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Joint Legislative Hearing on 2016-2017 Executive Budget Proposal Health and Medicaid

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

Monday, January 25
Legislative Office Building, Hearing Room B
Empire State Plaza
Albany, New York

HCA
HOME CARE ASSOCIATION OF NEW YORK STATE

Opening Remarks

Good afternoon Committee Chairs and Members of the Joint Budget Committee.

I'm Joanne Cunningham, President of the Home Care Association of New York State, "HCA."

Thank you for this opportunity to testify and provide the home care community's comments on the Executive's proposed 2016-17 State Budget. I will also describe **two priority proposals** that HCA is submitting for your consideration to include in your legislative budget bills and in the final adopted budget.

The Home Care Association of New York State

HCA is the statewide association representing the entire continuum of home care. HCA's provider members are hospitals, nursing homes, managed long term care plans and free-standing agencies that provide, manage and coordinate care at home programs. These programs include Certified Home Health Agencies (CHHAs), Licensed Home Care Services Agencies (LHCSAs), Long Term Home Health Care Programs (LTHHCPs), Hospices, Managed Long Term Care Plans (MLTCs), home and community based waiver programs, and others. HCA members also include key allied organizations (such as local aging services, quality improvement organizations, and others) that support and/or advocate quality home care services.

Home Care Integral to Patients Across the Service Spectrum

Home care specializes in the delivery of "in-home" services and the coordination and management of integrated plans of care. But home care also has critical core roles and competencies that are applied throughout the spectrum. For example, home care agencies are integral partners to facilities and physicians in care transition from hospitals or nursing homes to community, emergency room intervention/redirection programs, management of complex medical conditions, community public health, new hospital-at-home models, telemedicine/telehealth, maternal and child health, and other.

The state and the broader health care system are heavily relying on home care for success of major new health care models and policies. These include managed care, Delivery System Reform Incentive (DSRIP) Payment programs, Value Based Payment models, Fully Integrated Duals Advantage Plans, and other integrated care/coverage solutions. Indeed, billions of dollars in federal funds to New York State are contingent on the state's and the system's ability to meet strict performance goals. Under these goals, the state must reduce hospital use and expenditures by twenty-five percent over five years, while simultaneously demonstrating improvement in quality and population health. Home care is core to meeting these goals and ensuring the flow of these funds to New York.

Home care is being asked and expected to provide the care that must now shift from hospital to community. The state's sought-after (and now obligatory) system transformation program, and the billions of dollars at stake, rests with accessible, viable home care.

Home care providers continue working diligently to meet these needs and demands. But in this changing environment, home care agencies are in urgent need of fiscal investment and policy supports to enable it to function at this new level.

The Fragile Financial State of Home Care and Managed Long Term Care

HCA has appended as part of this testimony a financial report revealing the striking, fragile condition of home care agencies and managed long term care plans in the state.

We submit this for Legislative and Executive consideration as we urge support for these services in the 2016-17 budget.

The report is based on a review of home care and MLTC cost reports, provider surveys and other data sources. The following is a summary of findings, discussed at further length in the appended report.

- Nearly half of agencies face a need to reduce staff and other expenses to function.

- 70 percent of Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs) had negative operating margins in 2013, with similar results for 2014.

- For 2014, the average operating margin for CHHAs and LTHHCPs was -11.65 percent.

- One-half of home care agencies have had to use a line of credit or borrow money to pay for operating expenses over the past two years.

- 63 percent of MLTCs had negative premium incomes in 2014, up from 57 percent in 2013 and 42 percent in 2012 (a 49 percent increase since 2012).

- 15 percent of home care agencies indicated that more than 20 percent of their anticipated revenue winds up as bad-debt (meaning they are not getting paid for 20 percent of their claims). Another ten percent of home care agencies reported that over 30 percent of their revenue results in bad-debt.

- On average, less than half (45 percent) of Medicaid claims are paid to home care providers within the prompt-pay law. Their Medicaid revenue was in accounts-receivable for an average of 72 days.

- Of the managed care plans which do not pay on time, the average length of time to receive payment is 61 to 180 days for about half of the home care respondents to HCA's 2015 managed care survey.

- 45% of agencies indicate that 15% of their revenue is affected by a lack of timely payment.

- Home care agencies, on average, saw a 0.5% decrease in their managed care contracted rates between 2014 and 2015.

- More than half of agencies indicate that inadequate rates, delays in managed care payments and reimbursement changes are the top reason for a decrease in their Medicaid revenues between 2014 and 2015.

- The average percentage cut attributable to CHHA Medicaid Episodic Payment System rebasing is 25.3 percent. However, over half of agencies actually reported that they are experiencing a rebasing cut of more than 30 percent.

- Wage, overtime and benefit costs accounted for the biggest impact on agencies' financial challenges.

- A $15-per-hour minimum mandate would cost the home care industry $1.74 billion – well above the estimated $1.17 billion impact for hospitals and nursing homes *combined.*

- Over half of home care providers say they have little confidence that committees overseeing state-funded Delivery System Reform Incentive Payment (DSRIP) Performing Provider Systems (PPS) understand the role of home care in meeting DSRIP goals.

- Of survey respondents involve in a DSRIP PPS, over half are unsure whether payments will adequately cover costs and make their participation worthwhile. An additional 30 percent are sure payments will not adequately cover costs.

The Proposed Executive Budget and Implications for Home Care

Given this extremely fragile nature of the home care/MLTC system, it is a daunting expectation to expect these providers to deliver services under existing terms, let alone at the dramatically increased levels now asked by the state.

