Testimony by Joanne Cunningham

President of the Home Care Association of New York State (HCA)

Joint Legislative Hearing on the Health and Medicaid Budget

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INTRODUCTION

- Thank you for the opportunity to testify on behalf of New York's Home Care community.

- This week, my organization, the Home Care Association of New York State (HCA), invited several of our provider members to meet with you and your colleagues in the Legislature and Administration to outline home care's urgent need for **regulatory relief, transition support**, and a **stable fiscal environment** in this year's budget and legislative session.

- Further details of these priority areas are outlined in the documentation that HCA is submitting to the panel today, specifically our report entitled: ***A Three-Point Plan to Support Home Care and Ensure Success of State Redesign Efforts***. Many Senate and Assembly Members on the legislative panel have already seen this plan and have discussed its proposals with HCA provider members this past week. I thank you again for the time, attention, and consideration you have already committed to these issues, which I will be reinforcing in my testimony today.

- As you well know, New York's home care system is at a crossroads. Massive reimbursement cuts have left **79% of home care providers operating in the red,** according to the most recently available Medicaid cost report data, as analyzed in HCA's 2013 *Report on the Fiscal Health of Home Care in New York State*, which is also presented today to the panel. Unfortunately, many of these cuts would continue in the Governor's 2013 budget proposal.

- Home care providers are the lifeblood of the home and community-based care infrastructure, delivering vital home health aide, nursing, therapy and other services to help keep patients out of higher-cost settings. In order to achieve the state's Medicaid redesign goals, these long-established front-line providers **desperately need stability in the financial, policy-transition, and regulatory arenas.** The Legislature and Executive can be of enormous assistance on these matters as part of budget negotiations during the coming weeks, and **I urge your strong backing for the concepts and specific proposals under HCA's three-point plan.**

SPECIFIC REGULATORY PROPOSALS

- Over the past two years, state Medicaid redesign policies have rapidly and fundamentally begun to change the relationship between home care providers and their patients. These state policies have moved one foot down the path toward mandatory managed care enrollment for thousands of home care patients while the other foot remains planted in a regulatory structure that is designed for a much different fee-for-service Medicaid environment.

- By modernizing the regulatory structure in home care – and by securing adequate Medicaid payment to managed long term care (MLTC) plans, as well as adequate reimbursement for contracting home care providers – we can assure: a smoother transition, better continuity-of-care for patients, and operational efficiencies which are in the best interest of patients, the state's fiscal policies, and the stability of provider and health plan infrastructures.

- Let me give you some **concrete examples** and explain why these issues are of urgent concern and need.

- As you know, the state's new approach to care delivery now requires that home care providers increasingly subcontract with MLTC plans in order to deliver services at home to patients.

- Yet, within this new context, the current regulatory structure for home care lacks consistency in some cases and is altogether duplicative in other cases when it comes to the managed care contracting environment. This is a major problem of growing concern as the level of contracting activity is expected to accelerate in the months ahead, in line with the rollout of the state's mandatory MLTC enrollment policies.

- For instance, Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), and Licensed Home Care Services Agencies (LHCSAs) are currently held to regulations that reflect a fee-for-service world where home care providers have jurisdictional responsibility over the enrolled patient.

- However, when the managed care plan has jurisdiction, it is not necessary or feasible for home care providers to meet overly stringent regulatory and compliance requirements that are duplicative or unnecessary to the provider's role as a contractor, such as current regulations governing the frequency of nurse supervision visits or reassessments and OASIS reporting requirements, among other regulations. **HCA is asking the Legislature and Administration to consider changing or exempting certain aspects of the current home care provider regulations especially in cases where these home care providers are functioning in a subcontracting role with managed long term care plans.**

- Long Term Home Health Care Programs in particular are held to unique programmatic requirements that even further stifle their participation in a contractor relationship. For example, LTHHCPs have a nursing-home-eligibility standard for the care of patients but MLTC plans do not. Thus, while both entities are ostensibly designed to serve a similar patient population, it does not make sense for LTHHCPs to have a different set of eligibility standards which preclude these highly skilled and advanced care-management programs from serving an MLTC's more expansive patient population, especially at a time when these providers are now expected to function even more compatibly in a contract relationship under the state's Medicaid redesign policies.

- The current constraints for LTHHCP providers go even further than the eligibility rules: LTHHCPs are also subject to a provider-specific cap on the actual number of patients they can serve. This is yet another impediment to

the contracting relationships envisioned by the state's Medicaid redesign goals, since MLTCs are not similarly capped.

- Meanwhile, in other areas of regulation, the roles and responsibilities of MLTCs and home care providers **contain costly and unnecessary overlaps.** This includes the responsibility for: obtaining physician orders; reporting changes in a patient's condition to the physician; fulfilling documentation requirements; collecting Medicaid spend-down amounts; and other areas.

- **HCA is recommending a budget provision that convenes a technical panel of home care/health plan representatives which would outline areas for streamlining and sorting of these lines of responsibility in statute.**

- Home care providers want and need to be partners in this emerging system, but we urgently need regulatory change and transition support to do so. Without this support and regulatory clarity, providers are not in the best position to meet the state's redesign goals, and they cannot effectively budget or plan for the future.

HOME TELEHEALTH AND CARE-CONTINUITY

- I want to thank several member of this legislative panel for your strong advocacy and all of the work you have done in recent years on behalf of the home telehealth program. This program, as you know, has proven to reduce expenses and enhance care outcomes using cutting-edge disease-management technologies. In fact, a recent study by Simione Healthcare Consultants tracked the outcomes of just five New York State home telehealth programs

and found that these programs saved over $1 million in averted hospital readmissions for discrete patient populations.

- The home telehealth program has a provider-based financing structure which, unfortunately, faces extinction in the transition to mandatory managed care enrollment.

