TESTIMONY OF SCOTT AMRHEIN
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JOINT LEGISLATIVE PUBLIC HEARING
ON THE FY 2020 EXECUTIVE BUDGET PROPOSAL

INTRODUCTION

Good Afternoon. I am Scott Amrhein, President, Continuing Care Leadership Coalition (CCLC), which represents not-for-profit and public long term care providers in the New York metropolitan area and beyond. Our members represent the full continuum of long term care services including skilled nursing care, home health care, adult day health care, respite and hospice care, rehabilitation and sub-acute care, senior housing and assisted living, and continuing care services to special populations. We appreciate the opportunity to provide testimony to the Senate and Assembly Health committees, the Senate Finance Committee, and the Assembly Ways and Means Committee regarding Governor Cuomo's Executive Budget Proposal for Fiscal year (FY) 2020

KEY POINTS

1. **New York's Age Wave is hitting our shores, and now is the time for NYS to recommit itself to supporting and sustaining high quality long term care providers.**

2. **This budget takes a step forward for healthcare broadly – but, as proposed, it will move us three steps back by undercutting investment in vital long term care services needed by growing numbers of New Yorkers.**

3. **We respectfully ask your Committees, and the Members the Senate and Assembly, to consider a series of recommendations to strike or change damaging budget provisions – including the proposed quarter billion dollar case mix cut to nursing home rates – and to consider additional recommendations to shore up struggling long term care providers across the continuum to ensure services for our growing population in need.**

NEW YORK'S AGE WAVE: ENSURING QUALITY LONG TERM CARE FOR NEW YORK'S CHANGING POPULATION

The need for quality long term care services - vital not only for meeting individual needs, maximizing ability and independence, and alleviating suffering, but also for the optimal and cost-

effective functioning of our State's health care system - will grow in parallel with the needs of a Statewide population that, over the next 25 years, is becoming older, will have increased rates of disability, and will drive greater needs for formal care options as the share of the working age population diminishes relative to that of the population most likely to need long term care services. These three trends are charted in the graphs below. Their implications are clear: we must be doing all we can to sustain and develop the providers and programs best equipped to manage and address the growing needs of the State's older and disabled populations.

Table 1

NYS Population Growth: 2015 - 2040 (over 65 and 85+)