Support and infrastructure investment for home care and MLTC are urgently needed in this budget to secure the delivery system. Yet, how is the Executive's proposal responding?

Of the Executive's priority or "signature" budget proposals, nearly all proposals target non-health areas for investment.

Meanwhile the proposed Medicaid budget is contingent on the providers and managed care plans delivering the state's Medicaid Redesign Team (MRT) reforms, not only without urgently needed aid but with imposition of massive and unsustainable new mandates.

Minimum Wage Increase to $15/Hour

Of all of the proposals in the Executive budget, the proposed minimum wage increase, without commensurate funds, would financially devastate the health care system, home care in particular.

The proposed $15 per-hour minimum wage would cost the home care industry a projected $1.74 billion in unfunded new costs.

The wage increase would also raise the cost of home care for individuals paying privately, and create an unrecognized/unreimbursed cost for Medicare-covered patients.

HCA has long advocated state, federal and commercial insurance reimbursement levels necessary to deservedly compensate its direct-care workers. Particularly in view of the financial state of home care as previously outlined, and the projected $1.7 billion impact of the wage proposal, HCA urges the Legislature and Governor to fully fund and account for this proposal's fiscal impact before any attempt to adopt this well-intentioned but unsustainable standard.

Health Care Facility Transformation Funding

Last year, the adopted budget included over $2 billion in new investment funding largely for the state's hospitals and institutions. This support was provided on top of the $7 billion plus provided largely to the hospital sector through DSRIP.

Home and community health providers desperately need investment to participate in the changing health system in order to meet patients' needs and also to participate in, and help achieve the success of, the state's new delivery models.

HCA urges the Legislature and Governor to ensure that health care investments in the 2016-17 budget include home and community health care providers, and that continued or new investments under existing programs be amended to fully apply to the home care sector.

As it stands, the budget proposal currently amends a Health Facility Transformation program adopted last for health care facilities in Oneida County, repurposing $200 million of the $300

million in funds primarily statewide for health care facility projects. While providers that would be eligible for these funds include general hospitals, residential health care facilities, diagnostic and treatment centers, clinics, primary care providers, and home care providers, the program's parameters are very narrow and the Executive's language needs amendment to ensure that proportional and needed funding amounts truly make it to the community provider level.

Advanced Home Health Aides

The budget narrative includes a proposal to establish an Advanced Home Health Aide level within home care and hospice. Neither the language nor fiscals have yet to be revealed for this proposal.

HCA strongly supports increased flexibility for home health aides and for registered professional nurses in their authority to train, assign and supervise aides in performing critical tasks for patients. Thus, conceptually, HCA supports and has previously worked hard for enactment of enabling legislation and/or regulatory authority. However, the Executive's prior Advanced Aide proposals have lacked funding, procedural alignment between home care and managed care, and lacked other important elements necessary for successful implementation. HCA will await the 2016-17 language and, hopefully, an accompanying adequate appropriation. HCA looks forward to working with the Legislature and Governor to shape a successful enhanced home health aide program.

MLTC Changes

The budget proposal seeks changes to basic MLTC financing and eligibility that may present consequences for patients, plans and home care agencies. HCA will seek clarification as to both

the purpose and projected implications of these MLTC proposals and provide detailed comments to the Legislature and Executive.

Missing from the Budget Proposal

What is perhaps the most striking about the proposed health and Medicaid budget is what is notably absent.

Especially notable absences include:

- As previously stated, funding to accommodate the massive $1.74 billion projected impact of the Governor's minimum wage increase on the home care sector.

- Funding to account for the total financial impact of the implementation of the Federal Fair Labor Standards Act (FLSA) rule changes. These pertain to payment for home care worker overtime, travel and 24-hour sleep-in cases and the additional costs of the intensive new tracking and reporting requirements accompanying the rule change.

- Funding to pay the required higher wage levels for home care aides in Long Island and Westchester under the state's Wage Parity Law.

- Dedicated funding for home care and other community health care providers to enable their needed participation in the state's health transformation programs, like the Delivery System Reform Incentive Payment (DSRIP) Program, Value Based Payment, managed care and others. Home care and other community health providers are in urgent need of infrastructure support to fulfill these new system goals.

- Funding to secure service payments due to providers from defaulting health plans, such as Health Republic or any possible future managed care plans.

- As noted, funding to support implementation of the Governor's Advanced Home Health Aide proposal.

HCA's 2016-17 Budget Platform

To keep New York's home care system viable, action is needed in a number of critical areas falling under **two broad principles**: 1) reimbursement fixes; and 2) statutory or budget language to optimize home care participation in the new health care environment.

HCA asks that State Legislators and the Governor advance and adopt the following two priority proposals in the 2016 state legislative session and budget.

HCA has legislative language ready to support each of these principles for assuring home care viability on behalf of patients and the state.

Proposal I: Adopt legislation to fix the state's reimbursement laws and levels to cover and reimburse needed services

The state's reimbursement laws and levels covering home care need to be fixed, as shown in the previously summarized (and appended) financial condition study.

Reimbursement fixes can be accomplished through amendments to the state's public health and insurance laws, and adjustments to the state's home care and managed care methodologies and procedures.