- **We strongly urge provisions in this year's budget that would maintain a distinct provider-based line of service and reimbursement for home telehealth.**

- The preservation of home telehealth is just one element of HCA's call for strong and consistent continuity-of-care provisions for patients in all segments of the home care system as the state transitions to a mandatory enrollment environment.

FINANCING SUPPORT

- In addition to regulatory changes, home care urgently needs a stable financing structure to weather these monumental shifts, especially at a time when the existing erosion of the home care financial base already challenges providers in helping to achieve the state's redesign goals.

- Transitions like those occurring right now in home care involve huge cost demands for program restructuring, staffing changes and other expenses. During past transitions in other areas of health care, the state has traditionally provided financing support. In fact, this time around is no

different, **except that the state's plan for Medicaid transition reinvestment does not currently include home care**, even though home care providers are among the most affected by the current changes.

- HCA urges the state to include home care transition support in its 1115 waiver request to the federal government. This request seeks reinvestment of up to $10 billion back into the state's Medicaid redesign efforts – and there is no other area of the redesign plan that needs transition reinvestment more than in home care.

- HCA's financial condition report makes clear the plummeting trend line of home care provider operating margins. **Seventy-nine percent of providers are operating in the red**. And now, this year's budget proposal continues the trend indefinitely with the extension of virtually all cuts enacted over the past two years, including a Medicaid global cap that further jeopardizes providers at a time when enrollment is increasing. In fact, the state's own data shows that the cap has exceeded the state's own projections in reducing home care expenditures.

- The equation for provider financial instability is clear: costs continue to rise, due in large part to state unfunded mandates, while reimbursement continues to be slashed and expenses capped. With all of these forces conspiring at once on an overloaded home care system coping with enormous structural changes, a comprehensive approach to regulatory and financial relief is desperately needed for the sake of New York's home care infrastructure and the patients it serves.

- I again want to thank the Legislature for your receptivity to these urgently needed proposals to reconfigure the home care regulatory structure and pursue transition and financing support. We will be reaching out to the Legislature and Administration with even more specific policy proposals as needed in the coming weeks. Thank you.

The Home Care Environment in New York State

New York's health care infrastructure is facing profound and unprecedented challenges in the wake of the state's rapid and foundation-changing push to realign services, payment, structures, and the relationship between patients and providers under its Medicaid redesign plan. This paradigm shift has placed home care, in particular, at the most significant crossroads in its history.

Home health care is vital to successful patient care and health outcomes, enabling timely and effective preventive, post-hospital and long term care, and public health support throughout the community.

The state's mandatory managed care enrollment effort – perhaps the most fundamental state-initiated change for home care – has already begun to redirect the care for elderly, disabled and chronically ill individuals covered under Medicare and Medicaid. By requiring enrollment of these patients into managed care and managed long term care plans, the move to mandatory enrollment not only fundamentally changes the venue for coverage and care of patients but it also fundamentally changes the longstanding jurisdiction, role, operations, responsibilities and viability of providers in the delivery of care. These changes also challenge managed care health plans with dramatic increases in enrollment and high financial risk.

To successfully adapt to this new policy environment, home care **urgently needs support** to achieve the state's goals as a viable and effective component of the health care system for patients.

A Three-Point Plan to Support Home Care and Ensure Success of State Redesign Efforts

HCA asks the Legislature and Administration to enact meaningful home care ***transition support*****,** ***regulatory relief*****,** *and* ***financing policies*** *to assist home care providers in meeting the demands of a changing home care delivery landscape.*

What does the home care community need to achieve the state's policy goals and to succeed in this environment?

HCA has identified three main areas of need, each detailed later in this document with a set of specific proposals:

Transition Support – Home care agencies need proactive support to accomplish the state's rapid push to a completely different care-delivery paradigm in which enrollment, coverage and delivery of long term home care services are being shifted to managed care. The substance and speed of the state's current transition path has unavoidable impacts on core functions of home care agency operations, personnel and patients as well as the operations and functions of partnering managed care plans. Both the providers and the health plans are subject to enormous pressure to make this transition. **HCA asks policymakers and lawmakers to enact concrete legislative, regulatory, and administrative proposals that help home care providers transition to this new paradigm.**

Regulatory Relief – The regulatory structure and requirements for home care providers have not been adjusted to complement the demands of this new policy direction. Without critical regulatory relief for home care providers that conforms to the new policy and market-based environment, providers and plans cannot achieve the contractual agreements or efficiencies as the state's policy intends. **HCA asks policymakers and lawmakers to enact meaningful and appropriate regulatory and mandate relief that would allow the home care provider community to be efficient partners in the new managed care environment.**

A Stable Fiscal Environment – The home care community has been subject to massive payment cuts and mandates over the past three years. These cuts and added costs have yielded unprecedented fiscal instability in the home care sector. In addition, the imposition of a Medicaid Global Spending Cap – combined with "super authorities" granted to the Commissioner of Health to unilaterally impose new cuts to home care if the cap is exceeded – continues to place home care providers in a precarious position. **HCA asks lawmakers to engage with the home care sector to seek protections from new cuts, particularly any new cuts that may be imposed through the Global Cap and the "super authority" power of the Commissioner.**

January 2013

HCA Priority Proposals for Administrative and Legislative Action

1. Transition Support

- **Provide a Clear Path to Contracting** – The need for a clear path to contracting is among the most fundamental transition supports that home care needs in order to be successful partners with health plans. The absence of transition supports thus far has been causing serious obstruction and/or imposition of higher costs in the contracting process between managed care plans, and especially for Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs). Such supports include:

  a. Applying Managed Care Organization (MCO)/Managed Long Term Care (MLTC) eligibility rules and standards uniformly to MCO/MLTC contractors in order to avoid silos within MCO/MLTC;

  b. Eliminating or bypassing certain program features which have been historically applied to the distinct home care or managed care worlds but which are obstacles to access and operation in a home care-managed care contract (e.g., slot limits on LTHHCPs make no sense in the new environment);

  c. Streamlining or bypassing of regulations which have applied distinctly in home care or managed care but which are duplicative, unnecessary, uneven and/or unnecessarily costly in the home care-managed care marketplace (e.g., extra supervision, assessment, reporting and other requirements for CHHAs, LHCSAs and LTHHCPs, which are not required and do not exist in a managed care-home care context).

