CONTINUING CARE LEADERSHIP COALITION CCLC

TESTIMONY OF SCOTT AMRHEIN
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JOINT LEGISLATIVE PUBLIC HEARING
ON THE FY 2021 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) 2021

KEY POINTS

1. **We need to be clear about the challenge before us. If we define it solely as a charge to find savings of $600 million in FY 2020 and $2.5 billion in FY 2021 to fill a Medicaid budget gap, we will fail the more than six million New Yorkers who rely on vital Medicaid-funded health and human services. We need to expand the charge to establish that our greatest priority is to ensure that essential health and long term care providers remain strong so that every New Yorker can know that when they or a family member are in need of care, it will be there, and it will be compassionate, high-quality care.**

2. **We need to recognize that key parts of our health care system – and very particularly many of our highest-quality nursing facilities and community-based long term care providers – are at significant risk, as evidenced by the extensive losses of these providers due to closures or conversions since the last Medicaid Redesign Team (MRT) undertook its work in 2011. This needs to be more fully understood; it needs to be prioritized; and it needs to be proactively addressed in 2020.**

3. **We need your support in considering a series of principles and recommendations that are vital to bolstering essential long term care providers and ensuring access to high-quality care for our growing population in need.**

THE CHARGE TO ACHIEVE BUDGET SAVINGS MUST BE BALANCED AGAINST THE GREATER IMPERATIVE OF ENSURING QUALITY CARE FOR ALL WHO NEED MEDICAID COVERED SERVICES IN OUR STATE

In June 2017, three health care scholars – David Grabowski, Jonathan Gruber, and Vincent Mor – wrote a joint op-ed for the New York Time entitled, "You're Probably Going to Need Medicaid," which underscored several important facts:

1. One in <u>three</u> people now turning 65 will require nursing home care at some point in their lifetime. (When home care is added, it becomes one in <u>two</u> people).

2. More than three quarters of long-stay nursing home residents will eventually be covered by Medicaid.

3. Cuts to long term care reimbursement have devastating effects on vulnerable patients – making it harder for these patients to access services – and when they can, they face other consequences of the cuts – with fewer staff to care for them, and much greater odds of negative outcomes, including increased unmanaged pain, reductions in functional ability, and increases in avoidable hospitalizations.

Their overarching point was that – across the population – experiencing a need for Medicaid-covered long term care is anything but rare. To the contrary, it is a likelihood in almost every family, and any significant cuts to Medicaid are, in effect, a "direct attack" affecting all of us.

Our State Constitution is clear on the point that we have a *mandate* to provide "aid, care, and support for the needy," *<u>and</u>* to provide for the "protection and promotion" of the health of all New Yorkers.

In a State facing huge future needs for long term care – with expected 94% growth in our population over the age of 85 in the next 20 years, and 36% growth in those who are both over 65 and disabled – we need to ensure that the clearest and highest goal for these budget deliberations and the work of the MRT is to assure we are providing the resources needed so all New Yorkers can be confident that high quality care <u>will</u> be there for them if and when they need it.

NEW YORK STATE NEEDS TO MOVE AGGRESSIVELY TO REVERSE THE LOSS OF HIGH QUALITY LONG TERM CARE PROVIDERS DUE TO CLOSURES AND CONVERSIONS, AND TO TAKE ACTION TO ENSURE THE LONG TERM VIABILITY OF THESE PROVIDERS

In November 2018, the New York State Attorney General's Office – in a report released by its Charities Bureau – sounded an alarm over the accelerating loss of high-quality, community-based, not-for-profit long term care providers in New York State due to closures or conversions. Citing research linking not-for-profit sponsorship with especially strong quality outcomes in patient care and patient satisfaction, it flagged the deeply concerning trend that in recent years New York has lost close to 5% of its not-for-profit nursing homes *annually* to sales where the purchaser was not another not-for-profit provider.

Of great concern, the challenges facing not-for-profits, and the rate at which their numbers have been diminishing in our State, have grown worse since 2011, when the last MRT issued its recommendations.

In my testimony before your committees in 2011, I made two observations. The first was that our long term care system had the distinction of delivering some of the best quality care in the nation, and the second was that it was simultaneously incredibly fragile. I made the point that "if we do not take extreme care to keep the system strong while pursuing budget savings and reform, the consequences will be dire not only for seniors and the disabled, but also for our economy and for the ability of our health care system overall to operate efficiently and effectively."

Unfortunately, as it relates to the fragility of the system, things have gone from bad to worse.