HCA has prepared budgetary fix language for **Proposal I** for the Legislature's and Governor's introduction. The fix language includes measures to close the gap in:

- **Workforce costs**, to meet major new expenses in compensation, most urgently those resulting from state and federal wage mandates, including the state's home care worker wage parity law, new federal overtime rules and the proposed minimum wage increase – all of which also fall within the constraints of declining reimbursement and a Medicaid cap.

- **Premium calculations for meeting managed care plan costs, and the reimbursement calculations for home care under managed care,** to cover the costs of services by managed care plans and network providers.

- **Needed support for home care infrastructure** (such as health information technology, workforce resources to meet community needs, etc.) for success of the state's policy goals; and

- **The state's "Episodic Payment System" for home care**, at a time when affected agencies, on average, are experiencing a State Department of Health effectuated 29% cut

in reimbursement from EPS rebasing – an amount nearly three times the figure adopted in the state budget agreement last year. HCA applauds the Legislature for unanimous passage of legislation to hold the Department to the budget agreement, which, regrettably, the Governor vetoed.

- **Updating the long-antiquated state insurance law coverage provisions for home care agency services** to reflect a more modern health care infrastructure where patients and state policies more heavily rely on home care than was the case when the insurance laws were created 40 years ago.

Proposal II: Adopt budget provisions that optimize home care's participation in NY's changing system, producing health improvements and cost savings

This testimony has underscored the critical role of home care in the state's major new health care policies and system redesigns.

Despite these strong state policy goals reliant on home care, state laws and policies are lagging behind this changing system, as is basic investment in home care's potential and development. This is hindering home care's ability to fully participate in, and optimize its value and benefits to, our state's evolving system.

To address these concerns, HCA has developed a legislative/budget initiative to unleash home care's ability to fully participate in the evolving system and asks its adoption by the Legislature and Governor.

Key components of the package include:

- Fast-track authority for state regulatory and procedural changes that streamline and better align home care with new roles and models of care;

- Harnessing home care in priority public health areas that are critical to patient care and to the state's major reform initiatives like DSRIP, Value Based Payment, Managed Care. These public health areas include: sepsis interventions, falls prevention, wound care prevention, maternal and child health, emergency response, and other areas that align with state health outcomes goals;

- A proactive health information technology policy to support integration for meeting state policy goals and care transitions;

- Funding for the hospital-homecare-physician collaboration program enacted in the 2015-16 state budget;

- Home care and hospice quality innovation and palliative care access; and

- The creation of innovative payment and delivery demonstration models.

HCA will provide the Legislature with legislative and budget language to implement these two proposal packages.

HCA appreciates this opportunity to testify. HCA is eager to work with the Legislature and Governor to address these critical needs of home care patients and providers, and to maximize the benefits of the home system for the state and system as a whole.

Thank you.

HCA
HOME CARE ASSOCIATION OF NEW YORK STATE

RISK FACTORS

What You Need to Know about the Financial Condition of New York State's Home Care Community

How inadequate reimbursement, new workforce cost mandates, and cash-flow challenges compromise home care's role in supporting health policy goals

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Background

New York's home care community continues to face monumental challenges. Enormous new reimbursement cuts, the threat of multi-billion-dollar cost mandates, as well as ongoing billing and care-authorization delays threaten home care viability in the current state Medicaid environment. These obstacles can be surmounted, but only by changes in reimbursement policy and regulatory changes to support home care infrastructure.

At a time when other sectors have received billions of dollars in Medicaid reinvestment funds for major new collaborative initiatives,[1] home care providers receive no investment and little support.[2] Meanwhile, these same providers are expected to participate in new models of care – like the $6.42 billion Delivery System Reform Incentive Payment (DSRIP) program – to meet otherwise laudable health outcomes like reduced hospital admissions.

According to a recent financial survey of HCA's home care provider membership conducted in November to January of 2015 and 2016,[3] over half of home care providers report little confidence that committees overseeing state-funded DSRIP Performing Provider Systems (PPS) understand the role of home care in meeting DSRIP goals.[4] Of agencies involved in DSRIP, over half are unsure whether payments will adequately cover the costs of DSRIP planning and operational work to make participation worthwhile. Another 30% are sure that DSRIP payments will be inadequate.

Rather than receiving support to help transform New York's health care system, home care providers find themselves with an uncertain role in these multi-billion-dollar program initiatives. Further, home care's already precarious financial condition undermines its ability to participate fully in these efforts due to:

- Medicaid reimbursement cuts and resultant staffing reductions (**more than half of agencies report facing a need to reduce staff and other expenses**[5]);
- Protracted billing and authorization delays from Medicaid health plans that result from inadequate payment to plans which are also coping with operating losses;

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Data Summary

In 2015 and early 2016, HCA conducted two surveys on the financial condition of home care agencies and their experience with system changes. Along with these surveys – which asked for detailed financial information – we conducted an analysis of Medicaid Cost Reports, Statistical Reports and Medicaid Managed Care Operating Reports for all home care agencies and managed long term care plans in the state. HCA also calculated the impact of the Governor's proposed $15 per hour minimum wage on home care. Below is a summary of findings, discussed at length with further context in this report.

- Almost 60% of agencies report facing a need to reduce staff and other expenses to function.
- 70% of Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs) had negative operating margins in 2013, with similar results for 2014.
- For 2014, the average operating margin for CHHAs and LTHHCPs was -11.65%.
- One-half of home care agencies have had to use a line of credit or borrow money to pay for operating expenses over the past two years.
- 63% of Managed Long Term Care (MLTC) plans had negative premium incomes in 2014, up from 57% in 2013 and 42% in 2012 (a 49% increase since 2012). This has a downstream effect on timely billing to providers as the plans cope with underfunded premiums, a condition which HCA has sought to mitigate in proposals seeking a sound actuarial analysis of payment adequacy to plans and contract providers.

