HCA
HOME CARE ASSOCIATION
OF NEW YORK STATE

Joint Legislative Public Hearing

On the 2015-2016 Executive Budget Proposal

Health and Medicaid

Testimony of the
Home Care Association
of New York State

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February 2, 2015

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Introductory Remarks

Thank you, Chairmen and members of the Joint Committee.

I'm Al Cardillo, Executive Vice President of the Home Care Association of New York State (HCA) testifying today on behalf of HCA. HCA appreciates this opportunity to present the home care community's priority needs and recommendations for the State Budget.

HCA is the statewide association representative of nearly 400 health care providers, organizations and individuals involved in the delivery of home and community-based care services to hundreds of thousands patients throughout New York State. HCA's provider members comprise the continuum of home care services, including Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Licensed Home Care Services Agencies (LHCSAs), Managed Long Term Care Plans (MLTCs), Hospices and waiver program providers.

Structure of Testimony

Our testimony will:

- Highlight the current state policy and health system context, in which the state and health system leaders are significantly looking to home care, in partnership with hospitals, physicians and others, to help drive new models and goals for health care improvement and efficiency for New Yorkers.

- Describe several key actions necessary to help equip home care to fulfill these goals that the Legislature and Executive can take in the 2015-16 state budget.

- Offer perspective on various Executive Budget proposals affecting home care, as well as on those which could be modified to include home care in the support being offered to other sectors.

Home care is being asked to assume a major role in the state's reform plans and models; home care is eager to respond, and asks your help for key legislative and budget actions to help equip providers and health plans to fulfill the state's goals.

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To further detail for you the priorities areas that I am highlighting for you today, we have appended to this testimony our document: ***Driving Health Care Improvement and Savings Through Home Care*** - *2015-2016 State Budget Actions Needed to Equip Home Care to Meet State Goals and Citizens' Needs*.

Also appended is HCA's just published financial condition report on the state of home care. This document, entitled ***Home Care Financial and Program Support Vital for Success of New Care-Delivery Models,*** is an analysis of providers' certified cost reports, Medicaid managed care plan operating reports (commonly referred to as "MMCORs"), State Department of Health home care statistical reports, and results and perspectives from a home care provider survey conducted by HCA.

In sum, the financial condition report reveals the continued, severely compromised financial status of home care agencies, especially driven by: (i) the Medicaid payment system and severe cuts that have been rolling from year to year, and indeed are again proposed for continuation in the Executive's budget; (ii) ongoing, piling of unfunded mandates; (iii) service to needier and costlier patients, and (iv) further reimbursement reductions resulting from the replacement of state-set rates to rate negotiation with managed care plans, which is deriving rates 7-13% below already under-reimbursed state-set service rates. (We note that rates are more severely reduced from those managed care plans who are similarly in a negative financial position under Medicaid, due to funding inadequacies.) These factors combine with the fact that our state's home health agencies have been subject to negative Medicare margins for 12 straight years.

The report provides important information in tandem with the our budget proposals as it gives evidence of the need for the state's support to enable home care to fulfill state policy goals as well as to meet the continued, increasing need for care by medically needy children, adults and elderly New Yorkers.

I commend both of these documents to your consideration as part of this formal testimony and to serve as a resource for you and your committee staff in further assessing our recommendations.

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Driving Health Care Improvement and Savings through Home Care

Current State Policy and Program Context

State, national and health system leaders are turning heavily to home care to help drive an agenda of health improvement, quality and cost savings.

Home care providers are being commissioned for this task through their vital partnerships with hospitals, physicians, and other stakeholders in achieving the 'triple aim' of better care for individuals, better care for health populations, and cost-effective service utilization.

Home Care's Vital Role in New Priority State Policies and Health Care Models

Home care is vital to new, priority state policies, and to the evolving health care delivery and payment models, which include:

- The state's mandated enrollment and care management of individuals in managed care.
- Operation of the state's new Fully Integrated Duals Advantage (FIDA) program, implemented on January 1, 2015.
- Implementation and operation of the Delivery System Reform Incentive Payment (DSRIP) program, beginning in April.
- Avoidance of preventable hospital readmissions, and in turn, avoidance of state and federal financial penalties that would otherwise be applied to hospitals.
- Successful implementation of the state's health home initiative.
- New Executive state budget proposal seeking to move the entire health payment system in the state to a Value Based Payment model, which is also part of the state's terms and conditions for receipt of $8+ Billion in federal aid to New York under the state's Medicaid waiver agreement.
- And more.

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Home Care Vital to Medically Needy New Yorkers

Of course, home and community based care continues to be the overwhelming preference of medically needy individuals seeking to remain independent and healthy at home, as well as their families.

Home care's reach is not solely the in-home visit, but it's expertise extends support across the continuum, from linking with hospitals to assist care transitions, to partnering for emergency room diversion programs, to partnering with primary care practices for patients' medical management, to providing health care access to remote rural and inner-city residents, to conducting local public health services, to providing care management and support for health plan enrollees, and more.

Home care is also uniquely situated to help address the extremely challenging and costly public health problem of populations with treatment disparity (who due to certain factors are without sufficient care, unnecessarily suffer morbidity and mortality, and trigger high system costs). HCA is currently undertaking an initiative with other partners to address through home care some of the challenges and gaps in the care of veterans; next week, HCA and the New York State Health Foundation will be conducting a roundtable to further assess and identify recommendations for follow-up.

For the sake of better health, lower costs and improved system operation, home care must be available, supported, and at the ready.

2015-2016 State Budget Actions Needed to Equip Home Care to Meet State Goals and Citizens' Needs

New York's home care community asks the Executive and Legislature to adopt the following support measures so that home care can best fulfill the state's intended service, health outcome and cost-reduction policy goals, and ultimately the needs of New York's citizens.

1. Finance and Incentivize Health Information Technology and Clinical Technology Development – Connecting and Unleashing Home Care Innovation and Integration

Health information technology (HIT) and clinical technology are at the core of every aspect of health facility/agency operation; they are integral to service delivery, quality evaluation and outcomes, cost-effectiveness and administration.

Technology, especially HIT and provider connectivity to other health system partners, is vital to the success of the state's reform policies and new care models.

However, state, federal and private payors have long overlooked home care in allocating support for HIT development.

Last fall, HCA in collaboration with the New York e-Collaborative (NYeC), the Healthcare Association of New York State (HANYS), the Iroquois Healthcare Alliance (IHA) and Greater New York Hospital Association (GNYHA), launched a hospital-homecare HIT partnership to help advance and guide HIT connectivity between sectors, beginning with low capital methods for meeting hospitals' phase 2 "meaningful use" requirements. This demonstrates home care's commitment and collaboration to move the system forward, but without further support is only a toe in the water.

HCA followed with a 10+ point HIT support plan for home care, submitted to the State Health Department, and which we will submit to the Legislature and Executive for adoption in the 2015-16 state budget.

HCA respectfully asks the Legislature and Executive to incorporate provisions in the 2015 state budget to invest in health information technology and integrated clinical technology for home care. Technology investments should be targeted to promote health care quality, cost-effectiveness, care management, and integration of home care within provider systems, between sectors, and with regional and statewide health information systems.