  HCA urges the Administration to take immediate action on these and other relief measures and also seeks the Legislature's active support for such administrative action, or Legislation to accomplish the same.

- **Enact Strong Provisions for Continuity of Care** – Strong continuity-of-care provisions are vital to protect patients, their caregivers and the stability of the provider infrastructure as patients are moved from provider rolls to managed care rolls. A rigorous set of protections was put into place for the personal care-to-managed care transition in New York City, but parallel protections have not been incorporated for patients and providers in other home health programs or other geographic areas. **HCA requests the Administration's adoption of equally protective continuity-of-care policies for other home health programs and geographic areas, and asks for the Legislature's assistance with this need by supporting administrative action or by adopting the necessary changes through Legislative action.**

- **Preserve and Continue the Home Telehealth Program** – Home telehealth faces a cliff in the transition to managed care. As patients are disenrolled from home care agencies and into MLTCs, these patients also face disenrollment from the telehealth program that is distinctly provided by home care agencies. There is currently no bridge between home telehealth and MLTCs, and no clarity as to the continuation of home telehealth. New York's Home Telehealth Program is a national landmark initiative and should be preserved. The clinical effectiveness of telehealth is well-proven: it improves health outcomes and it prevents avoidable acute-care hospital admissions, readmissions, and other high-cost service categories. It has also rapidly risen as a cornerstone of care-coordination partnerships between home care, hospitals and physicians, as well as a core "standard of care" in the treatment of complex conditions. **HCA requests that the home telehealth program be fully and distinctly continued in accordance with the programmatic and reimbursement provisions of the current home telehealth law; HCA will offer proposal options for achieving this goal.**

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Transition Support - continued

- **Provide Transitional Financial Support** – Home care providers are facing multiple and simultaneous transition demands compelled by state policy changes. Thus far, no program of financial support has been put forth to assist providers (who have no capital and whose negative financial margins continue to plummet) with the huge administrative and cost demands of transition (e.g., program/agency restructuring, professional/paraprofessional training, development of managed care partnerships, network affiliations, legal services fees, staffing impact, and many others). Over the years, both programmatic and financial assistance have been provided to hospitals, clinics, nursing facilities and other sectors in the case of such major, state-compelled transitions. Indeed, DOH has requested, and HCA supports, transition assistance for MLTCs as part of its 1115 waiver funding reinvestment proposal to CMS. **HCA requests that a similar allocation be included for home care agencies within this waiver reinvestment proposal, as well as the inclusion of financing in the state budget and HCRA pools for home care transition assistance.**

- **Continue to Support the Role and Future of the Long Term Home Health Care Program (LTHHCP)** – In approving the state's waiver amendment for mandatory enrollment, CMS has provided terms and conditions which carve out the LTHHCP as a continued, distinct care and service option for patients. In response, DOH has proposed to separately eliminate that option through an amendment to the 1915(c) federal waiver for the LTHHCP. **HCA supports the Legislature's ongoing support for the LTHHCP to remain as a distinct option and supports the Legislature's efforts to enact a legislative fix to ensure a stable, future role for the LTHHCP in the new paradigm.**

- **Support Partnerships and Collaboration in Health Care Delivery and Reform** – In the transition to a managed care and/or fully integrated environment, providers are seeking to establish partnerships and other collaborative relationships which promote efficiency, effective care transitions, care management, avoidance of preventable hospital/emergency room use and other health care goals. These collaborations are demonstrating significant clinical- and cost-effectiveness. Home care and hospitals in rural communities are currently working to explore such collaborations to address critical service needs and reforms in these areas. **HCA requests the Administration's and Legislature's support for the creation of such collaboratives, and urges designated financing for these initiatives in the state's 1115 waiver reinvestment plan, the 2013-14 state budget, and HCRA.**

- **Establish Quality Measurement, Assurance and Reporting Methods in the Managed Care-Home Care Context** – Rigorous quality measurement and assurance are critical for quality oversight of the care of post-hospital, chronically ill and disabled individuals. In the prior system, CHHAs and LTHHCPs have been required to report quality data and outcome measures to regulators. The same reporting is currently not required of MLTCs. Home care providers are concerned about how quality will be overseen, measured and reported in the new environment. Providers are also concerned about how their changed position under managed care will affect their patients' quality of care – and how a changing care-delivery system will affect the quality metrics by which providers continue to be evaluated. HCA understands that DOH has been modifying its quality metrics and reporting systems for managed care plans. **HCA requests a seat in the Department's technical discussions on quality metrics and reporting for the care of long term care/home care patients in managed care, and asks for the Legislature's active involvement in ensuring appropriate oversight, measures and reporting relating to these services in a managed care context.**

2. Regulatory Relief to Facilitate Services, Efficiency & State Policy

- **Revise and Streamline Regulations for Home Care Contracting and Service Delivery under Managed Care –** Home care standards and operating requirements must be made compatible with managed care, and streamlined for the efficient delivery of services. These regulatory revisions must be a state priority if the state's managed care policy is to be achieved (as identified in the "Transition Support" section earlier in this document).