- In 2011 the average shortfall between the daily Medicaid payment and the daily cost of caring for a Medicaid resident stood at $42.00. By 2017, it had widened to $64.00.

- In 2011, average not-for-profit nursing home margins stood at -1.8%. By 2017, they had worsened dramatically, falling to -5.2%

- In 2011, not-for-profit nursing homes numbered 252, and represented 40% of the facilities in the State. By 2017, the number of not-for-profit homes had dropped to 207, and they represented only 34% of the facilities in the State. In just six years,

our State lost 45 not-for-profit facilities – depriving 45 communities of a vital, high quality resource for their residents.

- In 2011, 70% of the State's Certified Home Health Agencies (CHHAs) operated in the red. By 2017, this percentage had grown to 78%, with the average New York State CHHA losing 13.5% on operations.

- As pressures on the CHHA sector have increased since 2011, we have seen several instances where high-quality, long-standing, and highly regarded CHHAs have been forced to scale back dramatically or exit their markets altogether.

Predictably, as financial pressures have mounted since 2011, and as we've lost increasing numbers of high-quality, not-for-profit long term care providers, New York is at risk of losing ground when its overall quality profile is compared with other states'. In point of fact, data compiled by the Centers for Medicare and Medicaid Services suggests we've seen slippage in our relative quality ranking since 2011.

Stopping and reversing these trends is paramount. But getting there will require the dedication of your committees and the legislative leadership, the Executive Branch and all of its relevant agencies, and the MRT and its members, to make it a priority to understand the pressures and causes behind these trends, to prioritize the preservation and sustainability of our State's long term care quality leaders, and to take concrete steps in this budget and MRT process to ensure that no effectively-run, high-quality provider of long term care services will be forced to sell or close in the future because of shortfalls in reimbursement or budget-saving actions.

RECOMMENDATIONS

We believe there are several key things that must be done to ensure that our duty to provide high quality long term care to all vulnerable New Yorkers is fulfilled as the MRT undertakes its work.

Ensure that the MRT Includes Strong Long Term Care Expertise

It is vital to make sure that the MRT has a strong representation of individuals who understand what is needed to sustain quality LTC services, and how those services work together to bring greater efficiency to our health and human services systems as a whole.

At a minimum, the MRT should include representatives who bring:

- Knowledge of the particular challenges and pressures facing not-for-profit long term care providers in NY;

- Clinical expertise and knowledge about what is required to consistently deliver quality outcomes to vulnerable elders and persons with disabilities requiring long term care services;

- Expertise in addressing social determinants of heath among older New Yorkers, and an understanding of how housing and supportive social services are integral to meeting these needs effectively and reducing unnecessary heath care spending overall; and

- An understanding of long term care's role in supporting a more efficient heath system - and how opportunities such as New York State's pending DSRIP plan can be leveraged to capture savings that Medicaid-funded long term care activities at the State level generate for the Federal government and the Medicare program overall.

Ensure the Protection and Preservation of High-Quality, Essential Community Providers of Long Term Care Services

Virtually all long term care providers in our State are "safety net" providers, insofar as they are deeply involved in serving the Medicaid-eligible population (with fully 72% of all nursing home days of care, and 87% of all home care and personal care services, tied to serving Medicaid beneficiaries). Among them are hundreds of immensely dedicated providers, with deep histories working to meet the needs of their communities, strong records as quality leaders, and proven ability to work with health system partners to deliver on vital health reform goals. Sustaining these providers is critically important. It will require the following commitments:

- **Assuring that Vital Long Term Care Providers are Protected from the Impact of Direct Provider Cuts.** The message here is simple. Our best providers are already losing hundreds of millions annually on Medicaid. Their margins are south of -5%. They are selling and closing at alarming rates. Already, the 1% nursing home cut implemented on January 1st is taking away two thirds of the revenue from the 1.5% transformation adjustment provided during the same period – which itself was the first sector wide-increase received by nursing facilities in over ten years. Any further Medicaid cuts will drive good providers out of business and undermine quality for all. The MRT should do everything possible to avoid or offset new Medicaid cuts affecting these providers.

- **A Commitment to Understanding and Addressing the Root Causes Behind our Growing Loss of High Quality Long Term Care Providers.** The alarming trend of sales and closures of high-quality not-for-profit providers urgently needs to be addressed. It should be the subject of special focus within the MRT and beyond, and it should be an explicit goal of the State that no effectively-run, high-quality provider of long term care services should ever be forced to sell or close because of shortfalls in reimbursement or budget-savings actions.