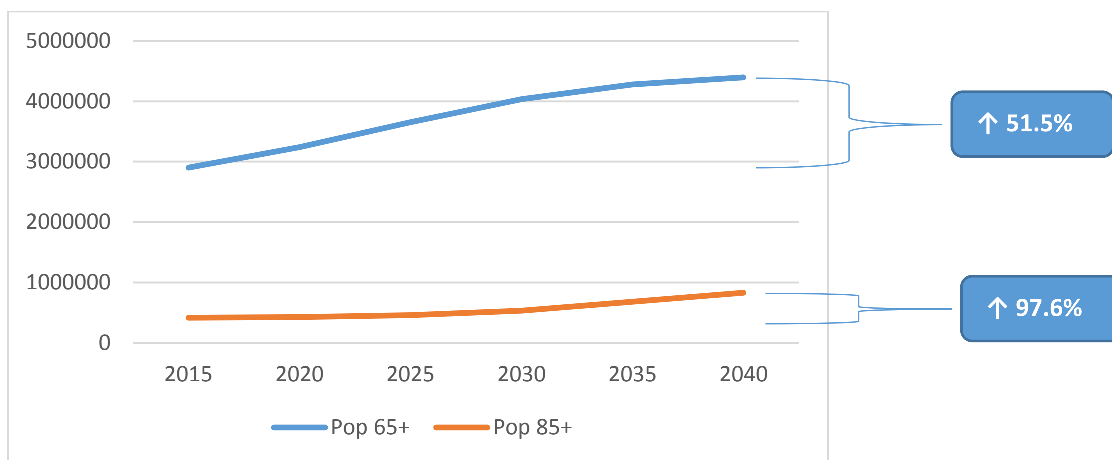


Table 2

NYS Disabled Population, Aged 65 and Older: 2015-2040

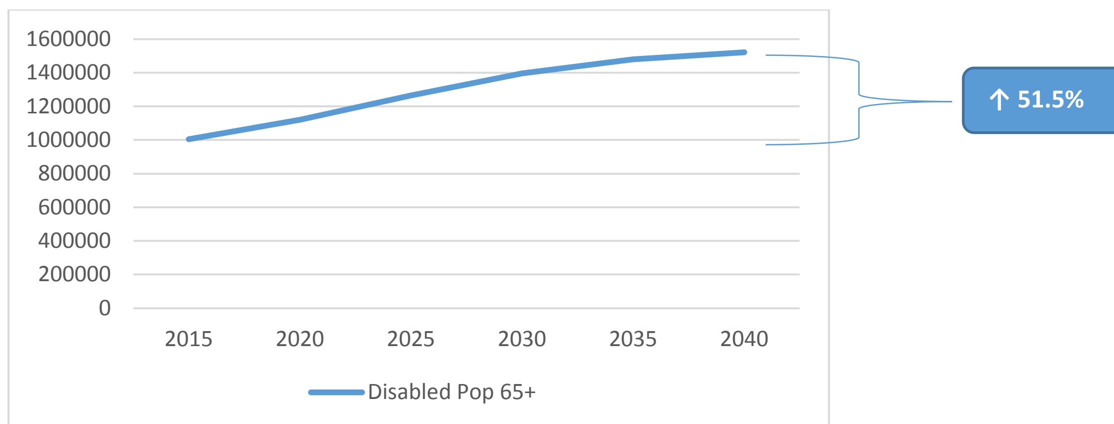
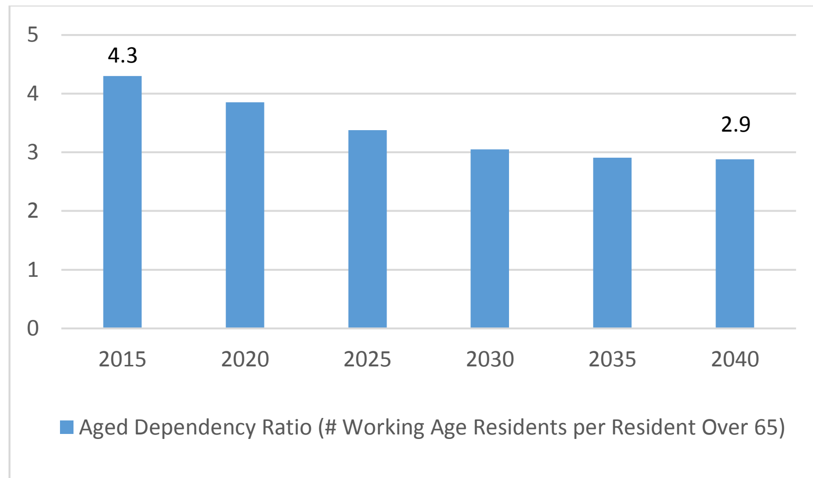


Table 3

NYS Dependency Ratio: 2015-2040



ENSURING WE DON'T TAKE ONE STEP FORWARD AND THREE STEPS BACK FOR THOSE IN NEED: CORRECTING THE BUDGET'S BIGGEST SHORTCOMINGS

Every year, nearly a million New Yorkers rely on the State's nursing homes and home care agencies for essential care.

As our population ages and disability rates grow, the very providers that these most vulnerable New Yorkers need the most are increasingly challenged financially - and increasingly at risk of disruption through closure, program downsizing, or changes in ownership.

These risks and challenges are starkly underscored in the tables below.

Table 4

NYS Nursing Home Financial Profile

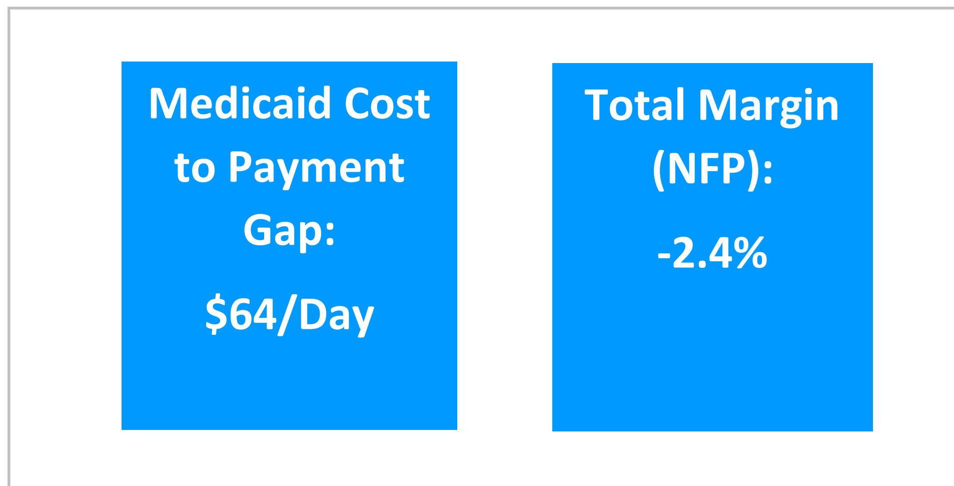


Table 5

NYS Home Health Financial Profile

% of NYS CHHAs Operating in the Red:	Average CHHA Operating Margin:	Total CHHA Statewide Operating Loss:
78%	-13.5%	-$110M

These challenges stem from a confluence of pressures over the last decade, chief among them the inexorable rise in the costs of delivering high quality care - including the essential need to continuously invest in a high quality workforce - set against a full ten years during which there has been no corresponding adjustment to the Medicaid rates for annual inflation increases.

