Testimony of The
Home Care Association of New York State (HCA)

To The

Joint Legislative Budget Hearing
on Health

January 29, 2020

Al Cardillo
HCA President and CEO

INTRODUCTION

Good afternoon. I'm Al Cardillo, President and CEO of Home Care Association of New York State (HCA). HCA thanks the Joint Committee Chairs and members for this opportunity to testify on the proposed 2020-21 Health and Medicaid Budget.

While there are major issues and imperatives to secure stable financing, workforce, technology and service integration for home and community based care – all of which merit critical budget consideration – the budget crisis at hand dictates that this testimony today focus on Medicaid and the pending Medicaid Redesign Team (MRT) process.

This testimony will offer home care, Managed Long Term Care (MLTC) and hospice proposals that can contribute solutions to the state's health and Medicaid needs. We believe substantial Medicaid offsets and savings are achievable in these proposals. These are offered beginning on page 8. We are prepared to follow-up with details and/or language for each and are eager to work with the Legislature and Executive toward the state's health and Budget goals.

Overview of HCA Budget Proposal

I. Lower state Medicaid outlays by optimizing Medicare-Medicaid coordination and usage; ensure full entitled Medicare coverage for service payments, allowing greater Medicaid shift to secondary payor status for these services, and also more cost-effective use of Medicaid when necessary for wrap-around.

II. Change statutes and practices to strengthen cost controls and system efficiencies in MLTC, home care, CDPAP, et al.

III. Leverage savings from home care intervention in high-cost/high-risk/complex care.

I preface with key points on: 1) HCA and our representation; 2) NY's home care system, its roles and significance to patients and the entire care continuum; 3) state policy factors associated with Medicaid expenditure increases following the 2011 MRT reforms; and 4) recommendations for management of the proposed MRT II process.

HOME CARE ASSOCIATION OF NEW YORK STATE

HCA is the statewide association most broadly representative of home and community-based services. Our mission is "to promote the quality and accessibility of health care and support at home." HCA includes state and federally certified home health agencies, licensed home care services agencies, hospice providers, MLTC plans, waiver programs, fiscal intermediaries, Long Term Home Health Care Program (LTHHCP) providers and an array of allied support and service organizations aligned to the care-at-home mission. New York's home and community-based providers and programs include health systems, facilities and free-standing agencies certified or licensed to provide: home care under article 36 of the public health law, MLTC under article 44, and/or hospice under article 40.

HOME CARE IN NEW YORK STATE

The Public Health Law establishes home care as a core part of the health care system. It is interwoven and integral to the system's overall structure, function and cost-effectiveness. Most important, is the care and life quality provided patients and families through home care. Of major budget benefit, is home care's role in averting the enormous state, federal and private costs for care that would otherwise be taking place in the most expensive settings (e.g., hospitals, ERs and institutions). Care in these settings would also be accompanied by the extraordinary capital costs for bricks, mortar and beds that are avoided by the service that home care renders. It is critical to recognize home care's avoidance of these massive costs in care and capital.

For tens of thousands of New Yorkers, a single day without home care is a medical and potential life emergency, and likewise, a potential crisis for hospitals, nursing homes, physicians and surgeons who every day rely on home care's skilled nurses, therapists, social workers and

certified aides for collaborative medical treatment, continuity and/or management of the patient. Every day, across the state's regions, home care serves NYS Department of Health (DOH) "Priority-One" designated patients that number in the thousands (and tens of thousands); priority-one means patients whose *care cannot be interrupted*. The system, the budget and most importantly constituents, simply cannot do without these fully accessible services.

Over a half million individuals are served by New York's home care and hospice providers. Thousands more served are families caring for loved-ones who are also supported and sustained through home care's services, teaching and care management.

Home care provides highly skilled, complex and essential assistance services throughout the arc of health care need: from maternal, infant and child, to adult and elder care; from primary, public health and preventive care, to high skilled complex medical management, chronic and long term care, telehealth monitoring and intervention and palliative and end-of-life care.

Home care is a major employer and contributor to the state's economy, providing work opportunities and training for thousands of employees, and also in helping elderly and other individuals to maintain their home and community life and thereby also participate in the local economy. Recent counts of employment levels provided in home care include approximately 11,000 nurses, 200,000 home health aides, over 3000 therapists and social workers, and more.

Home care today cares for individuals of significant medical complexity – e.g., severe wounds, same-day-surgical, unstable medical, technology-dependent and more – that just a short time ago required hospitalization or long term care institutionalization.

<u>Home care is essential to the system, the patients, to state policies, and to budget support. Budget solutions lie in leveraging this critical and innovative system.</u>

2020 STATE BUDGET

This Joint Committee, the Legislature and Governor have the task of prioritizing 2020 -21 health and Medicaid funding amid an overall $178 billion proposed state budget, and a currently projected $6.1 billion deficit. The Executive Budget is seeking $2.5 billion in Medicaid savings actions, and the Governor has charged MRT II to make recommendations for how this might be accomplished.