- **A Commitment to Sustaining Benchmark Rates for Nursing Homes, and Establishing them for Home Health Providers.** The nursing home benchmark rate has been essential to providing a measure of stability as nursing homes were brought into mandatory Medicaid managed care following the last MRT. It will be important to keep this standard in place as the proportion of Medicaid MLTC enrollees in nursing homes is reduced, but not eliminated in the months ahead. Similarly, it is vital to provide a comparable mechanism to ensure fair and reasonable Medicaid payment levels for home health agencies in the State.

- **A Commitment to Addressing Weaknesses in Base Reimbursement Models for Nursing Homes and CHHAs.** The statistics cited above – showing that not-for-profit nursing homes in 2017 lost, on average, 5.2% on operations, while CHHAs on average lost 13.5% – are clear signals that we should be examining how the basic reimbursement models for these providers fall short, and how they could be improved. We are prepared to provide further recommendations on approaches to improving both models, and look forward to further opportunities to discuss these with the Committees.

- **A Commitment to Creating Stronger Financial Incentives to Reward High Quality Providers.** 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. The Legislature and the members of the MRT should prioritize making the NHQI's incentives more robust – ideally by dedicating new funding to supplement the current $50 million pool, or, as an alternative, by increasing the share of overall Medicaid spending on nursing home services that is pooled and distributed to the highest performing facilities.

Address the Cost Drivers in the Managed Long Term Care (MLTC) Program While Supporting the Continuation and Evolution of the Program to Preserve its Demonstrated Benefits. We urge the Committees and the MRT to take great care when looking at Medicaid growth within the MLTC program, and when considering options for reform of the program and the subparts within it. As noted in the Executive's budget materials, the greatest source of cost growth within the program stems from increased spending under the Consumer Directed Personal Assistance Program (CDPAP). Administrative actions are already underway to gain greater control over spending in the CDPAP program and other strategies will surely be explored as the MRT's work gets underway. At the same time, it should be noted that the core elements of the MLTC program in New York State have been shown to be highly effective in reducing the use of institutional care among community-based enrollees. It is important for the MRT to take careful measure of the program's benefits and the areas where constructive change is called for, and to develop recommendations that build on the program's strengths. Provider-based MLTC program sponsors have valuable insights to offer, and these should be leveraged as a plan is designed to improve and evolve these programs for the future.

Support Value-based Strategies to Capture the Long Term Care Community's full Potential to Drive System-Level Savings. The MRT process represents a golden opportunity to explore how best to bring the long term care and post-acute community into models that capture, and share, Federal savings generated as a result of interventions to help to avoid hospitalizations or otherwise minimize utilization in higher-cost institutional settings. We encourage the MRT to examine ways, for example, to enable nursing homes, CHHAs, and community-based human services organizations (alone or working in concert) to assume responsibility for being the lead player in managing the total cost of patient care during an episode of care. CMS has been considering potential new alternate payment models – including those engaging the long term care community – and this may be an ideal time to build structures that capitalize on the ways that these providers can generate system savings, with potential benefits to the State and to the providers themselves.

Ensure that any New State Revenues are Invested Back into the Medicaid Program. It is vital to the goal of sustaining quality providers, and ensuring quality care to beneficiaries, that any new revenues – whether generated through health-related or non-health-related taxes – are dedicated to the Medicaid program. Delivering quality health care requires enormous human capital, and dedicating any new revenues to strengthening Medicaid is fully aligned with our constitutional charge to care for those in need and to protect the health of our residents.

Reform the Global Cap. That fact the we are facing nearly 100% growth in our over-85 population in the next 20 years is exactly why we need to reform the Medicaid global cap this year. The cap was designed to grow only in relation to the 10-year rolling average of medical cost inflation. It was not built to accommodate major demographic shifts like the one ahead for our State – one that will necessarily drive legitimate new demands on our health system resources and on the Medicaid program itself. We need to reform the cap now – before we see the full impact of this shift, to ensure it has the needed flexibility to expand and adjust for the shift, and for other factors, such as enrollment changes, that need to be taken into account.

CONCLUSION

I greatly appreciate the opportunity to provide these perspectives and recommendations. We look forward to working in partnership with the Senate, Assembly, the Executive, and the MRT as it is established to find solutions to the challenges before us, and to ensure that essential long term care services remain strong and available to our State's older and disabled citizens.