Submitted

LeadingAge™ New York
formerly NYAHSA

# Joint Legislative Public Hearing on Health/Medicaid

## Testimony Presented By:

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Senate Standing Committee on Finance
John A. DeFrancisco, Chair

Assembly Standing Committee on Ways and Means
Herman D. Farrell, Chair

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## Introduction

LeadingAge New York (formerly the New York Association of Homes and Services for the Aging - NYAHSA) appreciates this opportunity to testify before the Senate and Assembly Joint Health Committees on the health and Medicaid provisions of the 2012-13 Executive Budget.

My name is James W. Clyne, and I am the president and CEO of LeadingAge NY. Founded in 1961, LeadingAge NY is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public continuing care, including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living and managed care plans.

LeadingAge NY's 500+ members serve an estimated 500,000 New Yorkers of all ages annually. This broad representation gives us a unique understanding of the impact of Medicaid redesign and other initiatives on the entire long term care (LTC) system.

## Overall Perspective on Medicaid Redesign

As we speak, the state is embarking on the second year of an ambitious and far-reaching plan developed by the administration and the Medicaid Redesign Team (MRT). LeadingAge NY is a longstanding advocate of Medicaid reform, and embraces the major themes of Medicaid redesign which include: (1) expanding care management; (2) recalibrating Medicaid benefits; (3) revisiting reimbursement systems and incentives; (4) promoting personal responsibility; (5) eliminating government barriers; (6) empowering patients; and (7) aligning with federal policy objectives. We also support many of the individual MRT proposals in each of these areas. The MRT package creates a framework within which consumers, government, providers and other payors can collaborate to advance broader system objectives of containing cost, improving quality and ensuring access.

The enacted budget for state fiscal year (SFY) 2011-12 marked a dramatic turning point in New York's Medicaid program and health policy. While historically the state has sought to expand the role of managed care and care coordination models in Medicaid, managed care has always operated alongside traditional fee-for-service systems. The work of the MRT as incorporated into the State budget lays the groundwork for covering almost all Medicaid recipients under some form of managed care in the near future.

With that said, the process of moving nearly all Medicaid recipients into managed care creates many issues for recipients and providers alike. Under the best of circumstances, implementing sweeping change in a system as complex as our state's Medicaid program will invariably result in missteps along the way. The fundamental concern is the speed at which change is sought. When one looks at the breakneck pace at which changes are being thrust upon the system, it begs the question of what factors are driving this extraordinary sense of urgency. There is the recurring danger that political pressures and bureaucratic timelines could take precedence over consumers' best interests. Medicaid redesign will not only affect Medicaid recipients; it will have major implications for all individuals who need LTC services.

Along with the needs of consumers, it is also critical to keep in mind the current state of the provider community. When it comes to LTC, the relationship between the consumer and the provider is different from other areas of health care service delivery. In LTC and senior services, relationships are built that often span several years. The caregiver going into the consumer's home or attending to the resident's bedside often develops a relationship that is both professional and personal. In many cases, our caregivers are the individual's only remaining family. The impact on the care provider cannot help but translate down to an impact on patients, residents and their families.

**Impact on Providers**

With the understanding that provider impacts directly affect consumers, it is important to understand the challenges currently confronting the provider community.

Let us take a step back and understand the state of LTC services just prior to embarking upon Medicaid redesign. Overall, LTC providers were struggling due to years of state budget cuts resulting in reimbursements that failed to cover the cost of care. As the state entered into the same economic malaise that affected the entire nation, budgetary pressures resulted in even more cuts to provider funding.

As a result, Medicaid redesign is being imposed on a system that is already fragile and struggling, and, in many cases, near collapse. The threats to provider viability, and therefore to consumer access and quality of care have been far too real for far too long. Again, LeadingAge NY has been and remains one of the leading voices calling for desperately needed fundamental reforms to end this cycle. However, imposing massive changes to the Medicaid program on a LTC service system that is already fragile and financially tenuous – in a manner that seems almost dismissive

of the impact on current providers – is alarming and should be a real cause of concern for everyone who relies on LTC services.

**Stop...Let's Take a Breath**

In order for the current reforms to be successful, the transition must be managed deliberately, systematically and carefully. From the provider community perspective, on behalf of the consumers we serve, we indeed have serious concerns about how the transition is being managed.

Take for example, a small Long Term Home Health Care (LTHHCP) program (also known as a "Lombardi program"), an agency that has been helping nursing home eligible patients remain in their own homes in a rural upstate community for the past 20 years. The stark reality confronting that agency is that because of these changes, they don't know whether they will still be in operation a year from now. Yet this same agency must continue to operate and serve consumers, hire employees, and reassure its community, when the agency itself is operating in a state of nearly total uncertainty.

