for communities in New York State. This issue affects various regions of the state differently, including unique supply and geographic service spreads in the upstate region, as well as access and service capacity pressures in the downstate region.

Given the increased reliance on community-based services for vulnerable populations, it is long past time for the state to conduct a comprehensive needs-assessment and action plan regarding the home care workforce, especially with the state's newly imposed minimum wage requirement, which adds new competitive pressures that are likely to exacerbate long-standing concerns for workforce capacity and readiness.

Conclusion

I again thank you for the opportunity to testify before this hearing and urge each of you to engage with the home care providers in your legislative districts who can provide more locally specific details on these issues and pressures in the industry affecting not only the hundreds of thousands of home health beneficiaries in New York State but the workforce who serves them.

I also encourage you to read our attached reports, which provide a further summary of home care industry experiences as well as a concise statement of our state budget recommendations. As always, I am happy to answer any of your questions related to these matters. Thank you.



HCA 2017-18 State Budget Requests

1. **Managed Care & Home Care Rates**

ENACT sound rates for home care and MLTC. HCA has proposed amendments to the state's payment methodologies, which are underpaying managed care plans and providers. HCA's amendments ensure sound rates for managed care and provider payments to cover the costs of quality patient care, appropriate staffing, and compliance with minimum wage and other mandates.

REJECT the Executive's proposed cuts in MLTC: Instead, **RESTORE** MLTC funding for patient transportation, quality innovation funds, eligibility and marketing.

2. **Home Care Regulatory Flexibility**

ENACT flexibility necessary for home care to participate in state reforms and public health initiatives: HCA has proposed legislation enabling home care to better participate in and support new state reform models (like DSRIP, VBP, advanced primary care, ACOs, and others). These proposals aim home care's expertise at public health priority solutions (for urgent conditions like sepsis prevention, falls prevention, asthma mitigation, and disparities), yielding cost savings and better health outcomes for patients.

REWORK the "Health Regulation Modernization Team" proposal in the Executive's Budget: HCA strongly supports regulatory streamlining for home care (as proposed above) but recommends the addition of must-do parameters to the Governor's proposal to ensure system integrity and prevent the intrusion of one licensed sector into another, which is already an escalating problem in DSRIP and the marketplace as a whole.

3. **Home Care Capacity and Workforce**

ENACT a comprehensive statewide Home Care Capacity and Workforce Plan: HCA proposes budget language to address home care workforce and service shortages that impact patient/family home care needs. HCA's proposal directs the Commissioner of Health – with input from provider, consumer, insurer, practitioner and legislative stakeholders – to establish and implement a home care workforce shortage plan that focuses on underserved areas and populations, and addresses staff recruitment, retention and needed supply capacity issues that are unique to home care.

4. **Home Care Infrastructure**

ENACT home care infrastructure support: HCA supports the proposed \$500 million Executive Budget proposal for a Health Facility Transformation Pool; **but recommends that a minimum of 25 percent or \$125 million should be targeted to community health agencies.** We also call for flexibility necessary to meet home care and other community agency needs. (This year's \$500 million proposal is an increase from the \$200 million pool established and funded last year, with a \$30 million community care apportionment.)

RENEW funding for a Home Care Infrastructure and Capacity Expansion Program already existing in Article 36: This program was created to address demands for home care in the wake of previous state policies and reforms driving earlier hospital discharges and nursing home avoidance. **ENACT HCA's proposal to establish a "Working Capital Rate Factor" for home care** as an increased adjustment to managed care premiums and home care rates, including within the Episodic Payment System.



**State Budget Action Needed to Support Home Care
Access and Assist Priority Public Health Solutions**



State Budget Action Needed to Support Home Care Access and Assist Priority Public Health Solutions

New York's home care system is pivotal to meeting the medical and related support needs of our citizens. Home care does this in primary, home and community care settings – managing and delivering care out of hospitals, emergency rooms and institutions, saving untold dollars and supporting quality of life, in complete alignment with state and federal health care system goals.

Basic, adequate financing and regulatory flexibility are critical to these purposes – and this need is even further amplified by the cascade of new state/federal wage requirements, operating standards, and new models that depend on home care's participation.

The 2017-18 state budget *must* provide reimbursement stability and accompanying support needed for home care's workforce, infrastructure and regulatory flexibility.

These needed budget actions are described in this report.