Especially pivotal given these factors will be this year's still-to-come three-way agreement on final revenue projections to determine the final budget avails and deficit status in order to negotiate the 2020-21 fiscal plan. Safe to say that the actual health and Medicaid savings level that you will set will be based on the final revenue agreement, and an established appropriate, realizable agreed-upon Medicaid target; one that we know must indeed contribute to Medicaid's share of deficit reduction, but that we urge does not undermine the delivery system and care for New Yorkers.

Accordingly, we urge that the Legislature and Governor focus the MRT and budget process on significant, but responsible savings and tracks for reform, adjusted by the final revenue avail and spending/savings targets, which may well improve with the rising economy.

I will not go into detail here, but will importantly refer you to data analyses we have previously provided the Legislature and Executive from certified state cost-reports for home care, MLTC and hospice demonstrating the sweeping negative margins already besetting Medicaid providers and MLTCs in NY, as well as data which underscores the workforce shortages that severely affect access and cost. New York and the health delivery system can ill afford being driven into a further "going concern" status.

Moreover, we urge that the MRT charge, time period and process for producing budget proposals are appropriately staged so that prospective actions can be thoroughly considered, developed, vetted and implemented. This process should not be compressed into MRT time periods and venues devoid of proper development and stakeholder analysis. The harried 2011 MRT process resulted in actions and foundation that have contributed to today's Medicaid expense issues (i.e., MRT-driven expenditures that are exceeding MRT projected costs). Let's avoid this impact in MRT II.

In this vein, it important to be mindful that major areas of Medicaid expenditure in NY have grown in direct response to affirmative MRT I and state policy goals. These include:

- The state's instituted policy to maximize Medicaid eligibility and enrollment throughout the population as a means to cover the uninsured. With higher Medicaid enrollment comes higher expenditures.
- MRT *mandated* enrollment of virtually all Medicaid eligible persons' into managed care, and dually eligible Medicaid-Medicare recipients into MLTC. Under this policy, if individuals do not join a health plan, NYS mandatorily *auto-enrolls* them and triggers automatic "per member per month" state Medicaid payments for each enrollee. The PMPM prepays for a robust care package, intended to cover all of the long term care services (or full services depending on the model) that the individual needs. MLTCs and providers are implementing these mandates, and the state sets the cost and all of the requirements. With mandatory enrollment, naturally comes more Medicaid enrollees and mandated state payments for their coverage and care.

- With mandatory managed care enrollment, the MRT added the Consumer Directed Personal Assistance program as an entitlement within MLTC to permit individuals with disabilities to self-direct their own long term care under managed care. Consumers appoint their own personal assistants, including first-degree relatives, and approve Medicaid payment. The care and care plan are under the consumer's direction, not the MLTC or the FI home care agency, and state policies reinforce the consumer's control. The combination of the state's approach to the program and reliance on it to fill workforce gaps (a great deal of which should be filled by state support of agency-based home health aides) have substantially escalated the program's utilization and cost growth, beyond its underlying purpose for consumers.
- The state has raised the minimum wage and added Medicaid funds to the state budget to cover a portion of the wages attributable to Medicaid aide services. This policy alone has added several billion dollars to the state budget over the past several years. HCA strongly advocates wage advancement for home care aides, but notes here the Medicaid impact of the wage improvement as it relates to NY's overall trend of Medicaid expenditures.
- The state has continued to expand the mandates on providers and health plans. While HCA maintains that many of these mandates are either unfunded or inadequately funded, they still drive added costs to the system.
- Most of the original 2011 and ensuing MRT/DOH policies in home care and long term care overlooked the use of dual Medicare-Medicaid qualified providers, such as Certified Home Health Agencies (CHHAs), LTHHCPs and hospices and the benefit to Medicaid as secondary payor when Medicare is optimized under these models. HCA believes that the

overlooked and reduced use of these Medicare providers is costing significant opportunities for optimizing Medicare entitlement benefits, with costs instead assumed by Medicaid. The shift has also left behind other cost-savings capabilities offered in these models.

These are just some of the actions that the state has taken that have driven Medicaid expenses. Additional actions include the impact of the state's assumption of local Medicaid share cited by the Governor, state funding increases to cover hospital and nursing home labor contract changes, the cost impact of federal Fair Labor Standards Act revisions, and other. We note these along with aforementioned drivers of Medicaid increases that must be taken into account by the Legislature, Executive and MRT II in overall assessment of state Medicaid outlays and potential directions for savings and reforms.

We recognize that there will need to be a series of immediate actions to bring the Medicaid program into balance; however, we urge thoughtful, methodical and time-appropriate approaches to these, and especially to the development of intermediate and longer-term actions.

HCA is eager to work with the Legislature, Governor and MRT members, to help shape the best reform steps for Medicaid that are responsive and realistic to the need, and progressive toward an improved health care system for this year, next year and the future.

HCA RECOMMENDATIONS

I will focus this next section of testimony on HCA recommendations for Medicaid and overall budget support.