- **Establish Clarity in the Compliance Roles of Home Care Providers and MLTCs/MCOs –** Under their separate regulatory and statutory requirements, home care agencies and health plans have many identical responsibilities for the care and treatment of patients. In the new environment, clarification of each entities' responsibilities is vital to not only prevent gaps in service or compliance but also to eliminate costly and wasteful expenditures. Clarification is also essential to ensuring a common understanding of compliance requirements by the plans, providers, the state Department of Health (DOH) and the state Office of the Medicaid Inspector General (OMIG). Due to the complexity of this issue, **HCA recommends the establishment of a technical workgroup that includes representatives of both the home care and managed care sectors to provide a constructive venue for sorting and articulating the lines and details of the respective health plan/home care agency responsibilities. HCA further recommends the adoption of any regulatory or statutory reforms to accomplish this goal.**

- **Allow Hospice-MLTC Collaboration in Patient Care –** Currently, state policies do not allow hospice/MLTC collaboration for the joint service of patients who simultaneously could benefit from hospice services and still require MLTC services. This is an artificial barrier to care and unnecessarily maintains silos between hospices and MLTCs. It is unjustifiable that a dying or pain-stricken patient should be forced to choose between hospice and MLTC should both services be required to meet the patient's needs. **HCA requests the Administration to adopt regulatory/procedural change to eliminate this barrier to hospice/MLTC collaboration in patient care. HCA also asks for the Legislature's support for administrative action or enactment of legislation if necessary.**

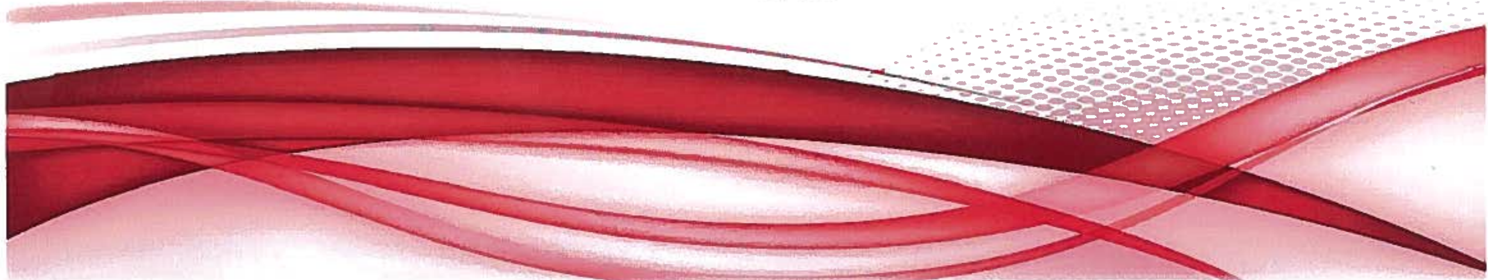
- **Provide Emergency Response Preparedness and Regulatory Relief –** Home care agencies play major roles in emergency preparedness and response efforts. Recent examples include the home care community's responses as front-line providers attending to very vulnerable elderly and disabled patients affected by Hurricanes Irene and Sandy. Regulatory policy changes and flexibility as well as fiscal support are critical to enabling home care agencies and personnel to reach and assist patients in dire need during emergencies. **HCA supports the policy attention to emergency response in the Executive budget and urges the Administration and Legislature to work with HCA, which will be advancing specific proposals (such as emergency access designation for home care personnel) to assist home care agencies' efforts to reach, service and help protect vulnerable, medically needy citizens during times of crisis.**

3. A Stable Fiscal Environment

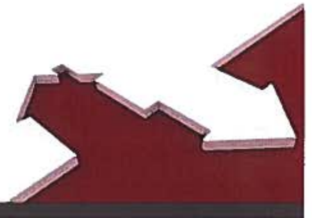
- **Provide for Adequacy of MLTC/MCO Premium and Home Health Agency Reimbursement for Services and Direct Care Personnel –** Payment of adequate premiums to MLTCs/MCOs, who in turn may appropriately reimburse providers for their services, is central to the viability of the state's managed care/home care policy. Mandatory enrollment of the long term care population carries prospects of adverse risk to the health plans as well as their contracting providers delivering services to severely medically needy populations. Rate adequacy is also critical for appropriate compensation for the home care workforce, which, in certain regions, must be compensated according to the Home Care Worker Wage Parity Law, and statewide is in dire need of expanded recruitment and retention investment to meet the growing need for services. Thus far, under mandatory enrollment, DOH has ensured at least some provisions for payment adequacy for services in New York City, at least to the extent of sustaining pre-managed care payment levels, including for wage parity; however, DOH has not committed to these or any other payment adequacy provisions for plans and providers outside of New York City. Such disparate treatment is unjustified and poses financial risk to the system's stability and the achievement of the intended state goals. **HCA requests the Administration's assurance of premium adequacy for managed care plans, with associated provisions for payment adequacy for services, care management and essential personnel by home care agencies. HCA asks for the Legislature's support for such Administrative action or, in absence, the enactment of legislation to accomplish this.**

- **No further erosion of the already plummeting, and worsening, financial base of home care agencies –** The past two years have seen unprecedented cuts in home care funding, on top of years of damaging, inadequate reimbursement for services. In addition, the Medicaid Global Cap, adopted as part of the 2011 state budget, incorporates deep projected cuts to home care agencies and services in the state, along with a host of cuts in other areas, and defers to the Commissioner of Health "superpowers" enabling the Commissioner to further reduce reimbursement or to make other design changes in the system should expenditures anywhere in the Medicaid program exceed the projections used in calculating the Cap. State reports calculate the reductions to home care at ***$197 million further below*** the massive cuts already enacted and projected as part of the first measured year of the Cap. These further reductions are all the more alarming considering that 79% of certified agencies are reporting negative financial status as of the most currently available cost report data. Home care cannot be sustained, let alone fulfill its needed role in the health care system, with a further degradation in its financial viability. **HCA urges the Administration and Legislature to resist any further erosion of the fiscal viability of the home care system in the budget negotiations or in post-budget actions affecting either payment or the level of already untenable unfunded mandates imposed upon this system.**

HCA
HOME CARE ASSOCIATION
OF NEW YORK STATE
388 BROADWAY
FOURTH FLOOR
ALBANY, NEW YORK 12207
PHONE (518) 426-8764



A Report on the Fiscal Health of Home Care in New York State



Key Findings

- **Home care provider margins plunge further into the red, threatening viability**. The percentage of home care providers with negative operating margins increased by an alarming 22% between 2010 and 2011, the most recent year of data available. In 2011, 79% of surveyed home care providers had negative operating margins.