THE ISSUE: Participation in the State's New Models of Care Requires Flexible and Enabling Home Care Regulation.

New York State has invested in multibillion-dollar policy changes, such as the Delivery System Reform Incentive Payment (DSRIP) program and Value Based Payments, seeking to dramatically expand the service shift from hospitals to primary and community care settings. Experience shows that longstanding regulatory requirements in the system disserve home care's freer capacity in these new models. These requirements also miss further opportunity for home care proficiency to drive down costs, reduce unnecessary hospitalizations, and address critical areas of public health, as home care has always done.

HCA has proposed budget language that would target home care regulatory flexibility for these express public health and new model purposes. The Governor's Executive Budget is similarly seeking regulatory flexibility, but through a proposed "Health Care Regulation Modernization Team." This Team would consist of appointed stakeholders to recommend regulatory changes across the system, and with great emphasis on home and community based care. This initiative is based on the right theme, but will need to be tailored to effectively address home care issues and also to ensure that, overall, this proposed Team process and outcome maintains the basic order and integrity of system roles.

Home care licensure – and indeed all provider licensure – is established for fundamental public health protection, operational standards, expertise and integrity. Increasingly, institutions and entities that are *not* lawfully designated providers of state and federally licensed home care services are trying to overstep explicit licensure and sanctioned service jurisdictions to provide home care. Any budget authorization creating a Regulation Modernization Team as the vehicle for flexibility must contain explicit language to ensure the Team's scope and outcome do not cross such lines, exacerbating an already serious problem for home care or inviting the same problems for other sectors. With these and other appropriate parameters, the budget needs to adopt language to maximize long-needed opportunities for flexibility for home care and all providers. HCA has provided the appropriately tailored language for home care.

Flexibility for home care, with appropriate reinforcement of home care's position in the continuum, would ensure that the right and lawfully intended entities participate effectively and efficiently to meet model goals.

THE SOLUTION: Rework the Executive budget proposal to incorporate regulatory flexibility for home care's maximal participation in new delivery and payment models (including DSRIP, Value Based Payments, patient centered medical homes/advanced primary care practices, Accountable Care Organizations, bundled payments, etc.). This language should also harness home care's public health capabilities in major health and cost-saving areas such as: maternal and child health; sepsis prevention, early identification and treatment; falls prevention; asthma mitigation; cardiovascular health management; disparities; and others. HCA has already advanced draft legislative language to this effect for inclusion in the budget process.

THE ISSUE: Payment Rates to Managed Care Plans and Home Care Providers MUST Adequately Cover Services.

Payment and service decisions in today's home care system are substantially integrated with managed care. This means that managed care plans are paid a premium rate to cover and manage the service costs of network providers, including home care and other long term care services entities. This shift has involved changes in payment patterns for coverage of thousands of patients, with a second wave of enormous new changes underway in the shift to Value Based Payments.

The state's current payment methodologies for home care providers and managed care plans ("mainstream" managed care and Managed Long Term Care, or "MLTC," plans) need to be further honed in statute so that these methods consider all of the real and relevant costs of: providing services; meeting state and federal wage mandates; complying with operating standards; and enabling home care's participation in the state's new reform models. Absent these changes, managed care plans and providers now shoulder destabilizing financial losses for the services they provide, as revealed in HCA's latest comprehensive financial report of the industry. These losses come at a time when plans and providers cope with a battery of new costs imposed on the system, including labor costs like the recent minimum wage hike.

The Governor's budget proposes \$242.7 million for home care/MLTC costs for fiscal year 2017-18 minimum wage increases under Medicaid. But recent Medicaid distributions for minimum wage costs have been highly problematic and inadequate for matching the needs of managed care plans, providers and the workforce. This is largely due to state distribution guidelines that have been vague or inconsistent in the direction of funds. Payment rates to plans and providers for labor and other costs must be consistent, predictable, timely and sound. They must also account for the cost impact on plans and providers of the state's higher wage mandates that equally apply to services to Medicare and other non-Medicaid beneficiaries, primarily the elderly and disabled on fixed incomes.

At the same time, the Governor's budget proposes a series of actions that will cut funding to MLTCs and otherwise erode their financial position. These include cuts in rate payments promised for quality performance, changes in recipient eligibility, the carve-out of transportation services, a ban on plans' ability to market, and other deleterious actions. These kinds of cuts and actions only further financially strangle an already financially strained managed care plan-provider delivery system.