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Background - continued

- Nonexistent capital for health information technology (IT) and other infrastructure enhancements needed to network with health partners; and
- Massive new cost mandates, especially in the area of workforce costs.

All of these factors are challenging enough for the home care community to conduct its traditional, core work, much less to fulfill the state's desired role as a central player in system reform, health care cost-reduction, community health improvement and highest quality care. These new systems urgently need home care's expertise, its human capital, and the experience and performance of its infrastructure to meet the state's ambitious outcomes goals under DSRIP, value-based payments, and other emerging models.[6]

Data Summary Continued...

- 15% of home care agencies indicated that more than 20% of their anticipated revenue winds up as bad-debt (meaning they are not getting paid for 20% of their claims). One in ten home care agencies reported that over 30% of their revenue results in bad-debt.
- 45% of agencies indicate that over 15% of their revenue is affected by a lack of timely payment.
- More than half of agencies indicate that inadequate rates, delays in managed care payments and reimbursement changes – due to inadequate premium payments for managed care – are the top reason for a decrease in their Medicaid revenues between 2014 and 2015.
- The average percentage cut attributable to CHHA Medicaid Episodic Payment System rebasing is 25.3%. However, over half of agencies actually reported that they are experiencing a rebasing cut of more than 30%.
- Wage, overtime and benefit costs accounted for the biggest impact on agencies' financial challenges.
- A $15-per-hour minimum mandate would cost the home care industry $1.7 billion – well above the estimated $1.17 billion impact for hospitals and nursing homes *combined*.

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The Current Financial Landscape for Home Care

According to 2013 Medicaid Cost Reports required from all home care providers in the state (the most comprehensive and current data available to HCA), **70% of Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs) had negative operating margins in 2013,**[7] with similar results for 2014 based on the recent 2015-16 HCA financial survey of our home care provider membership.

According to HCA's survey, for 2014, **the average operating margin for CHHAs and LTHHCPs was -11.65%,**[8] meaning that, as of 2014, providers had to absorb losses in their provision of services to patients compared to their across-the-board revenue. **Meanwhile, one-half of agencies have had to use a line of credit or borrow money to pay for operating and service expenses** over the past two years.[9]

This underfunded financial status (negative margins and lagging cash-flow) is mostly attributable to the fact that revenue for home care agencies comes almost exclusively from government payor sources (Medicaid and Medicare), including funds passed through Medicaid managed care plans, which are an increasingly larger source of payment for home care. Government payors, like New York's Medicaid program, set the premium rates for managed care plans; but these rates do not account for many critical costs needed in service structure and delivery, nor do they account for new costs and mandates mid-year. Home care has also been debilitated by rebasing adjustments over this past year, with cuts far exceeding state fiscal plan projections, leading to a negative downstream effect across the continuum of home and community-based services. [10]

Inadequate Premiums to Managed Care Add Financial Distress across Entire Home Care System

Last year (2015) the state completed its transition to managed long term care in all 62 counties for home care patients deemed to require more than 120 days of Medicaid long term community-based care services (with some exemptions, largely for pediatric cases).

Under this system, home care providers contract with MLTC plans. The MLTCs receive Medicaid payments from the state for managing the entire long term care service package of Medicaid enrollees. The MLTC's function includes authorizing home care services and paying its network providers for serving the home care, personal care, nursing-home, and other needs of the long term care population in New York State. This transition has been a profound shift for home care providers who are now increasingly tied to managed care plans for service authorization and for billing/receipt of their Medicaid payments. [11]

Data Summary Continued...

- Over half of home care providers say they have little confidence that committees overseeing state-funded Delivery System Reform Incentive Payment (DSRIP) Performing Provider Systems (PPS) understand the role of home care in meeting DSRIP goals.
- Of agencies involved in DSRIP, over half are unsure whether payments will adequately cover the costs of DSRIP planning and operational work to make participation worthwhile. Another 30% are sure that DSRIP payments will be inadequate.

The home care provider's role in this system requires it to contract with the plans for a negotiated rate of payment to render services for enrollees – distinct from Medicaid fee-for-service (FFS) billing, where home care providers have billed/received payment directly from the state (and/or through contracts with local social services districts) at state-established rates.

According to the most recent data available, **63% of MLTC plans had negative premium incomes in 2014,** up from 57% in 2013 and 42% in 2012 (a 49% increase since 2012).[12] A negative premium income means that operating costs exceed the total revenue a plan has received from its premiums.

Given that MLTC plans are currently the payment source for a vast majority of Medicaid community-based long term care services,[13] one can see a strong correlation between the compromised financial condition of MLTC plans (as shown in their premium income losses) and the payment obstacles faced by downstream home care providers. This compounds the financial distress for providers who are already coping with the impact of prior-year cuts and mandates.[14] Home care provider agencies – who are at the end of the payment chain – continue to cope with billing and service-authorization delays, uncertain regulatory alignment duties with the plans, and other issues.