HCA's 10 point HIT plan outlines mechanisms for providing these investments, including through adjustments to managed care and managed long term care

premiums, adjustments to provider fee-for-service rates, the addition of technology investment as a criterion for quality incentive payments to managed care plans, inclusion of technology investment as an explicit expectation of all Performing Provider Systems seeking DSRIP funds, and other measures.

2. Modernize State Health Insurance Coverage Statute to Reflect Home Care's Current Role and Innovation

The current home care coverage provisions, adopted in the early 1970s, were designed for the health care system at that time.

In that era, hospitals were reimbursed per diem and without today's limitations on length of stay; nursing homes were the primary option for chronically ill patients who lacked family support; and home care itself occupied a very narrow niche versus its heavily relied-upon, core role in today's system. Simply put, the type of system that framed these original insurance provisions bears little resemblance to the health care system of today.

Modernization of this law would greatly improve patient access to care, facilitate the efficient and effective operation of our health care system, and help avoid cases of Medicaid spend-down/long term institutionalization of patients.

HCA respectfully asks the Legislature and Executive to incorporate provisions in the 2015 state budget to modernize the long-outdated insurance law coverage provisions for home care, which would support patients, the overall system and Medicaid savings.

3. Ensure Adequate and Efficient Managed Care-Home Care Provider Payment

The current state payment structure for the managed care-home care model needs updating and reinforcement in order to support the system's service goals and requirements. This system could also be revised to incorporate further new and needed efficiencies in billing and payment for plans and providers, as well as to better provide for workforce stability and other public health infrastructure needs.

As an example of the managed care-home care payment challenges, the 2014-15 adopted state budget included over $350 million for infusion into the managed care-home care payment system to support the increased costs of the state's home care aide wage parity law. Subsequent to the budget, additional funds were allocated, recognizing that the $350 million would still not adequately fund worker wages and agency costs under the mandate. However, even with these additional adjustments, the mandate is still underfunded. Moreover, these funds which were needed by agencies and managed care plan on April 1, 2014, have yet to be substantially provided. Indeed, the fully adjusted 2014 premium levels for managed long term care plans, which are supposed to be in force as of last April 1, have yet to be provided. Managed care plans and providers in the meantime, must deal with this still-further inadequacy of payment.

The Department's direct payment methodology for home care similarly needs responsiveness to the changing system and infrastructure needs. This methodology is otherwise the subject of a proposal in this Executive budget, which we will further address in this testimony.

Payment standards must be developed which ensure that managed care premiums and provider payment rates are adequate to meet the needs of: enrollee services, maintenance of a qualified home care workforce, and "public goods" (such as staff training, capital, public health, etc.). These standards should further ensure coverage of state mandates on health plans and providers, like the wage parity law requirements, the state's pre-claim "visit verification" requirement, costs for the Advanced Home Health Aide designation proposed in the Executive budget (and subsequently discussed in this testimony), and other mandates.

The managed care/home care financing system could further be updated to promote efficiency as well, such as by: (i) supporting the incorporation of the home telehealth program in the managed long term care model; (ii) streamlining billing and payment procedures for providers and plans through the development of a system of standardized codes, uniform bills and/or other procedural efficiencies; and (iii) addressing, through various incentives (such as through the managed care quality incentive pool) and other means, adherence to prompt-pay/clean claim payment standards.

With regard to direct agency payments, the Department of Health is working on a rebasing of the Medicaid payment methodology for certified home health agencies, the outcome of which will be crucial for both certified agencies and subcontracting licensed home care services agencies. I will further address the Executive's rebasing proposal, potential issues and opportunities for support in the ensuing portions of the testimony.

HCA asks the Legislature and Executive to add provisions in the 2015 state budget to ensure that rate methodologies for managed care and managed long term care premiums, as well as the ensuing payments to providers, are adequate to meet plan/provider/ patient needs and fulfill state public health goals and mandates. The same standard is also necessary in the state's direct payment to providers.

Senator Hannon and Assemblyman Gottfried have previously proposed budget proposals and free-standing bills that provide a foundation on which to build critical payment system improvements. These could also be explored in relationship to the Executive's other reimbursement reform proposals which the Governor has already included by in this budget.

Comments on Executive's Payment Proposals in the Budget

Executive's Proposed Value Based Purchasing (VBP) Initiative

The Executive budget proposal seeks sweeping change to the overall health care payment system in the state. The proposal aims to convert Medicaid, Medicare and eventually private/third-party payments into a "value based payment" (VBP) system.

The VBP proposal requests broad authority for the State Health Commissioner to "utilize reimbursement methodologies that are value based," as well as to authorize managed care plans, Performing Provider Systems operating under the Delivery System Reform Incentive Payment (DSRIP) program, and combinations of participating contracting providers to implement VBP.

Under the terms of its $8+ billion federal reinvestment waiver, the Department of Health agreed to move to a VBP model, by waiver year five (the end of 2019),

with the target that all managed care organizations must employ non-fee-for-service payment systems that "reward value over volume" for at least 90 percent of their provider payments.

The Department is now working on a timetable for submitting a VBP plan to the U.S. Centers for Medicare and Medicaid Services (CMS) before April 1.

To explore critical components of VBP models, the Department has recently convened a workgroup that taps the participation of HCA and representatives of the health care continuum. HCA appreciates our inclusion on this workgroup and the opportunity to work with the Department in these critical discussions.

HCA supports reimbursement innovations that better connect payment, care and quality, as well as promote the broader community health – advancing the triple aim. In this regard, however, we also recognize the extreme complexity and implications of the scope, timeline, applicability, designs, and implementation process that a reimbursement change of this nature and magnitude entails. There is need for very careful and controlled steps in such a process. Indeed, while there is great opportunity for innovation and improvement through a VBP model, there are also major risks and high-stakes for the health system and the patients.

HCA, together with association colleagues, have just provided an initial round of comments and recommendations to the Department on its draft "Roadmap" to VBP, and HCA has also followed with additional comments on behalf of the home care sector specifically.

HCA asks the opportunity for continued, very close work with the Department and the Legislature to effectively and prudently shape the Executive's VBP budget proposal.

CHHA Episodic Payment System (EPS) Rebasing

The Executive Budget proposal seeks to make the CHHA Episodic Payment System (EPS) permanent and to update the base year from 2009 to 2013. The current authorization for CHHA EPS expires on March 31, 2015, and DOH has indicated that there may be an extension of the current EPS system past

March 31, 2015, so providers have sufficient time to make any changes.

The Executive's intention is to incorporate a steeply reduced aggregate Medicaid funding level for CHHAs as triggered by rebasing. Aggregate CHHA EPS funding has additionally diminished due to the transition of long term CHHA patients into managed care.

DOH indicates that the rebasing calculations and methodology are still in process, and that because of the significant changes to the CHHA Medicaid claims data in 2013 compared to the original EPS base year of 2009, there will be changes to the CHHA EPS Base Price, as well as revised case-mix weights in the Medicaid Grouper and possibly revised Age Groups.

HCA has expressed concerns that the Department needs to give CHHAs sufficient time to make any necessary changes to their software billing systems in order to avoid billing problems and any potential cash-flow issues.