The state is obligated by law to ensure actuarially sound rates to managed care providers, so that costs are covered for beneficiaries. Rate soundness is all the more important as home care providers participate more fully in state reforms such as DSRIP and Value Based Payments.

THE SOLUTION: The state budget must include language and funding to ensure coverage of major new wage obligations, related labor expenses, and basic costs for delivering accessible, quality home care to the state's citizens, including restoration of the proposed MLTC cuts.

HCA has advanced legislation to further solidify statutory standards to ensure actuarially sound managed care and provider rates for program services and costs. These provisions are all the more urgent with imminent, next-phase increases in wage/labor expenses as well as other costs necessitated by state reforms. The HCA legislation would also ensure consistent adjustments under the Episodic Payment System (EPS) for those home care providers reimbursed directly by the state Medicaid program.

THE ISSUE: Capacity and Direct Care Staffing of the Home Care System Must be Adequate to Meet Statewide and Community Needs; Current Workforce Shortages are Jeopardizing Access to Care.

Throughout the state, there are serious geographic and professional area shortages preventing critical access to home care, affecting patient care quality, and hindering the success of state policies to lower costs through more appropriate and timely patient care in the community.

Workforce shortages, recruitment, and retention issues have challenged the home care system for many years. New wage requirements and labor costs (not reimbursed to home care agencies and managed care plans) complicate this dynamic, as do an array of factors that uniquely apply to direct care personnel in the home care field.

According to HCA's recent financial report on the home care industry, a 24% turnover rate is reported for home care aides and a 21% turnover rate for nurses and other professional staff. On average, anywhere from 10% to 17% of direct-care positions remain unfilled, as are additional positions which are desperately needed. Many agencies are unable to accept patient care cases due to staff shortages.

Statewide senior citizen groups are likewise characterizing this situation as a "crisis" in home care access and, with HCA, are advocating for a must-act solution in this budget.



THE SOLUTION: In addition to providing vital rate method changes and funding to better support the home care workforce and service accessibility, the state budget must also establish and set in timely motion a comprehensive, short-and-long term multifactorial plan to ensure statewide and regional home care capacity to meet the system's and citizens' needs. Both geographic and professional service (i.e., pediatrics, palliative care, mental/behavioral health) shortages and remedies must be addressed in this plan. HCA has presented the Legislature and Governor with proposals to this effect.

THE ISSUE: The State Lacks – and Needs – Dedicated Infrastructure Support for Enabling Home Care's System and Patient Care Mission

Home care is currently one of the only sectors without a dedicated working infrastructure fund, at the same time that other entities enjoy long-established working capital pools for Health Information Technology and other infrastructure needs.

The Governor's budget includes a commitment of \$500 million in infrastructure funding for all health care sectors. Last year's appropriation was \$200 million, with a minimum of \$30 million lined-out specifically for the community-based system, including clinics, home care, behavioral health, substance abuse providers, mental health services, and others.

HCA applauds the proposed increase in the total pool (from \$200 million to \$500 million), but asks that the minimum set-aside for home and community health care (static at \$30 million in the Governor's proposal) be likewise increased.

Since the state seeks to shift at least 25% of hospital use and expense into community-based care, the proportion of this \$500 million total pool should (at a minimum) be equitably indexed to this 25% shift – or a \$125-million community-care portion of the \$500 million. This would still fall short of funding needs, given that the community sector has long been overlooked in the billions of state and federal funds that have poured into the institutional sector infrastructure, which the state and feds are ironically seeking to shrink. In addition to a portion above the \$125 million, a fund specifically for home care is also needed.

Home care's infrastructure needs include clinical and information technology; electronic medical record integration; interoperability with physicians, hospitals, behavioral health, MLTCs, and others. Better technological integration of home care would alone have a profound, game-changing impact on the entire health system's operating intelligence when it comes to management of patient care conditions, quality outcomes, transitions across the system and further development of value based methods. This is especially vital in connection with reforms such as DSRIP, Medicaid Redesign, Value Based Payments, and other health and innovation efforts.

THE SOLUTION: Equitably index for home and community health a minimum of \$125 million from the Governor's \$500 million budget infrastructure pool proposal, building off of last year's budget agreement, and designating further funds and/or prospective mechanisms for home care specifically. These include the following: (i) Create a working capital rate factor for home care and MTLC and/or dedicate home care funds through an existing Article 36 infrastructure program with priority purposes and a portion of this year's pool; (ii) Support Article VII inclusion of Senator Hannon's and Assemblyman Gottfried's technology investment (S.8168) and quality innovation (S.7810/A.10696) legislation supporting this critical infrastructure on an ongoing basis, which also will provide for state savings opportunities (ROI) from such investment.