Consider the following data points from HCA's 2015-16 financial survey as well as HCA's 2015 managed care payment survey (conducted in the summer of 2015) to understand the landscape for today's home care providers under both fee-for-service and managed care:

- **15% of home care agencies indicated that more than 20% of their anticipated revenue winds up as bad-debt** (meaning they are not getting paid for 20% of their claims). Another one in ten home care agencies reported that over 30% of their revenue results in bad-debt.[15]
- Even when payments are received, remittances are often extensively delayed, affecting cash flow for an already struggling home care industry that has long operated at an aggregate loss, even under Medicaid FFS. The state's prompt-pay law requires that direct-service entities are paid within 30 days for electronic claims and 45 days for paper claims. Despite this protection, **on average, less than half (45%) of Medicaid claims are paid to home care providers within the prompt-pay law.** On average, agencies indicated that their **Medicaid revenue was in accounts-receivable for an average of 72 days,** again jeopardizing cash flow.[16]

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- Of the managed care plans which do not remit payment on time, **the average length of time to receive payment is 61 to 180 days for about half of the home care respondents to HCA's 2015 managed care survey**.[17]

- 45% of agencies indicate that **over 15% of their revenue is affected by a lack of timely payment**.[18]

While payment delays are a major concern, so, too, are the actual contracted rates of payment from managed care plans to providers. For home care agencies that reported a managed care negotiated rate below their fee-for-service rates, **the managed care rate was, on average, 20% lower than FFS for nursing and home health aide services**.[19]

Home care agencies also, on average, **saw a 0.5% decrease in their managed care contracted rates between 2014 and 2015,** again suggesting that managed care premium adjustments are necessary to ensure that plan premiums paid to plans by the state in turn enable them to meet their home care providers' costs. More than half of agencies indicate that inadequate rates, delays in managed care payments and reimbursement changes are the top reason for a decrease in their Medicaid revenues between 2014 and 2015.[20]

New, Emerging Cost and Reimbursement Challenges: Rebasing Cuts, Wage and Overtime Mandates

Several major cost and reimbursement challenges are plaguing the home care provider community, resulting in some of the previously cited financial outcomes for network home care providers and managed care plans alike. Beyond that, these challenges have implications for further long term catastrophic impacts across the home and community-based care system due to very new cuts and workforce mandates imposed on the system in 2015.

Rebasing

On the fee-for-service side, the first of these major new impacts is a state Department of Health (DOH) rebasing initiative for CHHAs under its system of reimbursement for Medicaid cases shorter than 120 days. This reimbursement system is called the Episodic Payment System (EPS).

HCA's 2015-16 financial survey of home care providers finds that the **average percentage cut attributable to this recent rebasing process is 25.3%**. However, **over half of agencies actually reported that they are experiencing a rebasing cut of more than 30%**.[21]

This massive cut – far bigger than the projected rebasing impact projected and adopted in the 2015-16 (current) fiscal year state budget – comes at a time when, as already mentioned, two-thirds of these agencies were already operating in the red in 2013, well before the rebasing cuts took hold.

New Overtime Mandate and Proposed $15 Wage Impact

A second new cost – and perhaps the biggest for all home care providers – is in the area of new workforce expenses that have spiked in 2015 and are expected to grow significantly under the Governor's proposed 2016-17 state budget.

Home care is a heavily human-services-oriented area of practice, with home health and personal care aides, nurses and other staff conducting millions of visits to over 400,000 patients annually in their homes to provide vital, cost-effective care. HCA and the home care community have long advocated state, federal and insurance adjustments in reimbursement to support and advance compensation of these devoted, essential staff.

The cost of staffing is rising at the same time that providers are operating within a fixed system of reimbursement established by a statewide cap on Medicaid[22] and otherwise subject to limitations, chronic cuts, payment delays and inadequate rates of reimbursement. The state has imposed a global cap on the Medicaid program, but Medicaid enrollment continues to rise,[23] and the state and federal governments have imposed new home care cost mandates within the fixed confines of this cap, especially in the area of newly imposed workforce expenses.

According to HCA's 2015-16 financial survey, **wage, overtime and benefit costs accounted for the biggest impact on agencies' financial challenges**. Sixty-nine percent of agencies reported "Wages and Overtime" as a "large" or "largest" impact. Sixty-three percent of agencies reported "Benefit Costs" as a "large" or "largest" impact. Fifty-two percent of survey respondents indicated that "billing/administrative expenses associated with managed care" have a "large" or "largest" impact on increased costs.

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Home care providers have reason to be concerned.

The federal government recently (October 13, 2015) changed the rules to require that home health aides in New York and other states are paid for overtime at time-and-a-half of their *actual* wage as opposed to time-and-a-half of the *minimum* wage. This is a new calculation that is exacerbated by Wage Parity Law minimums already established above the statewide minimum wage for home health and personal care aides providing services in New York City, Long Island and Westchester.

To its credit, New York State health officials are working to fill-in the gap with new reimbursement adjustments to pay for these overtime expenses; yet, the calculations thus far shared with the industry fall short in meeting the costs for providers directly billing Medicaid as well as those receiving Medicaid reimbursement from managed care plans.[24] As previously noted, most payments to home care providers now come from managed care plans to cover the costs of serving plans' Medicaid recipient enrollees.

While the state has promised and budgeted for managed care plans to receive wage-related adjustments to pass on to network direct-care providers for these new overtime costs, both plans and providers are suffering extreme delays in the provision of these funds, a significant proportion of which is more than a year overdue in payment, despite the onset of the higher wage payment requirements. Also evident (after the fact) is that the promised adjustments, even when eventually fully disbursed, will amount to less than half the actual amount needed to cover the wage increase that the funds were committed to cover. Added to this, other formula adjustments to meet the rising cost of services under managed care and home care are also far out of sync, and yet to be provided.