HCA has further urged DOH, and asks the Legislature and Governor, to incorporate language in the state budget for base-rate or rate add-on adjustments for critical home care investment, such as for health information technology, clinical technology, training and other essential needs for participation in the state's new models.

Continuation of Medicaid Redesign Team (MRT) actions, and of rolling cuts to home care

The Executive budget continues the MRT actions and repeated, rolling cuts to home care. This includes proposals to make the Medicaid Global Cap and many other prior actions permanent. HCA urges the Legislature and Executive to reconsider and not permanentize these cuts. With regard to home care specifically, the financial condition of the home care system necessitates relief and recovery from these cuts if home care is to operate with viability and play its role in fulfilling the state's overall health care goals.

New Health Care Infrastructure Investments in Executive Proposal – Please also include Home Care

The State budget includes funding for a series of new initiatives for hospitals, nursing homes and clinics. Thus far, home care is not an explicit part of this budget language, nor are there other proposals in the Executive's proposal to address home care-managed care regulatory and payment needs.

The newly proposed Executive initiatives include:

- **Sole Community Hospital Payment Enhancement Program** – The Executive proposes up to $12 million for sole community hospitals (as defined by the Medicare program) for enhanced payments or reimbursement for inpatient or outpatient services for the purpose of promoting access and improving quality of care.

- **Vital Access Carve Out for Clinics** – The Executive proposes to increase the Vital Access Provider (VAP) carve-out for Critical Access Hospitals as from $5 million annually to $7.5 million annually.

- **VAP Funds for Rural Areas** – The Executive proposes to add $10 million in VAP funding for hospitals, nursing homes and clinics serving rural areas and isolated geographic regions.

- **New Capital Development** -- The Executive Budget provides $1.4 billion in new investments to "make infrastructure improvements and provide additional tools to stabilize health care providers to advance health care transformation goals."

- **Disaster Preparedness Demonstration Program for Nursing Homes** – The Executive proposes to authorize an energy efficiency and/or disaster preparedness demonstration program for nursing homes. HCA has been advocating emergency preparedness funding across the continuum and will urges broad based emergency preparedness funding in the budget.

<u>HCA asks the Legislature and Executive to include home care within these or parallel initiatives to assist the home care system</u>.

4. Aligning and Streamlining Home Care-Managed Care Regulation

In 2011, the State Legislature and Governor enacted an MRT policy change mandating enrollment of long term care patients into managed care, and ultimately all Medicaid recipients into managed care. The mandate affecting home care calls for managed care plans and home care agencies to contract with one another for the delivery and financing of care.

The regulatory and procedural provisions for managed care and home care however continue to govern each sector as if they were still functioning under the former paradigm, rather than reflect the new contractual model. This lack of regulatory realignment to the new model has left in place overlapping, conflicting, confusing, excessive and costly duplication of requirements and procedures.

In 2013, the Legislature and Governor created, and in 2014 renewed, a Home and Community Based Care Regulatory Workgroup to make recommendations on alignment and streamlining of regulations for the new system. Additionally, a coalition of state health associations has been working diligently to support this effort. The Department should be given the authority and directive to act promptly and thoroughly on the workgroup's and provider/health plan association recommendations.

HCA asks that the Legislature incorporate provisions in the 2015 state budget to ensure specific DOH waiver authority and ability for expedited directives to implement clarifying, realigning and streamlining recommendations made by the State Home and Community Based Care Workgroup.

5. Facilitating Home Care Innovation and Participation in New Models

The state has created and encouraged formation of new models and partnerships for care and innovation. Elimination of barriers and enactment of supportive statutes would help to facilitate participation for home care and other partners.

HCA asks the Legislature and Governor to incorporate provisions in the 2015 state budget to facilitate home care innovation and participation in new models and partnerships for care, such as: with hospitals, physicians, long term care

facilities, behavioral health, and others; participation in ACOs and Health Homes; home care-housing/community service combinations; telehealth innovation; new innovations in care and agency service lines, and other.

Toward this goal, HCA strongly supports legislation introduced by Senator Kemp Hannon and Assemblywoman Aileen Gunther S.1110/A.2011. The legislation would establish a specific section of the Public Health Law devoted to programmatic, financial and regulatory flexibility support for collaboration programs among hospital, home care, physician, nursing home and/or other partners working together for improved care delivery, infrastructure and/or cost-effectiveness. The now-launched Delivery System Incentive Payment (DSRIP) program in fact borrowed elements of this bill which HCA and Iroquois brought to state leaders back in 2013. The partnership initiatives under the bill would be flexible and diverse.

6. Quality Enhancement – Finance and Incentivize Advances and Innovation

Many opportunities exist for the state to pursue quality advancement and cost-savings through investment and support of home care best practices, clinical protocols, clinical pathways, evidence-based practice, technology, staff training/specialty care development, quality risk assessment, quality benchmarking, and other initiatives.

In particular, the HCA Quality Committee has developed truly cutting-edge proposals for home care quality advancement in all of these areas. However, no dedicated funding pool has been provided for home care to help seed these quality innovations, which would carry benefits to all sectors – and, above all, benefits to patients.

HCA asks the Legislature and Governor to add provisions to the 2015 state budget, including allocation of funding, for quality innovation and enhancement for home care.

The Executive Budget proposal authorizes the Commissioner to establish a General Hospital Quality Pool for the purpose of incentivizing and facilitating quality improvements in hospitals. HCA urges applicability of that pool or establishment of a parallel pool for home care.

Comment on Executive's Proposed "Advanced Home Health Aide"

Again this year, the Executive budget proposes to provide an exemption to the Nurse Practice Act for advanced home health aides, which authorize these aides to perform advanced tasks in home care and hospice settings with appropriate training and supervision.

HCA has previously worked with the Legislature, Executive, home care community and New York State Nurses Association to craft legislation that would enable registered professional nurses, in conjunction with the consumer, to instruct and direct home health aides to perform services permissible under the Nurse Practice Act similar to a family member.

The Executive's proposal takes a different route, instead creating a separate exemption to the Nurse Practice Act for the proposed new level of advanced home health aide, and to set forth the scope, duties, qualifications, training, supervisions and other criteria by State Department of Health regulation.

HCA and others have been participating on a State Department of Health workgroup to help identify acceptable tasks, qualifications and other criteria.

HCA strongly supports the efforts to derive expanded roles for home health aides, especially as commensurate with the evolving health care system.

To date, many outstanding issues – including regulatory, fiscal, procedural, liability, and other – have been raised in the workgroup in relation to the Executive proposal, and critical areas remain outstanding at this time.

HCA looks forward to continued collaboration with the Executive, and opportunity for close work with the Legislature, to arrive at a workable proposal and implementation plan.

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Concluding Comments

HCA appreciates this opportunity to advance these perspectives and our related to the Executive Budget.

HCA will be submitting language as necessary in support of our home care proposals.

HCA looks forward to continued engagement with the Legislature and Executive on these and other relevant areas of the budget.

We stand ready to assist with any information that we can provide to you.

Thank you.