State Budget Action Needed to Support Home Care Access and Assist Priority Public Health Solutions



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NYS Home Care Program and Financial Trends 2017



A report on the financial and program condition of New York's home and community-based providers and managed care plans amid state reform policies and mandates.

Background on Data and Analysis Methods

The Home Care Association of New York State (HCA) recently conducted an analysis of Medicaid Cost Reports, Statistical Reports and Medicaid Managed Care Operating Reports for all home care agencies and managed care plans in the state. These reports – independently verified by accounting professionals -- provide the most comprehensive data available on the financial picture for home and community-based services in 2014 and 2015. These reports also form the basis for routine state Medicaid reimbursement calculations.

While these reports provide a vast range of data, HCA has also gathered important supplemental information on provider, health plan and worker status through a December 2016/January 2017 survey. **This just-completed survey netted responses from 70 home care entities** of various sizes and service regions across New York State, adding important new data and information for 2015 and 2016 that is not otherwise available in the cost, statistical and operating reports that HCA has obtained from the state.

The purpose of this analysis – reviewing both the public reports and the survey responses – is to inform the Legislature and Administration about some of the program and financial trends occurring in home care and managed care as officials deliberate over the state budget.

HCA has conducted a similar analysis in past years; however, this year's study adds a range of new issues to the profile, from the experience of providers operating in new state-developed models of care to the recent, multiyear implementation of minimum wage increases, beginning December 31, 2016. These increases have an estimated \$2.19 billion impact on home care alone in the multiyear rollout.



Summary of Data Reports and Survey Findings

Consistent with our findings from past years, the state's Managed Long Term Care (MLTC) plans – which manage, authorize and pay for long term care services provided by home care agency contractors – and the home care providers operating substantially in MLTC networks are together shouldering unsustainable negative operating margins.

Though the MLTC and home care connection in Medicaid is a major point of state underfunding, aggregate operating losses are presented across all sources of payment for home care providers. On average, Medicare, all forms of Medicaid, commercial insurance, and other payor sources are reimbursing below margins for home care services (though Medicaid and Medicare account for at least 90% of all home care reimbursement in New York State). These underpayments are unsustainable without compromising patient access, services, workforce and the crucial infrastructure that delivers and manages the care.

Our analysis finds that state underpayments result in **61%** of MLTC plans having negative premium incomes in 2015 and **72%** of Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs) having negative operating margins for 2014, with similar CHHA/LTHHCP results in 2015.

CHHAs and LTHHCPs are Medicare-certified home care provider agencies authorized to receive Medicaid and Medicare coverage for services, though both entity types are reimbursed for most of their services through contracts with MLTCs and other managed care entities. These entities receive their payments from the state, and, in turn, remit payments to network providers for services. Another provider type, Licensed Home Care Service Agencies (LHCSAs), traditionally provides home health aide and personal care aide services, as well as aide training, recruitment and oversight, under contract with Medicare-certified agencies and, increasingly so, under contract with MLTCs and other managed care plans. They, too, face enormous financial stresses, particularly for increasing wage and overtime costs, as well as accumulating state mandates ignored in the state's payment methods. Many LHCSAs each report budgeting millions of dollars for these new cost obligations underfunded by state Medicaid, as explored later in this report.

These system-wide operating losses in managed care and home care are due in large part to inadequate state Medicaid methodologies and rates below the requisite, baseline costs of care delivery; and many of the serious financial findings from our study (in 2015 and 2016) predate the recent increased minimum wage implementation, which suggests that a deeper financial impact is yet to be reported.

Meanwhile, as the state has pumped billions of dollars into efforts like the Delivery System Reform Incentive Payment (DSRIP) program for service projects and reforms, home care providers indicate in our survey that: they are not meaningfully included in the DSRIP decision-making process; they question the return on investment for the cost of strategic planning and implementation of DSRIP projects in home care; and, in many cases, they have yet to receive *any* payments for projects flowing through entities that the state has designated to manage the fund-flows and project designs for achieving DSRIP goals. Those goals include reducing avoidable hospital use by 25% over 5 years. Home care providers have long operated under metrics for reduced hospitalization admission and readmission rates. Thus, they inherently have a vital role to play in the reform effort, to which DSRIP should be better synched.

