VNS Health Testimony to the Joint Legislative

SFY2026 Budget Hearing on Health and Medicaid

February 11, 2025

Chairs Krueger, Pretlow, Rivera, and Paulin and members of the Senate and Assembly Health Committees, Assembly Ways and Means and Senate Finance: thank you for the opportunity to submit testimony for the Joint Legislative Budget Hearing on Health. I am Dan Lowenstein, Senior Vice President of Government Affairs for VNS Health, formerly known as the Visiting Nurse Service of New York.

VNS Health, a nonprofit that has operated continuously for more than 130 years, is the largest home and community-based health care organization in New York State (NYS). We provide or manage care to more than 70,000 NYS residents each day. We operate the largest certified home health agency (CHHA) and hospice in NYS and furnish community behavioral health services for more than 25,000 at-risk or seriously mentally ill New Yorkers each year We operate high-quality Medicaid, Medicare and integrated plans for seniors, people with disabilities, and people living with HIV/AIDS. Our plans are active in New York City and 32 counties, including Long Island, Hudson Valley, Capital District, Central NY and Western NY.

This testimony addresses several areas of interest and concern, but I am focusing our remarks on addressing the certified home health agency – or "CHHA" access crisis related to managed care payments.

Ensure Fair Funding and Managed Care Rates to Reverse the CHHA Access Crisis

What CHHAs Are, and What They Are Not

Certified Home Health Agencies (CHHAs) mostly provide short-term, intermittent care in the home when someone is homebound and has a "skilled need," meaning they require nursing, physical, occupational or speech therapy and social work services. CHHAs provide some aide services, but only as part of that skilled need. CHHAs are more accurately compared to the short-term services delivered in skilled nursing facilities (SNFs), but CHHAs provide it in the patient's home.

Different types of "home care," are often conflated, even though they are completely different programs. Here is what CHHAs are not:

- **CHHAs are not LHCSAs:** Licensed Home Care Service Agencies (LHCSAs) provide home health aide and personal care services, mostly in long-term care.

- **CHHAs are not CDPAP:** The Consumer Direct Personal Assistance Program (CDPAP), which has been a big issue of debate, allows people to have personal assistants, also for long term care.
- **CHHAs are not CHAs:** Community Health Advocates, or "CHAs" help people navigate the health care system.

Each year, CHHAs help more than 400,000 New York patients heal and recover in their homes and prevent infections, falls, adverse medication reactions, malnutrition, and other conditions.

CHHAs Play an Essential Role in the Health Care Ecosystem

Imagine this. You are enrolled in a Medicaid managed care plan. You spent two weeks in the hospital after emergency bypass surgery. It went well, and now it is time to go. Recovery time is six to eight weeks and will require regular nurse and physical therapy care. You live alone and while you have friends and neighbors, there's no one to regularly tend to your needs. The doctor orders home health care from a CHHA as part of your discharge plan.

The hospital makes a referral to a CHHA, but the CHHA doesn't take the case. They make another referral. Then another. And another. No CHHA takes the case. The hospital tries skilled nursing facilities in the area too, but they also don't have capacity. You spend four more days in the hospital with no CHHA willing to "admit" you.

You are growing frustrated and start developing blood clots. Meanwhile, the hospital wants to clear your bed for a new patient. Your doctor says you should have home health services, but you don't want to be in the hospital any longer, so you discharge yourself without services in place, call a neighbor to pick you up, and leave.

At home you do your best to care for yourself but it's hard and you get tired easily. Your incision hurts, so you take some Tylenol. After three days you have a fever and chills. The wound is throbbing. You can't get out of bed and your neighbor is not answering her phone. You call 911 and an ambulance rushes you to the hospital where you are diagnosed with septic shock from an infection at the incision. You spend two more weeks in the hospital recovering.