Attachments:

Driving Health Care Improvement and Savings Through Home Care

Home Care Financial and Program Support Vital for Success of New Care-Delivery Models

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Driving Health Care Improvement and Savings Through Home Care

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Home Care's Core Role in New Policies and Care Models

State, national and health system leaders are all turning to home care to help drive an agenda of health improvement, quality and cost savings. Home care providers are being commissioned for this task through their vital partnerships with hospitals, physicians, and other stakeholders in achieving the 'triple aim' of better care for individuals, better care for health populations, and cost-effective service utilization.

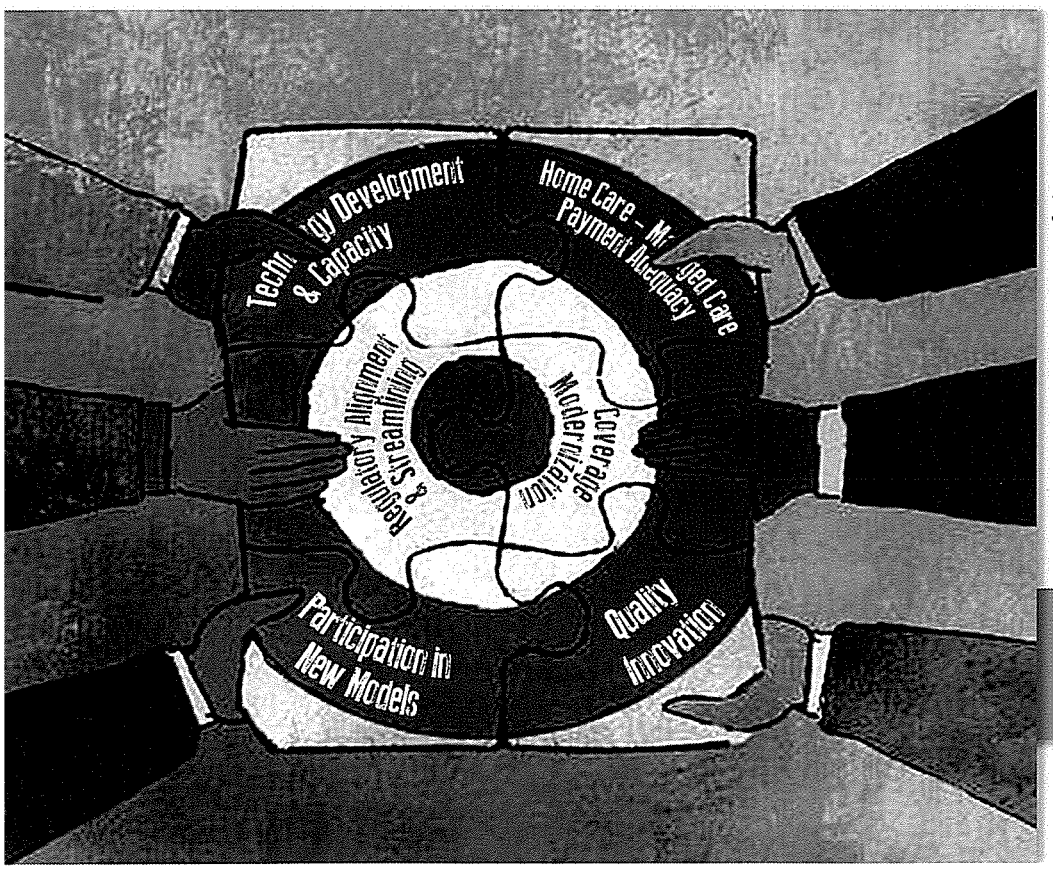
This overall policy vision assumes a core role for home care in virtually every major care model and cost-savings initiative. Home care providers are being asked to: coordinate and provide services to high need/complex care cases, help improve patient care transitions, prevent avoidable hospitalizations and long term care institutionalization, provide service access to remote and under-served populations, and more. Policy leaders are counting on home care's expertise and innovation for solving some of the most serious, costly and priority concerns plaguing the health system. The success of numerous priority initiatives hinges on a well-functioning home care system.

Home Care is vital to:

- The state-mandated enrollment of individuals into managed care;
- Operation of the state's new **Fully Integrated Duals Advantage (FIDA)** program, implemented on January 1, 2015;
- Implementation and operation of the **Delivery System Reform Incentive Payment (DSRIP)** program, beginning in April;
- **Avoidance of** state and federal financial penalties on hospitals for **readmissions**;
- Successful implementation of the state's **health home initiative**;
- and more.

The dependence on home care in today's policy environment is exceeded only by the direct and increasing needs of elderly, chronically ill and disabled individuals looking to home care as a means to remain independent and healthy at home, especially as the population ages.

For the sake of better health, lower costs and improved system operation, home care must be available, supported, and at the ready.



2015-2016 State Budget Actions Needed to Equip Home Care to Meet State Goals and Citizens' Needs

Driving Health Care Improvement and Savings Thr

Enabling Home Care to Fulfill the State's Health Program Goals and the Needs of NYers

New York's home care community asks the Executive and Legislature to adopt the following support measures so that home care can best fulfill the state's intended service, health outcome and cost-reduction policy goals, and ultimately the needs of New York's citizens.

Health Information Technology and Clinical Technology Development – Connecting and Unleashing Home Care Innovation and Integration

Requested State Action:

Finance and Incentivize Home Care Technology

Incorporate provisions in the 2015 state budget to invest in health information technology and integrated clinical technology for home care. Such technology investments should be targeted to promote health care quality, cost-effectiveness, care management, and integration of home care within provider systems, between sectors, and with regional and statewide health information systems.

These home care technology efforts can be accomplished through adjustments to managed care and managed long term care premiums, adjustments to provider fee-for-service rates, the addition of technology investment as a criterion for quality incentive payments to managed care plans, inclusion of home care technology investment as an explicit expectation of all Performing Provider Systems seeking DSRIP funds, and other measures.

Why it is needed:

Health information technology and clinical technology are at the core of every aspect of health facility/agency operation; they are integral to service delivery, quality evaluation and outcomes, cost-effectiveness and administration. However, state, federal and private payors have long overlooked home care in the health IT development arena, even though virtually every new state policy and care model requires this kind of technology infrastructure and interoperability to succeed.

Update Health Coverage/Payment Innovation to Reflect Home Care's Current Role

Requested State Action:

Update State Insurance Law Provisions for Home Care

Incorporate provisions in the 2015 state budget to modernize the long-outdated insurance law coverage provisions for home care, which would support patients, the overall system and Medicaid savings.

Why it is needed:

The current home care coverage provisions, adopted in the early 1970s, were designed for the health care system at that time. Back then, hospitals were reimbursed per diem and without today's limitations on length of stay; nursing homes were the primary option for chronically ill patients who lacked family support; and home care itself occupied a very narrow niche versus its heavily relied-upon, core role in today's system. Simply put, the type of system that framed these original insurance provisions bears little resemblance to the health care system of today.

The time is ripe for insurance reforms to: eliminate artificial limitations; create a framework that reflects today's home care service structure; and cover home care/partner innovations in care transitions, care management, telehealth, etc. These changes are essential to patient access, the efficient and effective operation of our health care system, the lowering of costs and the avoidance of Medicaid spend-down/long term institutionalization for many patients.