The state is also fast moving to shift its multibillion-dollar Medicaid payment infrastructure to operate through new models, like New York's Value Based Payment project. Value Based Payments involve performance and/or risk-bearing arrangements for services, covering all or subsets of services, conditions and populations, from primary, to acute, to long term care. Home care enters this new frontier of reimbursement shouldering major underpayments, as earlier described. They also have no state-invested working capital funds to help integrate their functions, operations and data. **Fewer than 7% of home care providers responding in our survey reported engagement in Value Based Payments thus far from payors or network partners.** Movement from current payment models to Value Based Payments will have major impacts. State support is crucial for providers and managed care plans in this transition.

...system-wide operating losses in managed care and home care are due in large part to inadequate state Medicaid methodologies and rates below the requisite, baseline costs of care delivery...

Home care workforce shortages, recruitment and retention are another area of urgent concern shown in our analysis. The state has, in the past, filtered rate add-ons in various places of its payment methods targeted to staff recruitment and wage payment. However, the payments – whether through managed care plans to providers, or directly from the state – are not in line with real infrastructure needs, nor is the state's response capturing (and enabling support of) the nonwage factors uniquely at play in home care.

According to HCA's survey, **a 24% turnover rate is reported for home care aides and a 21% turnover rate for nurses and other professional staff**. As the population ages, and the care delivery reforms continue to depend on home care to keep patients in the community longer, the state must move the home care workforce and capacity infrastructure into the forefront of planning efforts.

Below is a more detailed description of our analysis, with corresponding background to contextualize the data.

Inadequate State Medicaid Reimbursements to MLTCs and Home Care Produce System-wide Red Ink



New York's home care system is primarily partnered with managed care. This means that MLTC plans and other Medicaid Managed Care insurance payors receive "per-member-per-month" (PMPM) lump payments from the state to authorize and pay for services to enrollees. Managed care plans, in turn, contract with home care providers to provide and work with the plan to manage services.

Approximately 70% of a home care provider's Medicaid revenue in New York State comes from Medicaid Managed Care (MLTCs and mainstream managed care) contracts, while 30% comes directly from the state. This latter portion is primarily reimbursed through a reimbursement structure called the Episodic Payment System, discussed later in this report.

The state is required by law to produce actuarially sound rates that are sufficient for managed care plans to pay for quality care by their network providers. But our analysis finds that MLTC plans are operating with substantial losses, due to inadequate payment from the state, and these losses squeeze the contracted amounts available for home care providers in the plans' networks. This condition results in accumulating losses producing negative operating margins for plans and providers alike. It further produces service-authorization delays, cash-flow issues, and increasing debt loads across the spectrum of service entities.

According to our analysis:

- **61% of all MLTC plans had negative premium incomes in 2015**, up from 42% in 2012 (a 46% increase since 2012). A negative premium income means that the state's payment to the plan is less than the plan's costs.
- Approximately **43% of all MLTCs had medical expense ratios over 90%**, which indicates that PMPM revenues from the state are not sufficient to meet overall plan medical expenses.
- **72% of CHHAs and LTHHCPs had negative operating margins in 2014, with similar results for 2015**. For 2015, the average operating margin for CHHAs and LTHHCPs was -4.42%.
- **Thirty-one percent of all home care agencies (CHHAs, LTHHCPs and LHCSAs) have had to use a line of credit or borrow money** to pay for operating expenses over the past two years, and another **6% of agencies were unable to establish a line of credit** or financing due to various financial factors.

Inadequate State Medicaid Reimbursement Leads to Service and Payment Delays for Home Care

If a managed care plan is not adequately paid to cover the costs of contractor services, the plan faces major operational pressures that flow downstream to home care providers in the form of billing and care-authorization delays for enrollees, as plans and providers manage a dwindling revenue flow.