A Big Step Forward – The Budget's Proposal to Allow Additional Medicaid Spending Growth

After years of no trend factor – and years of limits to Medicaid growth under the constraints of the Global Cap – this budget proposal breaks new ground in two ways:

1. For the first time since the global cap was enacted in 2011, it would allow Medicaid to grow at a rate exceeding the cap's growth threshold (currently at 3.1%) - allowing total Medicaid spending to grow instead by 3.6%, or $680 million (in State funds).

2. It creates budget room for what effectively would be, for certain providers, the first trend factor increase in over a decade.

Globally, this is a vital gesture of commitment and support for health providers across the State, and CCLC commends the State for breaking this important ground.

Three Steps Back – The Nursing Home Case Mix Cut: Why It Must Be Rejected

CCLC is deeply concerned that this budget - while promising more help to sustain health providers globally - assumes actions by DOH that would target the nursing home community with cuts of nearly a quarter of a billion dollars - fully negating any benefit of the proposed trend factor increase, and burdening already struggling nursing homes with millions of dollars of devastating new cuts.

Specifically the budget would reduce nursing home rates by $246 million – the result of proposed actions by DOH to retroactively change how each facility's case mix is calculated. In theory, the proposal is about ensuring more accurate measurement of patient acuity, and thereby reducing overpayments related to the case mix adjustment of rates. In fact, the proposal would have the effect of massively under-reimbursing providers by millions, by pegging case mix calculations to old and incomplete data. This would be disastrous – and the proposal should be rejected for the following reasons:

1. **It would wipe out any benefit of the 1.5% rate adjustment for nursing homes implemented on November 1, 2018, under the transformation fund program authorized in last year's budget.**

   Last year's enacted budget provided for a $1 billion investment over four years in the form of a health care transformation fund with the explicit goal of improving "Medicaid rate adequacy."

   For nursing homes, the fund provided for a 1.5% Medicaid rate increase – an increase essential to helping offset labor cost increases that went into effect in 2018.

   But the $246 million case mix cut would fully wipe out the benefit of this new investment for nursing homes – leaving facilities Statewide roughly $150 million to the worse, even before the additional costs of the 2018 labor increases are taken into consideration.

2. **It creates a wildly unrealistic budget savings expectation that will never materialize if changes to the case mix data collection process are done right – and that will put the provider community at risk of severe across-the-board cuts if the State is nevertheless determined to achieve the unrealistic savings target.**

   The idea that changing the methodology for collecting nursing home patient assessment data (which is used to establish each facility's case mix index value and determine any corresponding rate adjustment) would lead to savings of anywhere near $246 million is simply not supported by what we know from the data reviews that the Office of the Medicaid Inspector General (OMIG) carries out every year.

   During 2016 and 2017, OMIG completed more than 700 reviews of nursing home Minimum Data Set (MDS) submissions. These reviews were done specifically to verify that the MDS information submitted by the nursing home was an accurate representation of each resident's medical condition, functional abilities, and care needs. Based on these reviews, the extent of overpayments found ($23 million was the average over the two years), falls short of the assumed savings in this proposal by more than tenfold.

   We understand that the reason for this tenfold difference is that the State based its savings estimates not on OMIG's findings, but on what we strongly believe to have been a flawed comparison of two sets of MDS filings from 2018. In short, the State compared MDS filings from a so-called picture date period (one that DOH announces in advance and that occurs twice annually) and a non-picture date period, and assumed that the disparity in CMI levels associated with the two collections was fully the result of intentional manipulation, or "upcoding," on the part of providers.

There are many reasons why this assumption is deeply flawed – but they boil down to the fact that facilities rationally may elect – during non-picture-date periods – to conserve staff time required for MDS completion and filing by adhering to minimum Federal and State filing requirements, while – during picture date periods, when the assessment submissions are used by DOH to determine CMI levels – it is common for facilities to complete and file additional assessments beyond those minimally required by CMS and DOH (as permitted by New York State), to ensure that the most up-to-date, and fullest possible, picture of the clinical status of a facility's patient population is reflected in the assessments completed during the period.