Ensuring Adequate and

Requested State Action:

Amend the Manage

Incorporate provisions in the 2015 s
managed long term care premiums,
plan/provider/patient needs and fulfill
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Why it is needed:

The current state payment structure
service goals and requirements. It als
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companionship exemption, the state
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With regard to direct agency payment
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Aligning and Streamlini

Requested State Action:

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implement existing recommendations a
Care for streamlining and aligning mana

Why it is needed:

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rebasing the Medicaid payment methodology for certified ıe payment level and responsiveness to critical needs) will g licensed home care services agencies.

Care-Managed Care Regulation

lexibility & Fix for this Model

o add specific DOH waiver authority and directives to by the State Workgroup on Home and Community Based ıe care regulations.

policy that mandates enrollment of long term home care aged care plans and home care agencies to contract with lowever, the regulatory provisions for managed care and ector in fragmented silos, rather than reflect the new This lack of realignment has left in place overlapping, ɔn. In 2013, the Legislature and Governor created, and in re Regulatory Workgroup to make recommendations on new system. Additionally, a coalition of state health this effort. The Department should be given the authority the workgroup's and provider/health plan/association

islative, budget and/or administrative language hese critical home care proposals.

Facilitating Home Care Innovation & Participation in New Models

Requested State Action:

Amend the Law to Encourage Innovation & Remove Barriers

Incorporate provisions in the 2015 state budget amending Article 36 and respective portions of the Public Health Law to facilitate home care innovation and participation in new models and partnerships for care, such as: new types of home care partnership initiatives with hospitals, physicians, long term care facilities, behavioral health, and others; participation in ACOs and Health Homes; home care-housing/community service combinations; telehealth innovation; new innovations in care and agency service lines, and other.

Why it is needed:

The state has created and encouraged formation of new models and partnerships for care. Such partnerships include home care and behavioral health providers, physicians, nursing homes, hospitals and others. In keeping with the state's assumption of a prominent role for home care in these designs, the governing statutes should be amended to better promote home care's participation and innovation.

Quality Enhancement

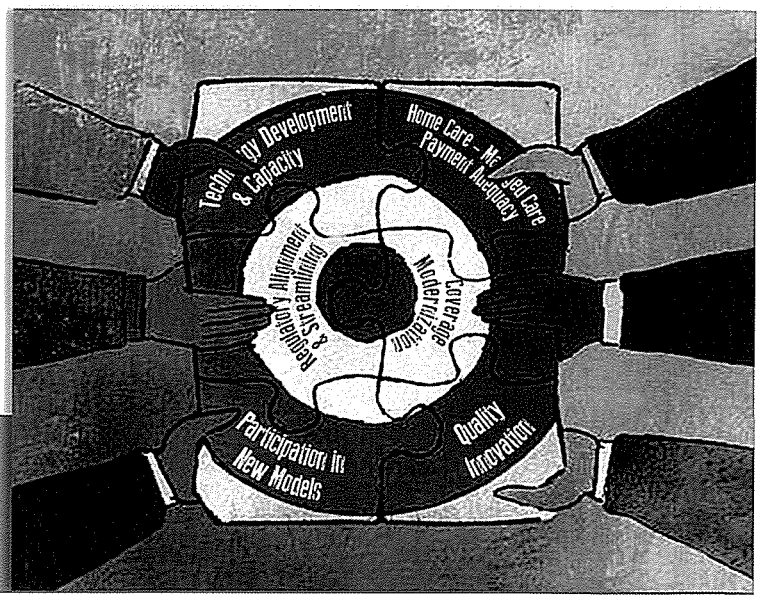
Requested State Action:

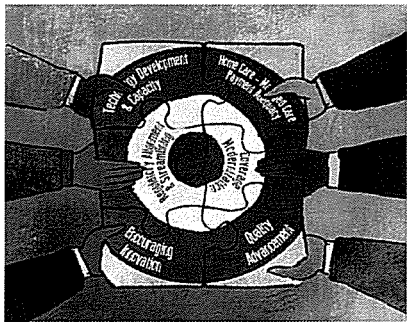
Finance and Incentivize Advances & Innovation in Quality

Incorporate in the 2015 state budget some set-aside funds and programmatic provisions for quality innovation and enhancement for home care.

Why it is needed:

So many opportunities exist for the state to pursue quality advancement and cost-savings by fostering home care's development of best practices, clinical protocols, clinical pathways, evidence-based practice, technology, staff training/specialty care development, quality risk assessment, quality benchmarking, and other initiatives. The HCA Quality Committee has developed groundbreaking proposals for home care quality advancement in all of these areas. However, no dedicated funding pool currently exists to help seed these quality innovations for home care, which would carry benefits to all sectors – and, above all, benefits to patients.





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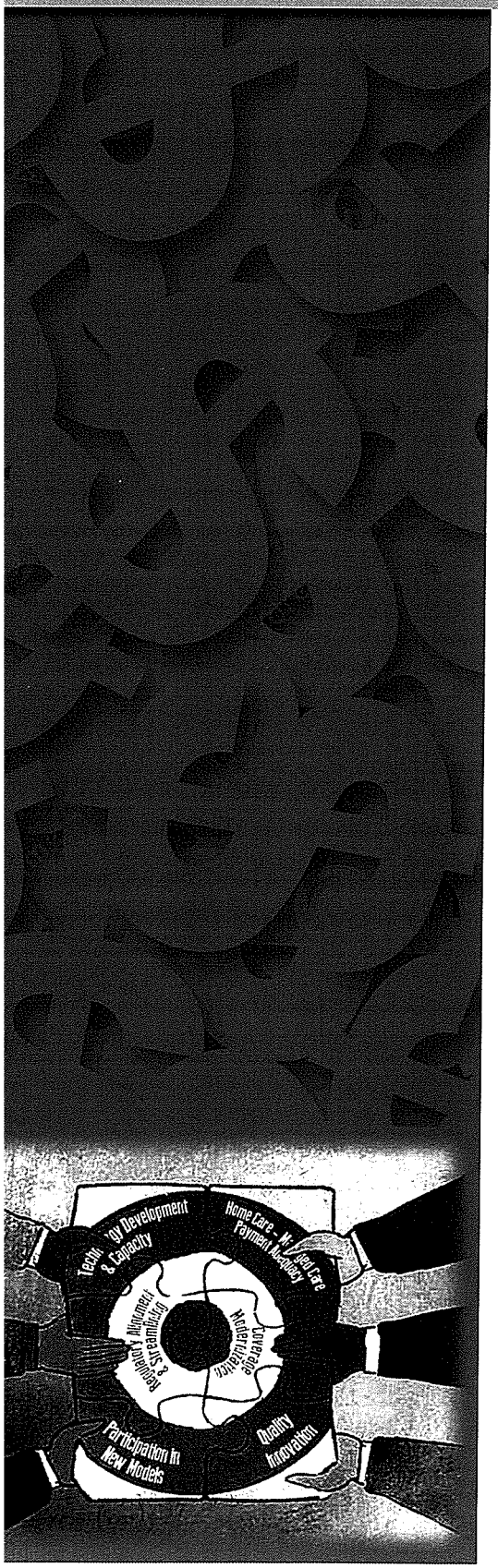
Home Care Financial and Program Support Vital for Success of New Care-Delivery Models



State leaders are looking to home care in new and heightened ways to help drive an agenda of health care improvement and cost-effectiveness for New York.