- **CHHA operating margins drive deeper into the red**. The median operating margin of surveyed Certified Home Health Agencies (CHHAs) was -13.94% in 2011, a precipitous drop from 2010 when the median operating margin was -0.31% for survey respondents.

- **LTHHCPs face a unique threat to their financial and programmatic viability**. The median operating margin of surveyed Long Term Home Health Care Programs (LTHHCPs) was -11.47% in 2011. Between 2009 and 2010, total operating losses for all LTHHCPs increased from -$21.2 million to -$38 million, a 79% increase in operating losses.

- **Wide variances in contract rates and a lack of transition support are further jeopardizing provider sustainability even as home care agencies work to meet the state's mandatory managed care enrollment policy.** HCA's survey finds that the vast majority of home care providers are working in good-faith to establish contract partnerships with Managed Long Term Care (MLTC) plans and Managed Care Organizations (MCOs). **Yet in 2011, when the Medicaid fee-for-service (FFS) rate has historically proven inadequate, two-thirds of survey respondents indicated they are receiving MLTC and MCO rates well below the already insufficient FFS rates**. For those providers who receive rates below FFS, their MLTC rates are on average 8% below FFS and their MCO rates are on average 20% below FFS, further compromising the fiscal stability of home care providers, 79% of whom are already operating in the red under FFS. These results speak to the need for adequate payments to providers as well as adequate premium payments to plans for the provision of home care services. Meanwhile, when asked which supports are needed to contract with MLTCs/MCOs, "stronger continuity-of-service/transition policies" ranked second only to concerns about adequate payment.

Why These Findings Matter

Home care providers deliver cost-effective services to patients at home in the community, helping to keep individuals out of institutions and other higher-cost settings. However, in an increasingly worsening pattern, rates of reimbursement have not kept pace with the already economical cost of delivering these services to patients at home, threatening access to home care services and potentially causing hospitalization or higher-cost services for vulnerable patients whose health status may spiral downward without the needed in-home support.

Meanwhile, the state is embarking on a policy of mandatory enrollment in MCOs and MLTCs for the financing and authorization of home care services. To ensure success, this policy depends on a strong network of home care providers to deliver home care services. Continued erosion of the home care provider financial base seriously jeopardizes the success of this policy.

Executive Summary

A financial data and survey analysis conducted by the Home Care Association of New York State (HCA) using the most recent data available from independently certified and state-required cost reports finds that home care financial margins have plunged alarmingly into the red due to chronic reimbursement cuts and state policy changes that have eroded the financial base of home care providers in an environment where costs continue to increase.

These findings were most dramatic in 2011 when an already consistent trend of declining home care operating margins plunged sharply into negative territory. 2011 was also a year of unprecedented state budget cuts for home care combined with continuing new cost burdens – especially for wages and benefits – that are likewise tied to state budget policies.

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Executive Summary - continued

To put this in perspective, while the percentage of home care providers with negative operating margins grew from **63% to 65%** between 2009 and 2010 (a 3% increase), this percentage rocketed to **79%** in 2011 (a 22% increase), according to conservative estimates culled from an analysis of providers completing HCA's *2012-13 Financial Condition Survey* late last year and early this year.

In the case of surveyed CHHAs, median operating margins dropped from +0.3% in 2009 to -0.31% in 2010 and then dove to -13.94% in 2011.

In the case of surveyed LTHHCPs, median operating margins had a similar negative trend line: -6.3% in 2009, -7.21% in 2010 and -11.47% in 2011 at a time when long term care policy changes have just begun to squeeze the referral base of LTHHCPs and will continue to do so as long term care policy changes take hold.

Meanwhile, variances in negotiated contract rates and a lack of transition support continue to jeopardize the standing of providers in their efforts to meet state-initiated changes in the long term care system – changes that home care providers are striving to meet in good faith. These findings make clear the need for more adequate FFS payments to providers as well as premium payments to plans for the provision of home care services.

At present, New York's home care system is operating under three payment models during this time of transition. The first and primary of these is a FFS system that has been in place for decades, although subject to budget cuts slashing reimbursement to levels which have not kept pace with the cost of providing care, as is evident from prior-year financial studies in home care and in the findings of this report.

More recently, the state has embarked on two additional payment models: an episodic payment system for CHHA cases up to 120 days in duration; and enrollment of certain patient populations in managed care and managed long term care for the provision of services, with the ultimate goal of near-universal mandatory enrollment. Given that HCA's 2009, 2010 and 2011 cost report analyses largely reflect a FFS world, HCA focused much of our provider survey on the current experiences of providers as they begin feeling the effect of the movement toward mandatory enrollment, which is expected to be the dominant payment model for the long term care system in the future.

At a time when the vast majority of home care providers were already operating at a loss under FFS rates that were largely still in place from 2009 to 2011, HCA's survey finds that the negotiated rates between home care programs and MLTCs/MCOs were substantially lower than this already inadequate FFS payment in the vast majority of cases. Two-thirds of survey respondents indicated they are receiving MLTC and MCO rates below their FFS rates. For rates that are below the FFS rate – a rate of payment which is already contributing to negative margins for 79% of providers – MLTC rates are on average 8% below FFS, and MCO rates are on average 20% below FFS, further compromising the fiscal stability of home care providers.

What follows below are further details on the data-collection process and survey methods used in this study as well as further elaboration of these key findings.

Background on HCA's Data and Survey Analysis Methods

In late 2012, HCA conducted a survey of our home care provider members to assess the financial impact of prior-year reimbursement cuts and to find out what actions providers are taking as a consequence of these cuts and other Medicaid redesign initiatives that are dramatically changing the delivery of home care services in New York State.