We take no issue with the State seeking to implement changes, developed in consultation with industry stakeholders and experts in MDS assessment – and applied prospectively – to ensure the truest and most accurate possible calculation of nursing home case mix.

That would be a reasonable approach – but it would almost certainly not result in savings at the levels estimated in the current budget proposal.

It is critical, therefore, to establish that whatever comes of a new approach that is broadly deemed reasonable, "the savings are the savings," and any gap between the actual savings and those assumed in the budget would not be used as a pretext for additional rate cuts. For nursing homes in our State – and acutely so for our not-for-profit and public providers – there is simply no capacity left to absorb the level of cuts initially estimated as part of this proposal.

3. **It undercuts the role of OMIG as the agency best positioned to identify and recover overpayments from the likely relative few providers with consistent problems in accurately reporting case mix data.**

   Ultimately, the most direct way to find and recover overpayments related to the MDS assessment process is through the audits and reviews undertaken by OMIG. Only through these audits can we know – at the provider level – whether the picture of patient acuity shown in the MDS assessments is backed up by the relevant clinical records. If there is gaming to be found – these audits will root it out and OMIG in turn will recover the resulting overpayments. In addition we would point out that OMIG is uniquely in the position to focus attention on providers with outlier values – as it presently does by reviewing all facilities with CMI growth of 5% or above between collection periods. We encourage OMIG similarly to ensure that assessment accuracy is tested routinely in cases of facilities with absolute CMI values at the extreme upper end of the spectrum – independent of the size of case mix growth from period to period.

Recommendation.

The Legislature should reject the nursing home case mix cut as proposed. It must further ensure – including through legislative language as necessary – that:

- No CMI changes shall be made based on data from dates prior to January 1, 2019;

- Any changes to the data collection process shall be implemented only prospectively – and only after the convening of a CMI workgroup consisting of industry stakeholders and experts in MDS assessment; and
- Whatever savings are generated in the fiscal year from any changes consistent with these guidelines shall be considered the "savings in full" applicable to the nursing home sector in this fiscal year, and no further actions shall be undertaken to reduce rates in an effort to meet the initial savings estimate of the proposed CMI cut.

OTHER RECOMMENDATIONS

In addition to counting on your support on the CMI issue just discussed, we respectfully seek your support on the following issues – each vitally important to our member providers and the communities they serve.

Rate Adequacy for Home Health Care Providers

CCLC is deeply concerned about the dire and worsening financial condition of the State's Certified Home Health Agencies (CHHAs). As shown in table 5 above, fully 78% of all CHHAs in New York State currently operate in the red. Average margins for CHHAs stand at -13.5%. And Statewide CHHA losses in the aggregate exceed $110 million annually.

We've been working assiduously to understand the full range of drivers behind the financial distress that's so widespread across the State's CHHAs. And we're undertaking this work in close alliance with the hospital community – in recognition of the fact that CHHAs play such a critical role in facilitating patient handoffs from the acute care setting and assuring successful and stable transitions back into patients' homes, and in so doing, reducing costly emergency department visits and avoidable hospital readmissions.

Inadequate Medicaid managed care rates are a major pressure point. Independent research shows that, for many CHHAs, Medicaid managed care reimbursement rates cover less than one-third of the cost of services provided by CHHAs. On average, CHHAs lose nearly $1,300 every time they take on a Medicaid managed care patient.[1] These losses are not offset by more generous payment on the part of Medicare. Medicare Advantage (managed care) represents roughly half of the Medicare market, and its rates cover only 56% of the cost of CHHA services.[2]

Shortfalls in Medicaid fee-for-service rates are also contributing substantially to the financial challenges facing CHHAs. Medicaid fee-for-service rates have not been updated to reflect minimum wage increases since 2017, when they were raised 6.18% to reflect the first $1 per-hour increase. Hourly minimum wages have increased $4 since then. Hourly NYC CHHA rates for home health aides in NYC are capped at $25.25, regardless of increases in the minimum wage.

[1] Data collected from 24 NYS Certified Home Health Agencies for Q3 2018 (8 NYC CHHAs and 16 non-NYC CHHAs). *Simione Healthcare Consultants,* 2019.

[2] Ibid.

These pressures are taking a toll. Managed care underpayments in particular are the primary reason why the Visiting Nurse Service of New York (VNSNY), New York State's largest CHHA, had losses in the tens of millions in 2018, and why New York City's second largest CHHA recently laid off more than 100 staff and significantly reduced its footprint.