This effect on CHHA, LTHHCP and LHCSA providers means that:

- On average, **only two-thirds (62%) of Medicaid Managed Care or MLTC claims are paid to home care providers within the prompt-pay timeframe**, our survey finds. Furthermore, home care providers report that their Medicaid Managed Care revenue was in accounts-receivable for an average of 85.6 days, and approximately 4% of Medicaid Managed Care revenue to home care resulted in bad-debt (meaning providers are not getting paid for 4% of their claims).
- Home care survey respondents indicate that nearly **20% of their managed care cases are affected by a lack of timely authorizations or reauthorizations**. More than 37% of agencies report that it takes up to 7 days to receive service authorizations or reauthorizations in cases where the authorizations and reauthorizations are late; an equal number of agencies report that it takes up to two weeks; and 21% said it takes up to four weeks. These delays lead agencies to commit valuable resources for obtaining such authorizations/reauthorizations.
- Approximately **77% of home care contracts with managed care plans do not cover the home care agency's costs**, with an average 18% difference between the amount providers are paid and their expenses in such cases.

Wage and Labor Costs Have the Biggest Impact on Providers

Wage and overtime costs have created enormous stresses across the system. This includes changes to the federal Fair Labor Standards Act (FLSA), in October 2015, which requires home health aide overtime to be paid at time-and-a-half of the aide's actual wage, as opposed to time-and-a-half of the minimum wage. On December 31, 2016, the state began requiring new minimum wage levels for regions of the state in a process that is expected to cost \$2.19 billion for home care across the multiyear phase-in.

The state has included Medicaid payment adjustments for these new costs. However, for both the new overtime and minimum wage changes, the amounts have been insufficient. Also, especially in the case of minimum wage, the state's payment adjustments have been directed to MLTC plans as a required pass-through to their network providers who employ – and directly pay – the workforce. Yet the state's guidelines for directing

the flow of payments have been vague and, in cases, contradictory, leading to a vast array of interpretations for how much a provider is ultimately paid. Meanwhile, providers face wage-related cost increases for their Medicare cases that have not been addressed by the state or federal government.

- Over 60% of survey respondents indicated that wage and overtime costs, along with the cost of worker benefits, has had a "large" or "largest impact" on their overall costs increasing.
- The minimum wage mandate has inundated providers with new costs. Larger LHCSA and CHHA programs report that **they have budgeted cost increases as high as \$1.5 million to \$11.9 million for the cost of minimum wage** just for the December 31, 2016 to December 31, 2017 period, with smaller and mid-size agencies budgeting between \$10,000 and \$450,000.

Rebasing Cuts Further Erode CHHA Operating Margins

As previously noted, 72% of CHHAs had negative operating margins in 2014 and 2015. One factor is the implementation of rebasing cuts under the CHHA Episodic Payment System (EPS).

While 70% of Medicaid home care payments are processed through managed care, the remaining 30% are still paid by the state through EPS. This payment system provides a base rate to providers, which is adjusted for acuity, regional wage differences and other factors. With this rate, providers deliver as much care as is needed for a patient during 60-day incremental periods (called episodes). In 2015, the state implemented a process called rebasing, which is essentially a series of adjustments intended to update the EPS rates for CHHAs to a “newer” (but not “cost-reflective”) base year. However, for most providers, the rebasing process was simply another payment cut, contributing further to the operational losses experience by CHHAs, as reported in our survey:

- The average percentage cut attributable to CHHA Medicaid EPS rebasing is a **19.6% reduction between 2015 and 2016**, according to survey respondents.
- Nearly **half of CHHAs** actually reported that they experienced a **rebasing cut of more than 30%** during this period.

Workforce Turnover and Shortages Jeopardize Home Care Capacity for Patient Care

HCA has proposed legislative language to address the long-standing recruitment, retention and workforce shortage issues in New York State, which affect various regions of the state differently. This includes unique supply and geographic service spreads in the upstate region, and distinct competitive pressures in the downstate region.

In some instances, providers report that workforce shortages limit their ability to accept new cases or fully fill service hours, jeopardizing access to care. According to our survey:

- Home care agencies must contend with high staff turnover rates, with a **24% turnover rate for aides and a 21% turnover rate for nurses and other professional staff**.
- Approximately 14% of home health aide positions, 17% of personal care aide positions, 13.51% of registered nurse positions, and 10.6% of therapist positions are unfilled due to shortages.
- On average, agencies are **unable to accept 37.3 cases** due to staff shortages, with at least three agencies reporting in our survey that over 100 cases can't be accepted because of shortages.

Home Care Providers Report High Costs, Low ROI, and Little Meaningful PPS Understanding of Their Role in DSRIP

New York State has initiated multibillion-dollar payment changes creating entirely new models of care, such as DSRIP and Value Based Payments. The intent of these changes is laudable; but the practical design and mechanics are obstacle-ridden for most of the community based system, including home care.