The right policy changes can improve Medicaid affordability, promote the advancement of health care and avert unnecessary, ravaging cuts to balance the state's budget.

Instead of immediately looking to raw cuts, we urge the Legislature, Executive and MRT members to first look to methods to ease Medicaid pressures by examining program practices and changes where Medicaid may appropriately shift to secondary payor, and where further system changes can improve Medicaid cost controls and system efficiencies, and improve health outcomes and associated savings. The following are among HCA's recommendations.

I. Lower state Medicaid outlays first by optimizing Medicare-Medicaid coordination and usage; ensure full entitled Medicare coverage for service payments, allowing Medicaid shift to secondary payor status for these services, and also allowing more cost-effective use of Medicaid under these Medicare models when needed as the wrap-around.

- Optimize use of Medicare Qualified Providers (CHHA, LTHHCP and hospice), utilizing Medicare coverage of services, and allowing Medicaid to shift to secondary payor source for the services. HCA has a series of specific proposals to pursue this direction including practice guidelines for Medicare optimization, flexibility in program eligibility to permit expanded use of Medicare-Medicaid models, and other.
- Further optimize Medicare coverage under the recent federal settlement on Medicare home health coverage (i.e., *Jimmo settlement)* clarifying Medicare coverage for services previously uncovered; and
- Seek Medicare coverage of expanded home care services through state pursuit of Medicare section 222 waivers, enabling Medicare coverage of services currently limited to Medicaid.

II. Change statutes and practices to strengthen cost controls and system efficiencies in MLTC, home care and CDPAP.

- **Address State Barriers to MLTC and Provider Cost Controls in MLTC.** As one example, ease the current total restriction on MLTC or provider ability to adjust the care plan of an incoming patient from a consolidating or withdrawing MLTC. Current state rules prohibit the receiving MLTC to change care plan for 120 days, even if the patient's needs have lessened. For another example, enable use of telehealth/telephonic means for aide orientation and/or supervision visits when appropriate to the patient, which now always requires an in-person agency visit and the associate cost of the visit; this enables both visit-and cost-savings, and supports more efficient deployment of nursing resources.
- **Streamline operational procedures and mandates** to eliminate expensive excess operational costs to plans and providers from the multiple layers of regulations under which MLTCs and providers operate; enable MLTC/CHHA/LHCSA models to implement a "LEAN" for state regulations and procedures.
- **Control program practices tied to higher cost** e.g., strengthen marketing and referral standards to address practices that lead to higher cost/use; improve cost control capability and efficiencies in Consumer Directed Care, such as by allowing yearly versus semi-annual assessments for certain stable cases (with savings achieved from reduced extraneous visits), and discontinue the mandatory practice requirement on MLTCs/providers of repeated offerings of Consumer Directed services when the MLTC/provider clinician has determined that the individual is not appropriate and safe for self-directed care, yet under state regulation the program *must* continue to offer and make it available.

- **Promote and Tap Private Home Care Coverage under Existing Insurance Law.** Existing private health insurance in NY has long provided for riders eligible to cover 365 home care visits per year; this has never been tapped by the state for its cost-savings potential. MRT should take steps to increase private coverage of home care through this mechanism, and drive potential Medicaid direct, Medicaid spend-down, Medicaid transfer-avoidance savings.

III. Leverage savings from home care intervention in high-cost/high-risk/complex care.

- Score state budget savings from home care interventions in public health, prevention, and better health outcomes (especially avoided hospital, emergency room, and institutional care use), through home care interventions such as in the areas of sepsis, asthma, housing support, mental health, telehealth, pediatric care, and other specialized, impactful home care intervention. As one example alone, sepsis is identified as the top expense for potentially avoidable Medicaid hospitalizations for the overall Medicaid population; Medicare fee-for-service payments for sepsis admissions from in-home care in NY totaled nearly $200 million in 2016, prior to HCA's home care's sepsis initiative. With home care and other community providers now implementing HCA's sepsis clinical tool, there is major potential to impact and reduce these costs in Medicaid and in the Medicare-Medicaid duals programs, and most importantly, save health and lives. An additional example involves a projected $19.5 million in Medicaid savings from implementation of home care asthma management initiatives, using evidenced based models in the field. The projection is based on MRT I asthma data and savings metrics.

NEXT STEPS

HCA believes these and additional proposals of the type that we are offering have the potential to avert several hundred million in Medicaid outlay. We have focused on proposals that can be a "win-win" for patients, plans/providers, and the system, and urge the MRT to include these concepts as a savings baseline.

HCA is prepared to fully and eagerly work with the Legislature, Governor and MRT members to consider and include such proposals in the budget package, which we note also align with the Governor's MRT charge of "zero impact on local governments, zero impact on beneficiaries, industry efficiencies/additional review."

HCA thanks the Joint Committee for this opportunity and we pledge the support of our organization to assist you, serve on MRT and otherwise work toward a positive outcome in the 2020-21 health and Medicaid Budget.

Thank you.