CCLC urges the Legislature to include language in the final budget providing for greater rate adequacy for New York State CHHAs, with specific attention to ensuring the following:

- **That DOH be charged with implementing mechanisms to assure reasonable and adequate Medicaid managed care rates. Among the approaches, DOH should consider establishing a benchmark rate standard, much like that used to ensure that nursing home MLTC rates do not fall below applicable fee-for-services rates for a given facility, among other potential approaches; and**

- **That Medicaid Fee-for-Service rates for CHHAs (inclusive of Episodic Payment System, hourly and per-visit rates) include trend factors and be fully adjusted to reflect minimum wage increases, including by raising or eliminating the ceiling that prevents adequate reimbursement.**

Nursing Facility Rate Methodology Improvements to Further Reward Investments in Staffing and Quality

Ensuring that high quality nursing homes are adequately reimbursed is vital to ensuring that New Yorkers continue to have quality long term care options. The current price-based reimbursement methodology – based on a single State-wide average rate for all nursing facilities – lacks the ability to compensate providers with a sufficient degree of differentiation to reasonably account for the different levels of investment that facilities make in delivering high-quality care.

While the State wisely established a Nursing Home Quality Initiative – which annually reallocates $50 million of the State's total annual Medicaid nursing home expenditures to facilities with the best quality outcomes – the amount of the financial incentive is very modest, and certainly does not cover the full extent of the extra investments that high-quality facilities make in order to deliver the best possible outcomes.

In light of these considerations, we urge the Legislature to consider directing DOH to implement reimbursement methodology changes to ensure that the State's best nursing facilities have the necessary financial resources to continue delivering the highest possible quality of care.

Specifically, we strongly encourage the Legislature to: 1) direct DOH to increase the share of overall Medicaid spending on nursing home services (currently $50 million) that is pooled and distributed to the highest performing facilities, and 2) direct DOH to pursue adjustments to the nursing home pricing rate methodology to more fully recognize the additional costs incurred by providers that invest disproportionately in direct care staff with high skill mix, low turnover, and consistent assignment.

Health Care Capital Funding

While the budget doesn't call for new funding for investments in health care capital projects, it does provide for flexibility in the use of funds already allocated for the Statewide Health Care Facility Transformation Program (SHCFTP), which CCLC supports. Specifically, the budget proposal would allow DOH to award up to $300 million of the $525 million in capital funds authorized in last year's budget for a "third phase" (SHCFTP III) of the Transformation Program to applicants with proposals pending under the "second phase" of the program.

CCLC believes that this budget proposal will expedite the movement of needed capital to providers with great need for it – a goal we support. We therefore strongly urge the Legislature to support this proposal. At the same time we note that the proposal will reduce the total pool of funding currently allocated to the program's third phase to just $225 million, and we urge the Legislature to ensure that, notwithstanding this reduction in the overall pool of funds, the vital set-asides of $45 million for residential health care facilities and $60 million for community-based health providers remain intact.

Mandated Staffing Ratios

The budget proposes that DOH conduct a study of health care staffing, evaluating approaches to ensuring that the staffing in health care facilities supports patient safety and quality, and assessing the potential fiscal impacts of alternative strategies and approaches. CCLC is prepared to work with the Executive and DOH to as they undertake these investigations. At the same time, we remain strongly opposed to actions mandating fixed staffing ratios in health care facilities, as they are inappropriate for a field where patient populations, and patient needs, vary greatly from facility to facility, and even in units within individual facilities – and they would deny facilities the flexibility to make real-time staffing decisions essential to meeting individualized resident and patient needs.

There is a fundament lack of evidence supporting mandatory staffing approaches, and it was this lack of evidence that led the Centers for Medicare and Medicaid Services (CMS), in July 2015, explicitly to reject a fixed staff ratio approach when considering how best to assure quality for nursing home residents within the provisions of the agency's update to the nursing home Conditions of Participation. In rejecting mandatory ratios, CMS instead chose to put in place a "competency-based approach" – which charges each facility with developing a staffing plan appropriate for the unique needs of the facility's specific patient population, and then using the plan to ensure that appropriate resources are deployed to provide for the safety and quality of care of their patients. CCLC strongly holds that this is a far more appropriate model than the inflexible and costly approach embodied in the Assembly and Senate staff ratio bills.

CCLC stands ready to participate in the DOH study on staffing in health care facilities, as called for in the budget proposal. Simultaneously, we express our strong opposition to forced staff ratios, and we urge the Legislature to reject any legislation imposing such ratios as inappropriately inflexible, costly, and inefficient.

CONCLUSION

I greatly appreciate the opportunity to provide these perspectives and recommendations. CCLC looks forward to working in partnership with the Senate, Assembly, and the Office of the Governor in ensuring that essential long term care services remain strong and available to our State's older and disabled citizens as the demand for these services grows in the year ahead.