To date, the project management teams and hospital leads in DSRIP have received over 70% of the promised federal funds across all of DSRIP's Performing Providers Systems (PPSs). These PPSs are orchestrating DSRIP network projects and facilitating the payments to downstream providers, like home care, for fulfilling health reform goals.

Home care providers are eager and have the expertise to participate in these and other new models but they report barriers to their participation in integrated systems, which include: funding issues; a perceived shortage of opportunities for LHCSAs in DSRIP; and a general lack of recognition and knowledge on the part of DSRIP networks to understand how home care can participate in reaching DSRIP goals.

(continued)

The state's own independent assessor for DSRIP (Public Consulting Group) compiled a midpoint DSRIP assessment. It recommends that over two-thirds of the PPSs should implement midpoint assessment action plans related to financial stability/sustainability and application of Value Based Payments for its provider network; generally, the IA found that many PPSs have not focused on detailed arrangements for sustainability. It also found that:

- PPSs need to work to **educate their partners** on their role with Value Based Payments in New York Medicaid.
- Most PPSs need to **focus their attention and funding to engage key partners**; a majority of the PPSs are behind on their Partner Engagement goals at this point in DSRIP.
- The PPSs **must execute their plans for contracts with their downstream partners** to ensure that they maximize engagement across the networks as soon as possible.
- To date, while the project management offices and hospitals have received over 70% of DSRIP funds across all PPSs, the **PPSs will need to fund their network partners at a meaningful level going forward.**

According to HCA's Provider Survey:

- **Thirty-eight percent of home care agencies have not yet received any funds from DSRIP PPSs**, despite many months of strategic planning work, DSRIP committee discussions, and preparation for project implementation. Meanwhile, **only 6.9% of home care agencies have yet entered into contracts for Value Based Payment**, which is fast becoming the overarching state Medicaid financing paradigm. Sixty-five percent have not entered into Value Based Payment contracts and 28% indicate that agreements are in progress or they are exploring their Value Based Payment options for the future. Those contracts which have been initiated are still just at Level 0 or Level 1.
- Of those providers who have received money from their PPSs, the amounts have varied between \$1,500 and \$138,000, for anything from meeting participation and attendance, to workforce recruitment, to specific project metric measures, as well as other training and implementation cost reimbursements. This varies substantially across PPS networks and regions, and speaks to the disjointed nature of the DSRIP program implementation. Agencies in multiple PPSs are dealing with these inconsistencies in status, expectation, reimbursement, and timelines. This exacerbates the already large administrative burden of DSRIP participation with little certainty of return on investment (ROI).
- Agencies report significant staff time and activity costs related to DSRIP planning, with some agencies reporting costs as high as \$200,000. Costs of functional DSRIP implementation activities average \$127,829.
- While nearly half of respondents expect money through Year 3 of the DSRIP implementation schedule, **these funds are not expected to cover costs for 43% of respondents**. Furthermore, over 35% of responding agencies are still unsure about whether they will receive future DSRIP payments, let alone whether those amounts would cover costs of expended time and resources.
- **Only around 28% of respondents feel that DSRIP's PPS leads understand home care's role** and have actively taken that into consideration/involved them in the design of payment systems and the flow of funds to downstream providers. Forty-eight percent feel somewhat involved and **24% do not feel involved at all.**
- According to home care providers, the majority of their current or future Value Based Payment participation centers on their work to manage chronic obstructive pulmonary disease, congestive heart failure, and post-acute joint replacement care. Additional areas of widespread interest are to manage diabetes, asthma, and coronary artery disease. Home care providers have long succeeded in addressing these core areas of public health through therapies, medical interventions, and assessments that make them singularly effective entities for reducing the rate of hospitalizations.

Conclusion

State Medicaid policies have in many ways exhibited laudable and impressive goals. Home care providers strongly support reforms promoting the triple aim of "better care, better quality and lower costs." They are eager to collaborate with government and all health sectors to ensure success for New York's citizens.

However, in the progression toward reform, many important and fundamental facets are being overlooked, to the serious detriment of system and reform goals. The Legislature and Governor can, and must, address these issues and needs in the 2017-18 State Budget.

NYS Home Care Program and Financial Trends 2017

A report on the financial and program condition of New York's home and community-based providers and managed care plans amid state reform policies and mandates



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