Home care providers are attempting to respond to this charge, looking to the future with vision, expertise, clinical tools, and a long-established functional role in the health care system that makes them uniquely designed and situated to embrace new and emerging models of care delivery.

They see within these new models a reflection and affirmation of their existing core function: to provide an array of skilled, therapeutic, post-acute, preventive, chronic and supportive care; to provide flexible, cost-effective care; to achieve quality outcomes that prevent needless hospitalizations or nursing-home admissions; to orient care decisions towards the individual and his or her family at the location of the individual's choosing; to navigate new, decentralized, and increasingly integrated payment structures; to coordinate care in an otherwise fragmented system; and more.

Over the past three years, the home care community has undergone a rapid and ground-shifting transition to Managed Long Term Care (MLTC) and Mainstream Medicaid Managed Care plans. While that transition is still happening, other major changes are now in motion. Home care providers are now also working to participate in other new models, such as the Delivery System Reform Incentive Payment (DSRIP) program and Fully Integrated Duals Advantage (FIDA) plans, which seek to further integrate services and payment. Both programs – FIDA and DSRIP – are priority components of the state government's vision for health care going forward. Both are fundamentally reliant on the availability, accessibility and ability of home care to play key care delivery and care management roles within their structures.

While home care is integral to these priority models, its participation requires critical supports commensurate with the state's intended roles and, most importantly, New Yorkers' medical needs. The state's methodologies for financing home care and managed care must be adapted to meet the realities of home care's infrastructure needs; and the state's home care-managed care regulatory structure likewise requires adaptation.

Especially concerning, then, are the results of a recent financial and program analysis conducted by the Home Care Association of New York State (HCA) showing home care to be in a severely compromised financial and regulatory state that is fundamentally challenging home care viability, let alone full and functional participation in these emerging care-delivery models sought by state leaders. A summary of the HCA analysis follows.

HCA's Survey and Financial Analysis

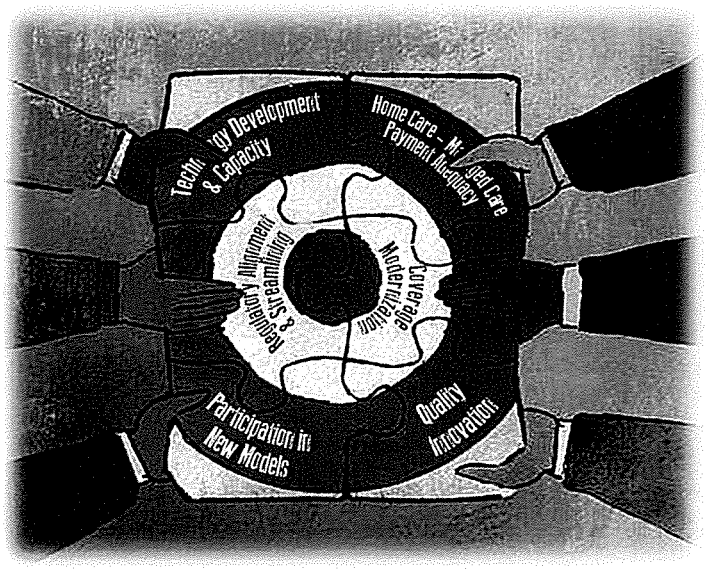
In late 2014, HCA conducted statistical, cost-report and survey-derived analyses of home care providers to assess the financial, programmatic and operational impact of state policies on the home care community and to gauge the home care community's needs and proactive steps in a changing health care landscape.

To gather the most up-to-date statistical data, HCA specifically asked Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs) to report key data elements from their 2013 Medicaid Cost Reports, adding to HCA-compiled data from prior-year cost reports. The Medicaid Cost Report provides official, independently certified financial and statistical data related to all categories of an organization's revenues and expenses.

In addition, HCA asked Licensed Home Care Services Agencies (LHCSAs) to report key elements from their 2012 Statistical Reports. The state Department of Health (DOH) requires LHCSAs to complete these yearly Statistical Reports, which contain demographic information, revenue data from LHCSA contracts with other home care agencies, as well as data on expenses/costs incurred in the provision of home care services.

More than 60 providers responded to HCA's survey, yielding an important set of statistical and descriptive data from a cross-section of providers representing various program types and demographics.

Alongside the survey analysis, HCA also analyzed the 2012 Medicaid Cost Reports submitted by all CHHAs and all LTHHCPs in the state. In addition, HCA examined the key financial elements submitted by managed care plans in their fourth quarter 2013 Medicaid Managed Care Operating Reports (MMCORs).



Some Key Findings at a Glance

- Approximately 70% of CHHAs and LTHHCPs had negative operating margins in 2011 and 2012 based on HCA's Medicaid Cost Report analysis. A similar result (70% of CHHAs/ LTHHCPs having negative margins) was also shown in 2013, based on provider responses to HCA's survey.
- Over 90% of LHCSAs in the survey sample reported negative operating margins in 2012 based on their latest Statistical Report data submitted to DOH.
- 57% of MLTCs had negative premium incomes in 2013, up from 42% in 2012 and 2011 (a 35% difference). MLTC plans are currently the payment source for a vast majority of Medicaid community-based long term care services. In the analysis, HCA found a strong correlation between the compromised financial condition of plans (as shown in their premium income losses) and a reduction in their rates of payment to downstream home care providers who are already coping with the impact of prior-year cuts and mandates like the Wage Parity Law. On average, home care providers who have negotiated MLTC contracts are receiving Medicaid rates 13% below their fee-for-service rates, according to HCA's survey.

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A Worsening Financial Picture in Home Care: Further Details

HCA's survey and cost-report analysis confirms several of the concerning trends that have been identified in prior-year financial reports. The impact of past home care cuts, unfunded mandates, the structure and flow of Medicaid payments under managed care, and other state changes have threatened the financial viability of home care providers and their contracting managed care plans at a time when the health care system relies on vital home care services to support the aims of models like DSRIP, ACOs, Health Homes, FIDA and MLTC.

The data from HCA's analysis clearly show that inadequate premium payments to managed care – coupled with regulatory, payment, billing and other obstacles in the financing and care-authorization structure – all have a compounding effect on cash-flow and the financial viability of home care providers.

More specifically, LTHHCPs continue to face a marked fiscal and viability challenge in this environment resulting from the state's policy to redirect virtually all Medicaid long term care enrollment into managed care plans. The policy change requires LTHHCPs – in order to maintain service to Medicaid patients – to land contracts with health plans and other new models that must recognize the value of LTHHCP's care-management, coordination and service-delivery expertise.

In last year's HCA survey, 12% of home care agencies said they planned to close their doors. In this year's survey, 20% said they plan to do so as a result of recent policy changes, including more than one-third of LTHHCPs pressured to pursue a phase-out of their programs absent supportive actions by the state.

More findings are below.

- In the past several years, home care provider margins have remained consistently in the red, compromising viability. Approximately 70% of home care providers had negative operating margins in 2011 and 2012, according to an analysis of home care cost reports, and over 70% were reporting negative operating margins in 2013 based on our survey respondents.