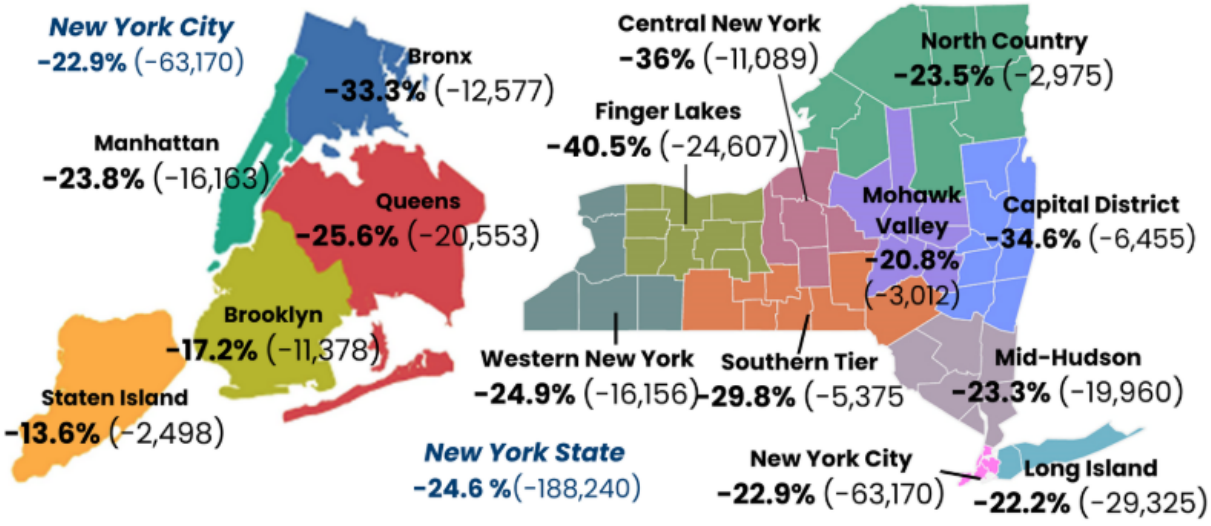
CHHA Access Across NYS Has Declined Precipitously

Scenarios like this one happen frequently to patients throughout New York. The need for home health care is increasing rapidly as hospitals try to discharge more patients with more complex conditions to make room for new patients. But with inadequate reimbursement – particularly from managed care – CHHAs are unable to meet this demand.

Between 2019-2023, NYS saw a ***25% decline*** in Medicare access to CHHA services, with far steeper drops in access in "Home Health Deserts" like the Bronx (33%), the Capital District (35%) and the Finger Lakes Region (40%). The result: ***more than 188,000 Medicare patients***

needed but did not receive CHHA services.[1] While similar data for Medicaid patients was not available, Medicaid patients likely saw similar or worse declines. The home health access crisis is highest in communities already suffering from serious health and socioeconomic disparities and poorer health outcomes. Urban, suburban, and rural communities already suffering from health disparities are becoming "home health deserts."

Figure 1: Change in CHHA Access for Medicare Enrollees 2019-2023



Key: Bold percentage is the estimated percent change in Medicare enrollees receiving CHHA services in 2023 compared to 2019; nonbold numbers are the estimated total number of Medicare enrollees unable to receive CHHA services between 2019-2023 based on 2019 utilization. **Source:** CMS Market Saturation file and County Data File (2019-2023)

Annual **hospital referrals to CHHAs increased exponentially** between 2019-2024, but CHHA capacity to accept those patients barely budged. All patients were impacted, but **Medicaid managed care patients suffered the worst decline in access.**

- The rate of Medicaid managed care patient referrals to CHHAs **increased 256%** but the rate of referrals admitted to CHHAs dropped **fell from 34% to 15%– a 56% decline**. *(Figure 2 – page 4)*
- The rate of referrals to CHHAs for non-Medicaid managed care patients (all other payers) **increased 216%**, while the percentage of referrals admitted to CHHAs **dropped from 48% in 2019 to 25% in 2024 – a 48% decline.**[2] *(Figure 3 – Page 4)*
- At least ***20 CHHAs across NYS stopped operating*** between 2019 and 2024. Those that remain struggle with inadequate resources to recruit and retain staff who can meet the demand for their services.[3]

[1] CMS Medicare Market Saturation Data: 2019-2023
[2] WellSky/Careport, analysis of referral and admissions data from New York State hospitals accounting for the majority of inpatient admissions.
[3] CMS Medicare Market Saturation Data: 2019-2023 and knowledge of closed CHHAs

Figure 2: Medicaid Managed Care Hospital Patients Referred to CHHAs vs. Admitted to CHHAs 2019-2024