Meanwhile, at a time when overtime costs are substantially increasing due to federal mandates, Governor Cuomo's budget proposes another huge new workforce cost – a $15 per hour statewide minimum wage.

For other industries, the fiscal requirements of the wage increase can be at least somewhat accommodated in price changes and diversification or product changes. Alternatively, the home care financial infrastructure under Medicaid is not only price-fixed but it is also capped and subject to increasingly risk-based contracts with managed care plans whose own premium receipts from the state require a more rigorous actuarial analysis to make sure the premiums they receive are adequate to cover costs.

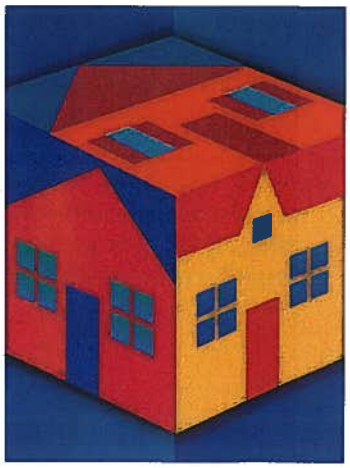
Anticipating this $15 minimum wage proposal, HCA has worked with partner associations across health care sectors over the past several months to calculate the impact of this wage increase on home care agencies, hospitals and nursing homes.

For home care, the impact is stunning: conservatively, this $15-per-hour mandate would **cost the industry an astonishing $1.7 billion** within a price-fixed system that has no cushion to absorb such a cost. In fact, the impact on home care is well above the estimated $1.17 billion impact for hospitals and nursing homes *combined*. And this figure does ***not*** include related costs that home care agencies will have to pay for price increases incurred in the purchase of services and goods resulting from the minimum wage impact on other service lines and vendors.

As noted, HCA has long advocated for increased funding to support home health worker compensation, recruitment and retention. We know that appropriate compensation for the home care workforce means better care and less turnover, supporting the overall mission of agencies. However, the Governor's wage proposal is a massive new, unfunded mandate that would be imposed on an already financially vulnerable home care system dealing with increasing costs, a plunge in operating margins, and reimbursement cuts.

As part of HCA's 2015-16 financial survey, HCA asked agencies if they had calculated the impact of a $15-per-hour minimum wage. The $1.7 billion statewide figure is astonishing enough, but some agencies conducted their own agency-specific calculations.

One agency reported that the "rates we pay our aide vendors will increase by 25% at least." Another pegged the impact at $830,000 per year, while another called the mandate "catastrophic." Some larger agencies reported an impact amounting to tens of millions of dollars.



Conclusion

A major irony of statewide health care policymaking is the fact that the one sector of health care best poised to meet the state's ambitious goals of reducing hospital admissions is home care. This sector is repeatedly emphasized by state officials as having a core role in the state's multi-billion dollar initiative to reduce admissions. Yet, home care is not considered as a point of financial investment; and, conversely, home care remains subject to disproportionately new cost mandates, outdated insurance laws, increasing risk loads, and direct reimbursement cuts.

Under these factors and conditions, home care, while in increasing demand, is underinvested and, indeed, straightjacketed by fiscal and regulatory constraints at the same time that the state is opening up new channels and billions of dollars in direct investments to other sectors.

For 2016, HCA has developed a package of legislative proposals to fix the state's reimbursement laws and levels to properly reimburse these needed services and to optimize home care's operation and contribution to laudable state policy goals. These proposals are both restorative and progressive, but require strong Legislative and Executive support to assure the viability of a system that hundreds of thousands of New Yorkers rely upon to stay healthy at home and to support the cost-effective utilization of services in an increasingly integrated health care environment.

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[1]The state has been authorized to reinvest up to $6.42 billion dollars from the federal government (the result of Medicaid Redesign savings) into a program called the Delivery System Reform Incentive Payment (DSRIP) program with a goal of reducing avoidable hospital use by 25% over five years. The funding is provided directly to "lead entities," mostly hospitals, which are expected to work with other providers in collaboration to meet outcomes goals. Though its participation and payment under DSRIP is uncertain, home care has long served as a major focal point for achieving avoidable hospital use because it is a cost-effective way to care for patients in their own homes instead of in costlier settings.

[2]For the purposes of this report, "home care providers" are defined as Certified Home Health Agencies (CHHAs), Long Term Home Health Care Program (LTHHCPs) and Licensed Home Care Services Agencies (LHCSAs), each of which have their own distinct role in the continuum of home care services delivery.

[3]In late 2015 to early 2016, HCA conducted a survey of its membership with questions about their finances (hereafter referred to as "HCA's 2015-16 financial survey.") The survey, which drew 85 responses, asked home care provider members to submit data from their most recent Medicaid Cost Reports (2014) and Medicaid Statistical Reports (2013). These reports are required by the state and include independently verifiable financial data signed by a Certified Public Accountant. HCA's 2015-16 financial survey also asked for responses related to other issues, like billing and authorization delays, experiences with new models of care, cost impacts, the difference between their contracted rates under managed care and fee-for-service Medicaid, and other issues. As part of the survey, HCA asked providers to submit their 2014 and 2013 cost data because the state only makes public its 2013 data for these providers at this time.

[4]Performing Provider Systems (PPSs) are 24 provider groups responsible for operating under the DSRIP networks that have applied for funding through their lead entities.

[5]Source: HCA's 2015-16 financial survey.