- Almost half of all survey respondents have had to use a line of credit or borrow money over the past two years to pay for operating expenses.

- Financial data confirms that LTHHCPs are experiencing the most severe losses in terms of financial or programmatic viability, despite having served as a linchpin of the state's community based long term care system for decades. Principally, state finance methodologies and lack of transition policy in the move to mandatory managed care enrollment resulted in a 85% of LTHHCPs having negative operating margins in 2012. The median operating margin of LTHHCPs who completed HCA's survey was -12.51 in 2013. Between 2011 and 2012, total operating losses for all LTHHCPs increased from -$47 million to -$75 million – a 60% increase in operating losses over one year. Due to the managed care transition, specifically, 34% of survey respondents have already phased-out or plan to phase out their LTHHCPs, and 62% of all home care survey respondents have already (or will) reduce staff and other expenses to become more efficient.

- As a result of state policies and Medicaid funding reductions in recent years, 21% of LTHHCPs have already closed their program since 2013, with 33% still planning a phase-out.

- A similar financial trend is shown in the CHHA sector where operating margins have only gotten worse in the past year. Over half of all CHHAs had negative operating margins in 2012 and 2013. The median operating margin of CHHAs surveyed in 2013 was approximately -1.3%, worse than the -0.5% median operating margin in the 2012 Cost Reports.

- Home care providers also reported that their revenue (from all payors) remained in Accounts Receivable (AR) for an average of 76 days, with 60 days being the median timeframe for AR, based on all survey respondents. More than 12% of providers indicated that 11% to 20% of their revenue in AR resulted in "bad-debt" or not getting paid.

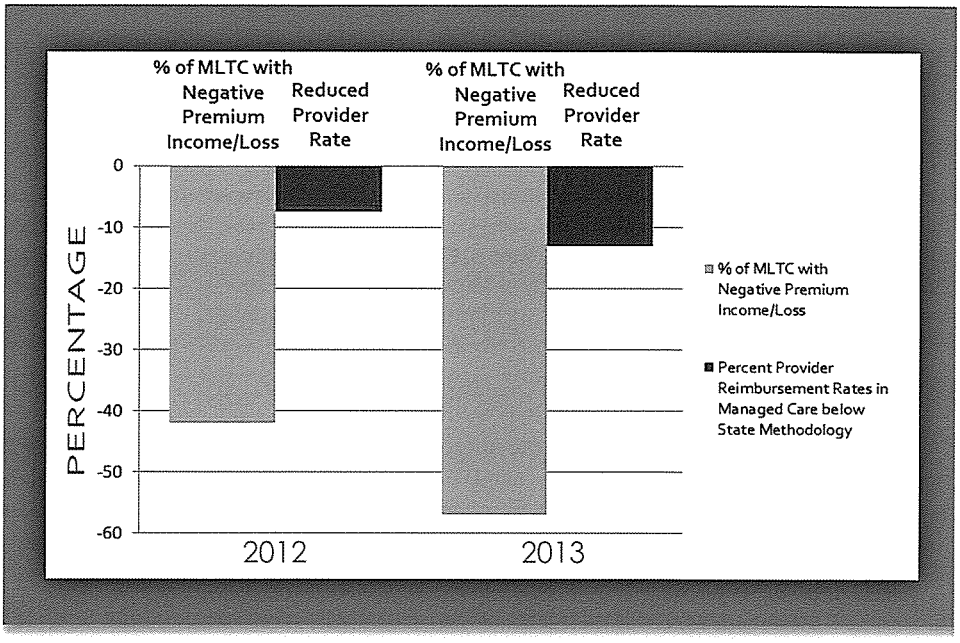
Negative Premium Income for Managed Care Has Downstream Effect on Home Care Provider Financial and Operational Stability

According to MMCOR data, 57% of MLTCs had negative premium incomes in 2013 – up from 42% in 2012 and 2011. As MLTC plans cope with the pressures of negative premium incomes, their downstream providers are seeing costs rise, especially administrative, wage and benefit costs. As a result, a major source of the financial vulnerability occurring system-wide in home care involves inadequate premium levels for managed care and the consequent squeeze this puts on rates to downstream providers who are negotiating from a financially precarious position.

According to HCA survey results, other financial and operational impediments in this working relationship between home care providers and managed care plans include: delays in authorizations and payment; inconsistent billing codes; inadequate rates; and a lack of state policy clarity about regulatory requirements under managed care.

Below are some detailed findings:

- HCA's data analysis finds a correlation between premium income for plans and the negotiated rate that providers receive from plans. As premium incomes get worse, so have the contracted rates to providers. On average, providers with MLTC contracts are receiving Medicaid rates 13% below their fee-for-service (FFS) rates, according to HCA's survey, at a time when 57% of MLTC plans have had negative premium income. Compare that to the prior year: When 42% of MLTCs had negative premium incomes, and the average provider contractual rate was 7.45% below fee-for-service rates.



- Considering that approximately 70% of home care providers were operating in the red in 2012 – at a time when the fee-for-service (FFS) rate was largely still in effect – this 13% variance from the already-inadequate FFS rate suggests that providers will continue to face extreme financial hardship and continued difficulty functioning as they are expected to do under current models.

- Inadequate managed care rates to home care providers ranked among the highest concerns voiced by respondents in HCA's survey. When asked about the overall impact of managed care contracting, more than two-thirds of providers selected "inadequate rates" as having the largest impact, along with "lack of timely authorizations," "lack of timely payment," "inconsistent billing codes," and lack of a clear state policy about regulatory requirements under managed care.

- Approximately 40% of survey respondents reported that their Medicaid Managed Care claims were not paid within the "prompt" pay law timeframe for "clean" claims needing no edits (30 days for electronic claims and 45 days for paper claims), a backlog which leads to significant cash-flow issues and, in some cases, "bad-debt" that contributes to operating losses.

Wage Parity Law and Other Regulatory Requirements Lead to Staffing Cuts, "Bad-Debt," and Operating Losses

Consistent with last year's findings, wages and benefits costs remain the biggest factor in rising costs for home care providers. Forty-two percent of respondents chose "wage costs" as having the "largest impact," while 35% said "benefits costs" had the "largest impact." Similarly, providers were most concerned about the Affordable Care Act (ACA) health coverage mandates and the elimination of the 'companionship exemption' for home care (now on hold due to court action) – two wage and benefit related mandates that providers ranked highest as having an impact on agencies.

The state's Worker Wage Parity Law continues to impact agency operations and services. Most providers have responded to these increased Worker Wage Parity costs by seeking a higher contractor rate, where possible; however, in an environment of inadequate managed care premium rates and mounting fee-for-service losses, providers have had to increasingly resort to staffing cuts and other measures to remain compliant with the law.

In our survey, HCA asked providers to indicate the current impact of wage parity as well as the expected 2015 impact of wage parity. For every impact of wage parity – whether it was staffing cuts, administrative cuts or changes in caseload – providers indicated that they would have to resort to even stronger remediation measures in 2015 versus 2014.

In addition to growing labor costs, other mandates like physician order issues are having a major impact on providers. As one respondent noted: "The 90-day Medicaid M.D. order requirement is too burdensome and, in some instances, not achievable. It drives high Medicaid bad-debt rates."