HCA had also previously obtained from the state Department of Health (via a Freedom of Information Act request), the 2009 and 2010 cost report data for all CHHAs and LTHHCPs in the state, comprising a statewide universe of financial data in home care for these years.

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HCA HOME CARE ASSOCIATION OF NEW YORK STATE

Background - continued

In home care, all CHHA and LTHHCP providers are required to submit cost reports annually to the state as a financial basis for the state's Medicaid rate-setting process. These cost reports provide official, independently certified financial and statistical data related to all categories of an organization's revenues and expenses (not just for Medicaid, but for all payors). Given this array of reliable data, these documents are a fundamental instrument for gauging an organization's financial health, especially in the context of discussions about Medicaid policy.

To obtain more recent data – which is not yet publicly available from the Department of Health – HCA used our 2012-13 financial condition survey of providers to specifically ask CHHA and LTHHCP member agencies to submit an array of 2011 financial data based on their just-submitted 2011 Medicaid Cost Reports.

HCA's collection of 2009 and 2010 cost report data for all 250 CHHAs and LTHHCPs, coupled with the survey respondent data in 2011, offered HCA the most up-to-date set of data practicable for assessing the financial health of New York's home care industry. (Since the state uses two-year-old cost reports as a base for setting provider reimbursement rates, the 2011 cost report data – which providers submitted to the state during the summer of 2012 – are the most current data available.)

Licensed Home Care Services Agencies (LHCSAs) also participated in HCA's survey. These agencies provide vital training, recruitment, employment, oversight and direction predominately of paraprofessional caregivers who meet the needs of thousands of elderly, chronically ill and disabled patients in the home under contract with LTHHCPs, CHHAs, MLTC and MCO plans and local social service districts. Only LHCSAs that have personal care contracts submit cost reports. Therefore, LHCSA cost report data was not included in HCA's financial analysis. However, HCA did capture other important financial data and survey responses for LHCSAs based on separate measures further detailed later in this study.

Because the Medicaid Cost Report includes various revenue and expenditure data, HCA was able to use these reports as a basis for calculating aggregate provider operating margins (calculated as the difference between revenue and expenses) and median operating margins. The operating margin is a benchmark indicator of an agency's financial health.

Of the nearly 80 home care providers that answered HCA's survey, 45 CHHAs and LTHHCPs submitted detailed information from their 2011 cost reports. This 2011 data was then compared to: 1) the 2009 and 2010 cost report data HCA had obtained for all 250 CHHAs and LTHHCPs statewide as well as 2) the 2009 and 2010 cost report data for those providers answering HCA's survey.

In employing this method, HCA found that the 2011 cost report data from surveyed providers was not only consistent with the financial trends globally in home care, but the 2011 survey data actually provided a *conservative* reflection of the margins for all home care providers in 2011 since the providers answering HCA's survey tended to have more positive operating margins than the industry as a whole.

In addition to compiling cost report data, HCA also used our 2012 - 2013 survey to ask providers about other financial, operational, programmatic and strategic experiences occurring in the field as a consequence of prior-year reimbursement cuts and policy changes.

These questions focused on a few key policy and fiscal areas, including: the state's ongoing transition of Medicaid cases to MLTC and MCO plans; unfunded mandates and new administrative costs such as the Home Care Worker Wage Parity Law; and the impact of nearly $1 billion in Medicaid cuts during the past two years as part of the state's Medicaid Redesign Team (MRT) and state budget process.

Background on MLTC Enrollment Transition

In order to appreciate the information found in our survey analysis, one needs to understand the policy framework driving these outcomes.

The 2011-12 State Budget began a process of requiring that dually-eligible patients 21 and older needing more than 120 days of Medicaid community based long term care services must enroll in an MLTC plan. This process, also known as "mandatory enrollment," has already gone into effect for specific populations in New York City, and it has or is about to go into effect for Long Island and Westchester. The policy is expected to be systematically implemented statewide under a fluid timetable that depends on the state Department of Health's determination of MLTC services in a county, federal waiver authorizations, and other determinations, eventually redirecting thousands upon thousands of patients and the providers that serve them.

For home care providers, this policy means that many agencies (including those with long-established care-management experience and well-established roots in the community) will increasingly expect to operate in a subcontracting role, providing services to this patient population under contract with MLTCs or MCOs rather than directly functioning as the care managers for these patients and the Medicaid program.

As the state's own policy objectives make clear, home care providers are instrumental to the success of this endeavor because they form the core infrastructure and expertise needed to deliver and care manage the services to patients under contract with MLTCs and MCOs. Their capacity to serve patients – and, thus, their financial viability – is paramount.

Mindful of these trends, several of HCA's survey questions attempted to gauge the current and future financial impact of mandatory MLTC/MCO enrollment on vital front-line home care providers who are only now starting to feel the effect of this policy change – a change that will become even more profound as New York State progresses to statewide "mandatory enrollment" implementation.

Thus, in an environment where prior-year cost reports show that the vast majority of home care providers are *already* operating in the red when directly billing under Medicaid FFS – due to reimbursement rates reduced below provider costs, as otherwise found in our report – some of HCA's survey questions attempted to determine how providers' negotiated contract rates with MLTCs/MCOs compared with the rates that providers have been receiving under Medicaid FFS.

This comparison – married with cost report data otherwise obtained in HCA's analysis – provides a sense of: 1) home care provider financial experiences under Medicaid FFS and 2) how this experience may be further challenged under market conditions where negotiated rates fall even further below the FFS rates that have already proven inadequate in meeting provider costs.

Starting on the next page is a summary of four key findings from HCA's cost report and survey analysis overall.

HCA
HOME CARE ASSOCIATION OF NEW YORK STATE

Finding 1: Home Care Provider Margins Plunge Further into the Red, Threatening Viability

Home care providers are experiencing continued erosion in their operating margins due to a combination of reimbursement cuts and increased costs – a condition which is only expected to intensify with the continuation of these trends alongside the continuing, broad state Medicaid cuts and the application of the global Medicaid cap cuts, and the state's sweeping process of transitioning home care cases into mandatory MLTC/MCO enrollment.