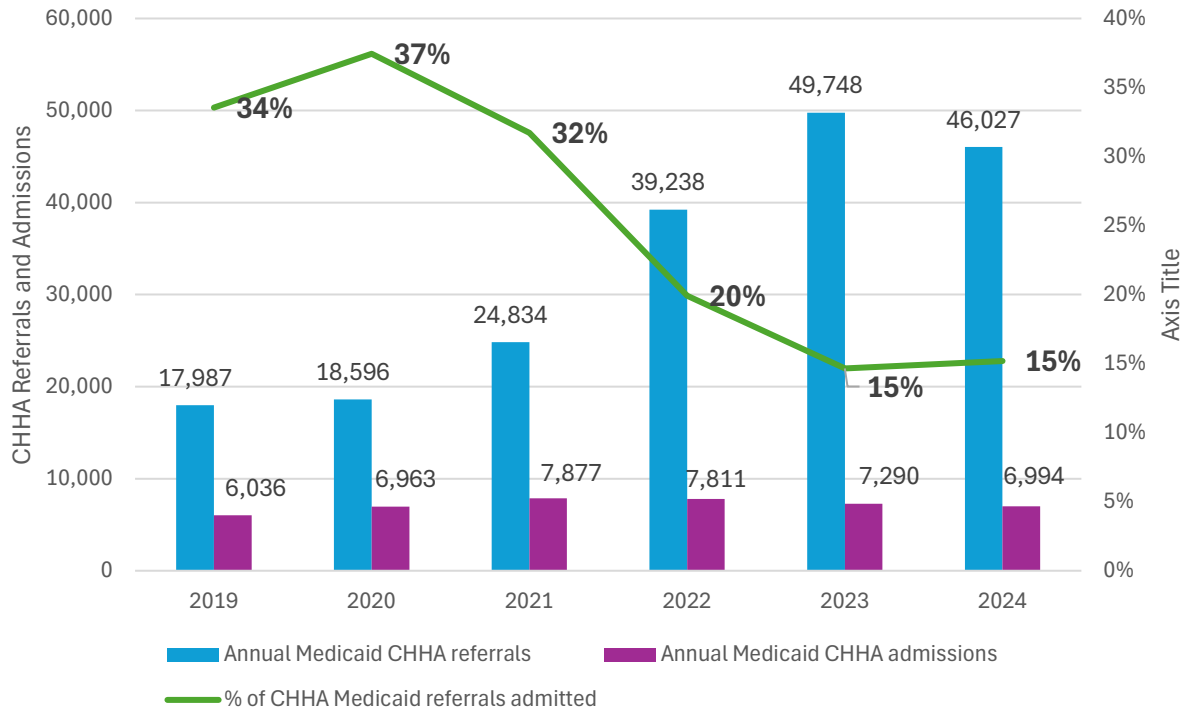
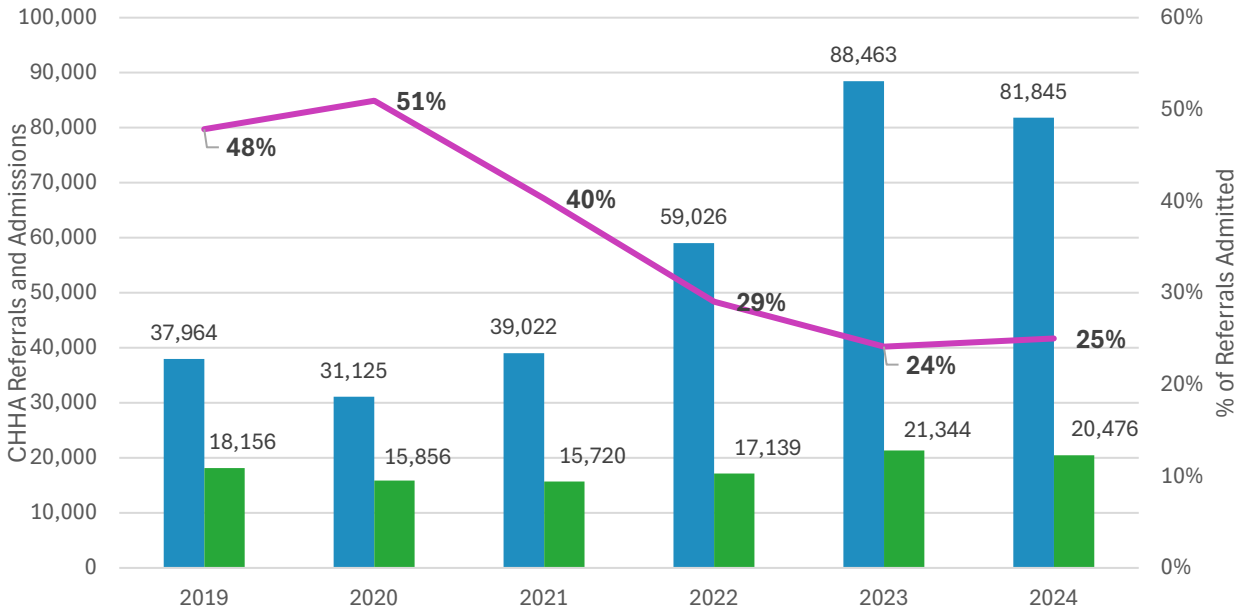