Below are some further findings about the impact of wage parity and other regulatory requirements.

- In 2014, 35% of providers (survey respondents) have reduced the hours of direct-care staff, due to wage parity, while 50% expect to do so in 2015.
- In 2014, 39% of providers have stopped accepting cases where the contractor rate was inadequate to meet wage parity expenses, while 62% expect to do so in 2015.
- Forty-eight percent of providers affected by wage parity have reduced staff overtime – an option (overtime hours) that agencies, workers and patients will likely find increasingly less available as the federal government looks to implement changes in the calculation of overtime under the Fair Labor Standards Act.
- The lack of receiving timely physician orders has adversely affected agency finances in terms of administrative expenses, delayed billing and unrecovered expenses. According to HCA's survey, almost 40% of respondents said that timely physician orders had a 'large' financial impact (defined as affecting between 6% and 10% of their Medicaid revenue).

Home Care Providers are Adjusting to New Models but Need Substantive Support to Participate Effectively

Home care agencies are working to retool their operations and adjust to the changes in the health care delivery system.

According to our survey, more than three-quarters of respondents have been recognized as safety-net providers for DSRIP and over half are participating as network providers in a DSRIP Performing Provider System (PPS).

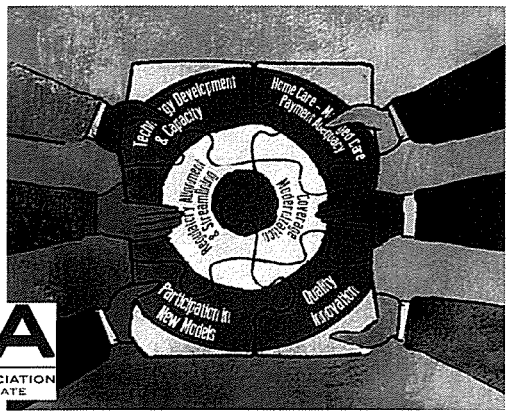
However, the role of home care in the DSRIP structure remains inadequately supported for home care providers – even as the DSRIP model, and home care's charged role, represents a central, multi-billion-dollar component of the state's plan to integrate New York's health care system.

For instance, 82% of home care providers already involved in a PPS under DSRIP have not yet been able to determine, fundamentally, how they would be paid under such a system. Moreover, to date, little to no support has been targeted to home care for its health information technology capacity and interoperability – both vital to functionality under DSRIP, FIDA, managed care or any integrated system.

New and emerging models of care also have not adequately supported care-management tools and functions in home care that could be of benefit to the new system. This includes home telehealth, which is an important and cost-effective disease-management technology that allows for remote monitoring of patients, prompting interventions that reduce the rate of hospital admissions.

In the current fiscal, regulatory and program environment, home care agencies indicate they need: greater state clarity on the role and regulatory responsibilities for agencies; regulatory relief; and capital and technology funding support.

- Only 27 percent of survey respondents answered that they have contracted with MLTCs/MCOs for telehealth services. Many providers have separately reported erosion of over 50 percent of their Medicaid home telehealth enrollment coinciding with the state's redirection of patients to managed care. The home telehealth program, created in 2007 by the State Legislature and Governor, has been a national leader. Telehealth viability under the state's policy changes is an area that requires major attention. MLTCs report that their current premium structure has not included costs for telehealth, and thus many do not yet regard it as a truly "covered" service. Telehealth "seems to fluctuate too much between authorized one time and then not authorized another time," writes one survey respondent about the inconsistency in home telehealth coverage, echoing the concerns of several respondents in HCA's survey.
- Home care providers have been, in large part, bypassed in state and federal efforts to promote Health Information Technology. Having systems that are interoperable with hospitals, Health Homes, ACOs, DSRIP partners and others is a vital but unrealized goal. Providers reported the need for IT funding to align with health policy directives such as: "becoming interoperable with local providers"; "interoperability to advance initiatives such as bundling and DSRIP"; "community portals to hospitals, managed care plans and patients"; "expand and upgrade the use and availability of mobile devices for all field staff."



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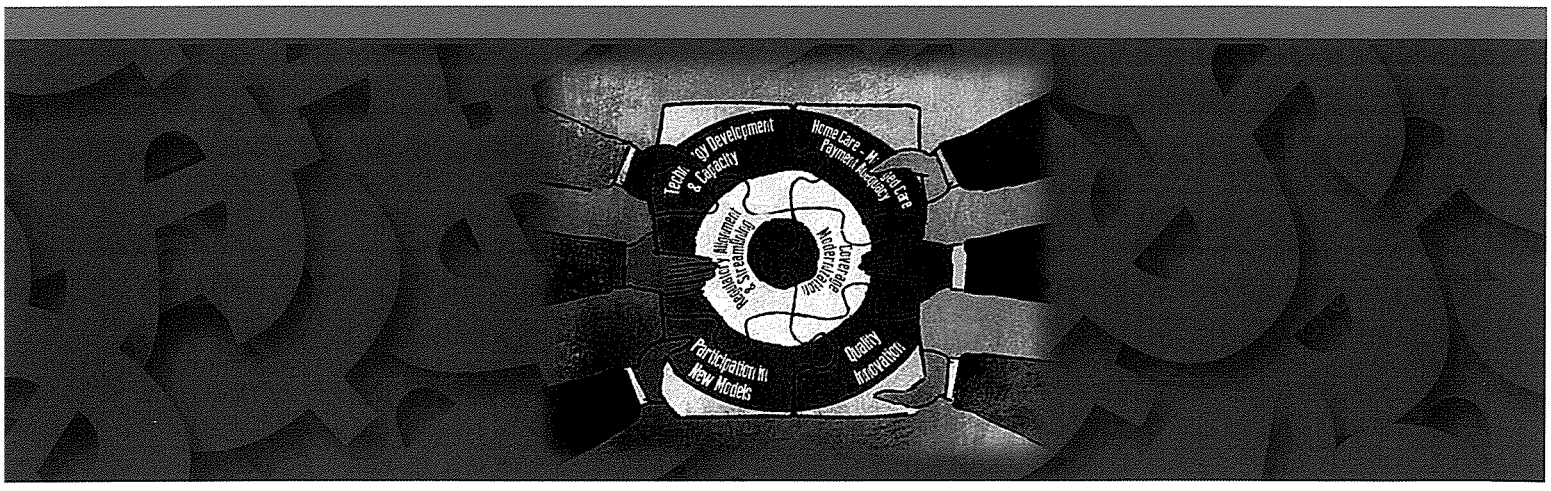
Conclusion

To maintain viability, to meet home care's burgeoning role in meeting patients' health care needs across the continuum, and to participate in the changing health care system as sought by government leaders, home care providers need support measures that: ensure adequate and effective managed care-provider payment structures; better align and streamline the regulations governing home care and managed care; promote innovations in Health Information Technology; and other infrastructure investment. Home care is uniquely designed and suited to help drive state and federal policy goals of better care for individuals, better care for health populations and cost effective service utilization. However, targeted relief and support measures are first needed to address chronic and emerging financial, operational and regulatory issues that compromise its abilities and the state's goals.

Home Care Financial and Program Support Vital for Success of New Care-Delivery Models



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