An organization's operating margin is calculated based on the difference between revenue and expenses. HCA's membership survey found that the two highest-ranked impacts on provider Medicaid revenue are: 1) the "Effect of Payment Changes/Reimbursement Cuts" and 2) the "Transition to Managed Care." On the expenditure side, the biggest cost increases were for wages, benefits and unfunded mandates.

Wrote one survey respondent: "Salaries, benefits, contractual and other expenses are increasing. Federal and state mandates have been exponentially added. Reimbursement has constantly eroded over the past few years. Counties are leaving home health. Other providers will too. New York State will be left with large, multi-area entities who drive the services provided, likely without the same local interactions, quality and outcomes."

These and other findings are detailed below.

Operating Margins

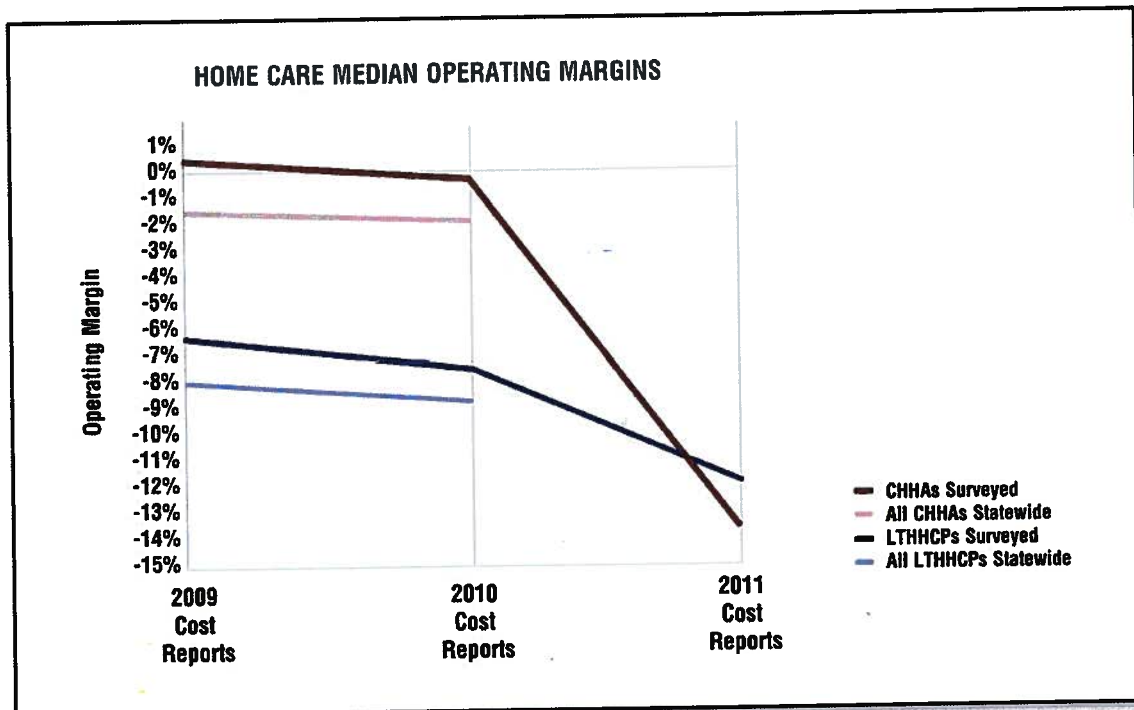
- HCA examined the 2009 and 2010 cost reports submitted by 45 providers that reported their 2011 data in our survey.

  The findings for these reported 2011 data are consistent with the trends globally in home care. For these survey respondents, the median operating margins dropped dramatically in 2011. In the case of CHHAs, the margins dipped from +0.3% in 2009 to -0.31% in 2010 to -13.94% in 2011. For LTHHCPs, the margins dropped from -6.3% in 2009 to -7.21% in 2010 to -11.47% in 2011.

  The table below and chart on page 6 illustrate these findings by comparing the median operating margins of surveyed CHHAs and LTHHCPs with the median operating margins from statewide cost report data.

Home Care Median Operating Margins

Provider	2009 Cost Report	2010 Cost Report	2011 Cost Report
All CHHAs statewide	-1.71%	-1.81%	
All LTHHCPs statewide	-8.1%	-8.771%	
CHHAs that completed HCA survey	+0.3%	-0.31%	-13.94%
LTHHCPs that completed HCA Survey	-6.3%	-7.21%	-11.47%
% of providers with negative operating margins	63%	65%	79%



- While 63% of CHHAs and LTHHCPs had negative operating margins in 2009 and 65% had negative operating margins in 2010, 79% of survey respondents had negative operating margins in 2011 – a sharp increase during a year of unprecedented budget cuts and policy changes.

- The number of all CHHAs and LTHHCPs experiencing operating losses greater than $500,000 increased 18% from 2009 to 2010.

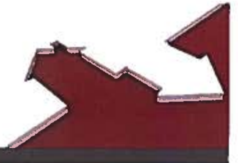
Revenue and Cost Impacts

- According to HCA's survey results, the top three factors having the "largest impact" on an agency's rising costs were: wages (66% of providers ranked it as "largest impact"); benefits (52%) and unfunded mandates (40%).

- Eighty-five percent of providers reported an increase in administrative costs due to state and federal audits alone.

- In response to the Wage Parity Law, in particular, 57% of providers have laid-off non-direct-care staff, 50% have stopped accepting cases where the contractor rate is inadequate to meet the costs of the unfunded mandate, 36% have reduced hours and overtime of direct-care staff and 7% of providers have laid off direct-care staff.

- Over the past two years, almost half of respondents had to use a line of credit or borrow money to meet expenses.