Figure 3: Non- Medicaid Managed Care Hospital Patients Referred to CHHAs vs. Admitted to a 2019-2024



Impact of the Home Health Access Crisis

The inability to access CHHA services is having devastating consequences on patient care and health care cost:

- Nationally, hospital Medicare patients referred to CHHAs who do not receive services are **34% more likely to be readmitted to the hospital**, **41% more likely to die, and have $2,170 higher health care costs** than those who do receive CHHA services.[4]
- The average length of stay (ALOS) for NYS hospital patients referred to home health has ***increased 9.2% between 2019-2023, to 8.2 days*** *(more than a day higher than the national average),* indicating that patients are waiting longer to be discharged home.[5]

Not Following Standard Payment Methodologies Creates Inadequate Managed Care Reimbursement and Dramatic Decline in CHHA Access – Especially for Low-Income Patients

CHHA access is declining for all patients, but it is worse for managed care patients than for Medicare and Medicaid fee-for-service patients. CHHAs are mostly reimbursed by managed care, which usually reimburse differently – and less – than fee-for-service. Medicaid managed care and other health plans for low-income NYS residents reimburse the least. CHHAs cannot afford to take many poorly reimbursed cases, resulting in less access for low-income patients.

The reason for the reimbursement disparities is less about the rate of payment than the type of payment. Fee-for-service typically reimburse CHHAs a fixed payment for a certain time period. Managed care plans typically reimburse CHHAs for each visit that is authorized and completed. A fixed payment enables CHHAs to manage patient care and resources with a predicable reimbursement, versus a visit-based payment that does not.

Medicare (for 65+ and disabled, including for those who are dually eligible for Medicare and Medicaid) is about 70% of CHHA reimbursement. This includes Medicare "fee-for-service," which reimburse through the "Patient-Driven Groupings Model (PDGM)," which includes 30-day "periods" of care. Payments are higher for patients with greater needs and lower for patients with fewer needs. If a minimum threshold of visits is not met, the CHHA receives payment for each visit instead of for an episode. Medicare is the most reasonable payer, though recent payment cuts have also impacted access. Medicare Advantage (MA) plans typically pay lower than PDGM.

[4] 2023 National CMS Medicare data based on home health admissions within 90 days of hospital discharge. Analyzed by CareJourney

[5] WellSky/Careport, analysis of data from New York State hospitals accounting for the majority of inpatient admissions.

Medicaid fee-for-service, Medicaid managed care, Essential Plan and Child Health Plus reimburse CHHAs for low-income patients not covered by Medicare (typically under 65 and non-disabled). NYS fee-for-service Medicaid uses an "Episodic Payment System (EPS)" that directly pays CHHAs for 60-day case-mix adjusted "episodes" of care. As with PDGM, payments are higher for patients who require more services and lower for patients who require fewer and there are safeguards to ensure appropriate care delivery.

EPS has several advantages over per-visit reimbursement:

- **Encourages Cost Efficiency** – CHHAs receive a fixed amount for an episode of care, incentivizing them to manage resources efficiently.
- **Promotes Care Coordination** – CHHAs can deliver comprehensive care within the episode, improving patient outcomes.
- **Reduces Unnecessary Services** – Limits the incentive to schedule excessive visits since payment is based on the episode, not the number of visits.
- **Improves Patient Outcomes** – Focuses on quality and efficiency, leading to better health results rather than maximizing visits.
- **Simplifies Billing** – Reduces administrative burdens by consolidating payments into an episode rather than billing for each visit.

But the vast majority of low-income CHHA patients are in managed care. ***These plans typically pay "per visit" instead of following EPS, resulting in reimbursements of about 50-65% less than EPS.***

One reason for this disparity is that the managed care plans do not refer to the EPS pricing system. Managed care plans usually negotiate rates around a pricing methodology established by government payors (e.g. Medicare or Medicaid). This is the case with hospitals, specialists, primary care, mental health, nursing homes, hospice and many other providers. Plans are not bound by these methodologies (unless a law requires them) and rates may be higher or lower than the established methodology and can include value-based payments. *Our research indicates that CHHAs may be the only provider where managed care payments are not based on a government rate methodology.*

NYS Budget Proposals to Address CHHA Access Crisis

NYS cannot ignore the CHHA access crisis any longer. CHHAs have been passed over for funding and rate increases for years while other sectors received them. The results of that inaction are now clear. We request that the Legislature include the following provisions in budget legislation:

1. **Make EPS Available and Set CHHA Access Expectations for Medicaid Managed Care, Essential Plan and Child Health Plus Plans (amend S.4791-B/A.7460-A introduced in 2023-2024).** Many health care provider types have been granted "minimum benchmark" rates that managed care plans cannot go below. The SFY 2025 budget included "no less than Medicaid fee-for-service" rate requirements for behavioral health, substance abuse and developmental disability providers.