[6]DSRIP is just one part of the state's efforts to realign payment and health outcomes by incentivizing provider partnerships. Value-based payments are another policy initiative whereby providers must choose from three risk models (with varying degrees of financial risk) to provide "value over volume." The intricacies of this new model are now being discussed at several high-level workgroup discussions involving state health officials, the health care provider community and other stakeholders.

[7]For this analysis, HCA requested from the state the most recent Medicaid Cost Report and Medicaid Managed Care Operating Report (MMCOR) data for all home care providers billing Medicaid and for all managed care plans who receive premium payments from the state to contract with home care providers for services. Under managed care, the state pays the managed care plan a premium (called a per-member per-month premium) to pay for all services rendered by direct-care providers in the plan's network. The two reports – the Cost Reports and the MMCORs – show how the providers and their plan partners are performing financially.

[8]Source: HCA's 2015-16 financial survey.

[9]Source: HCA's 2015-16 financial survey.

[10]Medicare, Medicare Advantage, Medicaid, Medicaid Managed Care (all publicly sourced funds for home care) collectively account for well upwards of 90% of New York home care services, with the rest being private pay or commercial insurance.

[11]In August of 2015, HCA issued a separate survey of providers (40 respondents) on managed care payment issues. The survey, hereafter referred to as "HCA's 2015 managed care payment survey," found the following mix of managed care contracts: 90% of home care agencies contracted with MLTCs; 82% contracted with Mainstream Managed Care; 65% contracted with Commercial Health Plans; 55% contracted with Medicare Advantage Plans; and 45% contracted with FIDA plans, which is a pilot program downstate for managing both the Medicare and Medicaid service package of enrollees in a fully-integrated model.

[12]Source: 2013 and 2014 MMCOR data received from the state Department of Health.

[13]On average, according to HCA's 2015-16 financial survey, agency Medicaid revenue was 31% fee-for-service while 60% of Medicaid revenue for home care was through managed care organizations or managed long term care plans.

[14]HCA has long been concerned that the premium payments to managed care plans are not adequate to meet the costs of covering negotiated services with their network, direct-care providers. During the 2015 state legislative session, we advanced language that would require an actuarially sound approach to setting these rates to cover costs across the entire spectrum, but this language was not adopted.

[15]Source: HCA's 2015-16 financial survey.

[16]Source: HCA's 2015-16 financial survey.

[17]Source: HCA's 2015 managed care payment survey.

[18]Source: HCA's 2015 managed care payment survey.

[19]Source: HCA's 2015-16 financial survey.

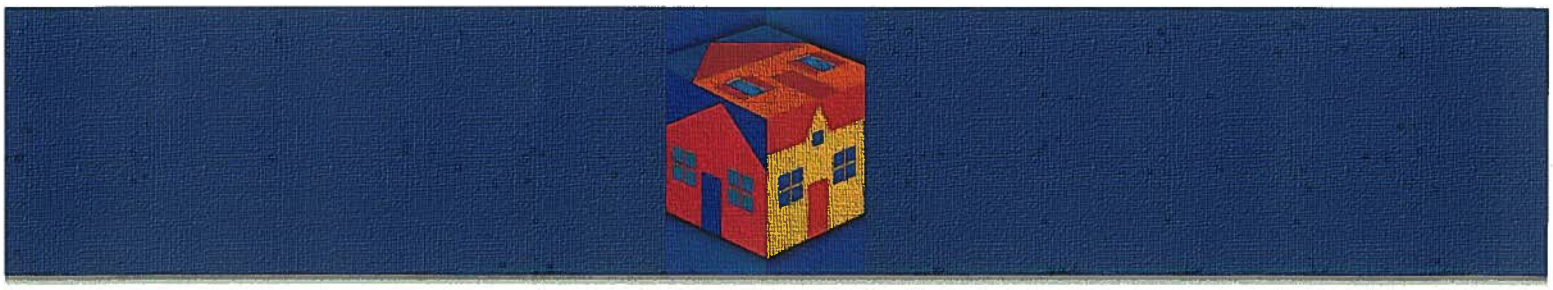
[20]Source: HCA's 2015-16 financial survey.

[21]CHHA rate rebasing was implemented in October 2015. Rebasing essentially means the resetting of the rates, in this case resulting in a massive cut beyond the projections for rate rebasing that the Legislature and Governor assumed in the negotiated 2015-16 state budget. The 2015-16 state budget projected a rebasing impact of 12 percent or $30 million; whereas the state Department of Health (DOH) issued much higher cuts between 28 and 36 percent or $70 to 90 million as part of the Cuomo Administration's rebasing regimen in October. Simultaneously, the Senate and Assembly unanimously passed legislation (S.5878/A.8171) intended to limit Medicaid rebasing cuts from exceeding the levels adopted in the state budget. This legislation was vetoed by Governor Cuomo on November 20, 2015.

[22]According to the state's most recent Medicaid Global Cap Report for the fiscal year ending October 2015, spending exceeded the global cap by $23 million for fiscal year 2015 through to October.

[23]The Medicaid Global Cap Report for the fiscal year ending October 2015 indicates that Medicaid total enrollment reached 6,325,794 enrollees at the end of October. This reflects an increase of 149,727 enrollees, or 2.4 percent, since March 2015.