Finding 2: CHHA Operating Margins Driven Deeper into the Red

Cuts enacted in the 2011-12 State Budget have taken an enormous toll on CHHA operating margins at the same time that state policies ostensibly, and ironically, view CHHAs as critical components of the state's mandatory enrollment policy, as demonstrated in the state's recent request for applications (RFA) to open up the CHHA licensure process.

- The median operating margin of CHHAs was -13.94% in 2011. For the CHHAs that completed HCA's financial condition survey, the drop in median operating margins went from 0.3% to -0.31% in 2009 and 2010, consistent with historic trends, but then dropped precipitously to -13.94% in 2011 at a time when CHHAs were hit with unprecedented cuts, including the CHHA-specific expenditure cap.

Finding 3: LTHHCPs Face a Unique Threat to their Financial and Programmatic Viability

At the time of this writing, the state is seeking a 1915(c) waiver amendment to discontinue LTHHCP enrollment in areas where the "mandatory enrollment" policy is going into effect. LTHHCPs already report a substantial drop in referrals due to this policy which is further eroding their financial stability.

LTHHCPs have a long history of care management expertise of enormous value to partners in an evolving long term care system; these already efficient programs serve nursing-home-eligible patients at an average of 50% the cost of nursing home care. However, LTHHCP providers are facing what may be insurmountable hurdles to viability in this context of both inadequate payments and the mandatory enrollment paradigm.

While the policy trends initiated in 2011 are already affecting the LTHHCP, the Department of Health's latest plan to eliminate enrollment of the program's core patient population without securing the program's role and providing for effective transition support will have an exponentially greater impact in the immediate future if the Department's LTHHCP waiver/policy intentions become a reality.

HCA's findings are detailed below.

- Between 2009 and 2010, total operating losses for all LTHHCPs increased from -$21.2 million to -$38 million, a 79% increase in operating losses during this period.
- The percentage of LTHHCPs reporting negative operating margins was 74% in 2009, 75% in 2010 and 77% in 2011.
- When providers were asked what changes they have made or expect will occur in order to prepare for subcontracting, 41% of respondents said they will phase-out or alter the use of their LTHHCP.

Finding 4: Wide Variances in Contract Rates and a Lack of Transition Support are Jeopardizing Providers in their Efforts to Meet the State's Mandatory Managed Care Enrollment Policy

Home Care providers are striving to participate in the state's plan for mandatory managed care enrollment. When asked several different ways about actions they have already taken or are planning as a result of past payment cuts or Medicaid redesign initiatives, the vast majority of providers answering HCA's survey said they had finalized or were pursuing MLTC/MCO contracting, but this process – for providers and plans alike – has been hobbled by a lack of transition guidance, lack of necessary regulatory changes, and already inadequate Medicaid payment rates from which contract negotiations are based.

Continued on next page

HCA HOME CARE ASSOCIATION OF NEW YORK STATE

Finding 4 - continued

Despite providers' good-faith efforts to support the state's mandatory enrollment policy, our survey reveals that contracted rates of payment under managed care are most often significantly lower than the FFS rate, which is already so inadequate that 79% of providers were operating in the red in 2011. Meanwhile, more than half of respondents have, or expect to, "reduce[d] staff and other expenses to become more efficient" as a means of participating in a mandatory enrollment contract arrangement.

Beyond the need for consistent rates of payment, providers seek additional transition supports to make contracting work for their organizations. Wrote one respondent to HCA's survey: "LTHHCPs need clear operating guidelines and possible changes in regulation to be able to compete in this new care environment."

These and other findings are detailed below.

- Providers are working to pursue contracts with MLTCs/MCOs. When asked "Have you, or are you planning to, contract with an MLTC/MCO to provide home care services?" almost 90% of providers answered "Yes".
- Yet, a state policy of chronic Medicaid under-payment and unclear transition guidelines nevertheless puts home care providers at risk even in cases where they are able to contract for services. Two-thirds of survey respondents indicated they are receiving MLTC and MCO rates below a FFS rate that is already inadequate; in many cases, the variance in contracted rates is substantial and inconsistent. For those rates below FFS Medicaid – under which nearly 80% of providers are operating in the red in 2011 – the MLTC rate is on average 8% below FFS Medicaid and the MCO rate is on average 20% below FFS Medicaid, with one respondent experiencing a rate difference as high as 50% below FFS.
- Overall, the transition to mandatory enrollment has affected agency finances at a time when the vast majority of providers were already operating at a loss: While most providers ranked "payment cuts/reimbursement changes" as the number 1 reason for a recent decrease in Medicaid revenues, "transition to managed care" ranked as the number 2 reason affecting most providers' Medicaid revenues.
- When asked which transition supports are needed to make it possible for providers to contract with an MLTC/MCO, the need for payment adequacy was rated highest by respondents, followed by "stronger continuity-of-service/transition policies" and then "staff retraining funds or support."

Conclusion

HCA's 2012-2013 cost report and survey analysis provide the most current information to date on the financial standing of New York's home care industry. While previous studies have shown a trend of under-reimbursement resulting in a consistent decline in home care provider operating margins, the data for 2011 reveals the starkest decline yet in the overall financial health of home care agencies at a time when the state has enacted unprecedented cuts and changes to the delivery of home care services.

Even while home care providers are clearly striving to work as partners in the state's effort to redesign the long term care system, past funding cuts, new and increasingly onerous mandates, an overall lack of transition and funding support or clear operating guidelines in the state's move to mandatory enrollment, and other factors have all worked in a counter-productive way to greatly hinder the efforts of home care providers in navigating this new system of care management on behalf of patients in the community.

HCA urges state policymakers to work with the home care community on a comprehensive set of transition supports, regulatory reforms, operating guidelines and funding assistance to ensure the sustainability of New York's vital home care infrastructure, which has been cultivated over time to: effectively manage long term care, help patients avoid higher-cost care, support care transitions, assist family caregivers and maintain the patient's quality of life.

388 Broadway
Fourth Floor
Albany, New York 12207
Phone: (518) 426-8764