   We are not asking for "minimum benchmarks" for CHHAs. We believe that with the right information and direction, managed care plans will see the value of CHHAs and negotiate in good faith to ensure access to care. We ask the Legislature to require that NYS DOH:

   - Update the NYS DOH CHHA Medicaid EPS to reflect actual costs.
   - Make the CHHA EPS pricing tool available to all Medicaid managed care, Essential Plan and Child Health Plus plans.
   - Notify plans that they are responsible for ensuring their members have access to CHHA services; that CHHA services are critical to improving patient care and reducing overall costs, particularly related to reducing avoidable hospital use and costs; and that *EPS is the standard payment methodology for NYS government agencies.* This would not prohibit good-faith negotiations and alternative payment methodologies, including value-based payments.

2. **Include Funding for CHHAs (A.1493 – Paulin).** While the executive budget proposes funding for hospitals, nursing homes, adult care facilities, hospices, physicians and clinics, CHHAs are not included. *At least $70M should be included to improve CHHA access.* This funding should be targeted to supporting access in the hardest to serve areas of NYS.

Additional Budget Requests (Health/Medicaid)

Restore the Medicaid MLTC Quality Incentive Program (QIP) and make it permanent in statute. The Executive Budget again eliminates QIP for managed long-term care (MLTC) plans and integrated care plans. VNS Health MLTC is a quality health plan that invests heavily in improving outcomes, including preventing falls, and avoidable hospitalizations. We rely on our partners to provide that quality care, which includes deploying home health aides who can communicate when something is or may be going wrong with our members so we can take action. Eliminating QIP only advantages lower-quality plans and hurts higher-quality plans. Please restore MLTC QIP funding ($22.4M) and make QIP permanent (A.2044 – Paulin) to ensure sustainable funding moving forward.

Add $1.5M for Nurse-Family Partnership (NFP). NFP is a national evidence-based model of parent support that pairs a specially trained nurse with a first-time pregnant person, starting as early in the pregnancy as possible and continuing to the child's second birthday. The goals of the NFP program are to improve pregnancy outcomes, child health and development and family economic self-sufficiency. VNS Health operates NFP programs in the Bronx and Nassau County. Please add $1.5M to the final budget to support NFP throughout NYS.

Support Medicaid Wheelchair Repair Coverage. We applaud Governor Hochul for proposing that Medicaid cover wheelchair repairs (NYS Medicaid Scorecard: Support Mobility for People with Physical Disabilities.) Power wheelchairs can break down, leaving people with physical disabilities (PWD) without a means of mobility for long periods of time. VNS Health has a significant number of MLTC members with physical disabilities, and we see a direct relationship between appropriate and functional equipment and positive health outcomes, saving money, and promoting greater community engagement for PWD.

The State investments to enhance rates for clinical specialty evaluations for new wheelchairs, expand coverage for wheelchair repairs, and provide preventative maintenance coverage will benefit New Yorkers with physical disabilities and strengthen the network of professionals and vendors that repair and provide durable medical equipment.

It is important that NYS DOH recognize these additional benefits in the calculation of MLTC rates. Further, under current guidelines only one wheelchair is to be maintained or repaired, leaving out coverage for a backup wheelchair. For certain disabilities and circumstances, this would be a valuable benefit that New York State should consider.

Allow NYS to Join the Interstate Nurse Licensure Compact. The nursing crisis deeply impacts access to home health and hospice care in New York State. We applaud the Governor for directing New York State to join the Nurse Licensure Compact, which would allow VNS Health and other agencies to recruit nurses from other states more easily. Currently 43 states are part

of the compact. Licensure from another state should not be a barrier to New York State providers recruiting from states with lower nursing salaries.

Include Hospice Funding. New York State is last in the country in hospice access. We request that at least $20M is invested in building access in hospice “deserts” (which often overlap home health deserts).

Thank you for the opportunity to provide this testimony. VNS Health is here every day for your NYS residents who need quality, compassionate care in their homes and communities. Thank you for helping us help your constituents.