[24]The state intends to increase the managed care plan rates by the state-share of $.34 per hour to account for new overtime, travel and live-in requirements and also provide an increase to Medicaid fee-for-service rates. The state has not decided how the money will flow from the managed care plans to their contracted home care providers; for instance, if the funds will be passed through on all home care hours or if the plans will have leeway in distributing an aggregate amount. The state Department of Health (DOH) intends to issue instructions on such a "pass-through" once it finalizes the method. At the time of this writing, DOH currently estimates the new federal overtime regulations will result in an increase of $0.34/hour across all aide hours. The Department is in the process of adding the state Medicaid share ($0.17/hour) retroactive to October 13, 2015 (in anticipation of federal approval on the other $0.17) as part of the 2015 Medicaid fee-for-service rate package and then will need to implement a similar adjustment to providers' initial 2016 Medicaid rates.



For more information, contact the
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Fix I:

Fix the state's reimbursement laws and levels to cover and reimburse needed services.

The state's reimbursement laws and levels covering home care need to be fixed, as shown in HCA's 2016 Financial Condition Report: two-thirds of agencies are operating at a loss; 15% of home care agencies find that more than 20% of their due revenue winds up as "bad-debt" (not getting paid); and over one-half of agencies have had to borrow money to pay for operating expenses in the past two years. These indicators are data points taken before the impact of massive cuts in Medicaid Rebasing have occurred and before workforce costs have skyrocketed.

Reimbursement fixes can be achieved by changing the public health and insurance law and by adjusting the state's payment methodologies. The fixes would address:

- **Paying managed care plans a rate to adequately cover their enrollee services by their network of home care providers**. This is fixed by ensuring that the statute governing premium/rate calculations includes critical cost factors for: workforce (below), essential infrastructure like health information technology (HIT), mandatory clinical standards, regulatory procedures, and related factors.
- **Assurance that workforce costs are properly incorporated in the payment methodology calculations. These costs are increasing because of state and federal mandates** (worker wage parity, new labor requirements such as federal overtime rules and a proposed minimum wage increase). These mandates need to be funded by the State.
- **Fixing the state's Medicaid "Episodic Payment System" for home care,** and addressing essential cost factors as referenced for managed care.
- **Updating the long-antiquated state insurance law coverage provisions for home care agency services** covered under private insurance, to sync with home care's actual clinical use today.

Fix II:

Pass legislation that enables home care to participate in New York's changing health care system. This saves money and improves health outcomes.

New York State's health care vision depends heavily on care to be provided at home and in the community. Despite this vision, state laws and policies are lagging behind this changing system, which is affecting home care's ability to fully engage and save dollars and enhance the patient experience.

To unleash home care's ability to fully participate in the evolving system, HCA advocates for legislation to:

- **Fast-track state regulatory changes that streamline** and better align regulations in a new system.
- **Harness home care in priority public health areas** that are critical to patient care – as well as to the state's major reform initiatives like DSRIP, Value Based Payment, and Managed Care – like sepsis interventions, falls prevention, wound care prevention, maternal and child health, emergency response. Home care's role in each of these areas saves the state health care dollars.
- **Provide for a proactive state HIT policy for home care,** to support home care HIT capacity and integration (with managed care plans, hospitals, physicians, and other partners) for meeting state policy and transformation goals.
- **Fund the hospital-homecare-physician collaboration program** enacted in the 2015-16 state budget.
- **Improve health care quality through innovations in home care and hospice care;** and improve access to palliative care for patients that would benefit.
- **Authorize new payment and delivery demonstration models,** as well as a homecare-primary care-housecalls initiative through nurse practitioner placement in home care.

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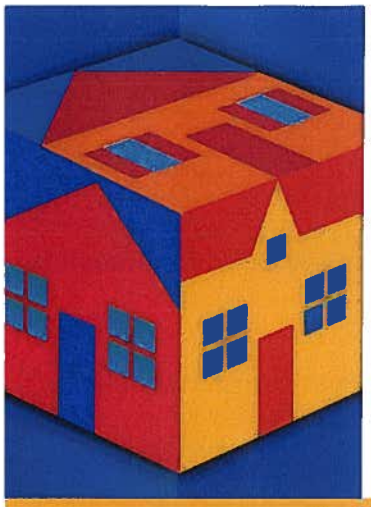
For more information, contact HCA at (518) 426-8764 or visit www.hca-nys.org.



HCA's Priority Asks:
Position Home Care to Meet the State's Policy Goals

Hundreds of thousands of frail, disabled and chronically ill patients across New York State receive their health care and critical services from home care agencies. Thousands of families rely on home care to enable family caregivers to work and families to function and participate in essential life activities.

Providing care in the home and community saves health care dollars and maximizes quality, flexibility and positive outcomes. Most of all, patients can be where they want to be and families can stay intact in difficult times. In addition, home care agencies are major community economic drivers and employ hundreds of thousands of nurses, therapists, home health aides and care professionals.

The health care system heavily depends upon home care for its role in enabling patients to rehabilitate at home, to age-in-place, and to prevent avoidable and costly nursing home placements, hospitalizations and emergency room visits. New York State relies on home care to achieve the state's goals to create new systems of care and to save dollars by avoiding hospital use by 25% over 5 years – and improving the community's health. These goals can't be accomplished without changes in reimbursement and support for the state's home care infrastructure.

In particular, action is needed in two basic ways to strengthen home care: 1) reimbursement fixes; and 2) budget language to enable home care to fully participate in the new health care environment.

The Home Care Association of New York State (HCA) asks that State Legislators and the Governor advance and adopt the following two priority proposals in the 2016 state legislative session and budget.

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