There are often no clear answers to the questions that providers need resolved, even after a particular redesign initiative has already been set in motion. What answers are out there can often change from one day to the next. Providers feel frustrated; at best they cannot reasonably plan for an uncertain future, and, at worst many believe they are being driven out of business for reasons that defy understanding.

And yet, in the meantime, these same providers continue to honor their professional and moral duty to provide care to their consumers. They and the consumers they serve deserve better. We can do better, and this Association stands ready to work with lawmakers and policymakers to better manage this transition.

**What We Need**

What is needed most of all is for the provider community to be able to partner with consumers and state government in managing this transition. As partners in this process, we need the Legislature to support the following **recommendations**:

- *Ensure that providers across the spectrum of LTC services are given the guidance necessary on Medicaid redesign to enable them to responsibly plan and operate their organizations, such that they are not left guessing as to their future existence and role.*

- *Assure current LTC providers and consumers will be able to transition smoothly into the new service system, and an ability to meaningfully work with state government to address the inevitable problem areas and unintended consequences; and*

- *Finally, where necessary, have the ability to slow the process down in order to minimize service disruptions, and in the long run better ensure the overall success of Medicaid redesign.*

With this overall picture in mind, I will now touch on more specific concerns of LTC providers and plans.

**Global Cap and Trend Factor Elimination**

As noted above, despite the focus on Medicaid redesign last year, providers still faced serious reimbursement cuts and/or additional provider taxes. In the end, between cuts and added provider taxes, Medicaid providers are dealing with yet another round of rate reductions that will automatically extend into the upcoming State fiscal year.

The current Medicaid global spending cap, which would be extended by an additional year in the 2012-13 Executive Budget, also grants the Commissioner of Health "superpowers" to unilaterally implement savings measures deemed necessary to stay under the cap. Even in a Medicaid redesign context, the potential for arbitrary provider rate cuts remains and is even less predictable. Several factors totally out of the control of the provider community could cause the cap to be breached (e.g., an expansion of Medicaid services due to federal mandates or an economic downturn), and yet it is the providers that would likely have to bear the brunt of dealing with the issue. Furthermore, how the administration develops spending projections for each category of service could have a bearing on whether a certain type of provider could face a non-uniform cut if the cap is exceeded.

***Recommendation:*** *As Medicaid redesign proceeds and funding shifts among service categories, the Legislature should continue to closely monitor the development of spending projections by service category as well as actual spending trends by sector. Lawmakers should also be prepared to provide input to the administration on any proposed Medicaid savings plans, taking into account the potential impact on LTC providers and recipients.*

In spite of growing operating costs – including costly mandates like the wage parity law passed last year – providers will receive no cost-of-living adjustment once again in 2012. Now the Executive Budget includes a proposal to permanently

eliminate any statutory requirements to provide needed inflationary adjustments to Medicaid rates and other state payments to providers, in favor of "performance-based" adjustments made at the discretion of state agencies. This would effectively eliminate any legislative input into the rate setting process and, in the context of the global spending cap, make it unlikely that service providers will receive necessary inflationary adjustments anytime soon.

***Recommendation:*** *Lawmakers should reject this proposal and ensure that state law continues to require inflationary adjustments to payments made to Medicaid and other service providers, and that providers are not arbitrarily penalized for macroeconomic factors that negatively impact on the global spending cap. We are ready to work with the State on performance based adjustments but without knowing the State's intent inflation adjustments are needed.*

**Limits on Executive Compensation and Administrative Costs**

The 2012-13 Executive Budget and Executive Order #38 would require state agencies to impose new limitations on the state's reimbursement of the costs of executive compensation, and on the use of state funds to offset provider administrative costs. Since Medicaid payments for most long term care services already include limitations on executive compensation and or administrative caps it is unclear how this proposal would be implemented.

The proposal has generated numerous other questions and concerns as to how key terms would be defined; how various state agencies will interpret the requirements and their ability to provide waivers for good cause; what effect the requirements could have on recruitment and retention of competent executives; and whether the proposal will create disparate impacts across service providers depending on the degree to which they serve recipients of Medicaid and other forms of public assistance.

**Managed Long Term Care**

My testimony so far has focused on LTC service providers. Managed long term care (MLTC) plans are facing their own critical and compelling set of challenges.

Major concern again stems from the aggressive timeframes the state has established for the transition to managed care, with the Department of Health (DOH) publicly stating that all Medicaid recipients will be enrolled in managed care plans within 3 years. This ambitious overall timeframe is also reflected in individual MRT initiatives. Most notable is MRT #90, requiring all Medicaid recipients aged 21+ who need 120 days or more of home and community-based services to enroll in

MLTC, beginning on or about April 1, 2012. Starting in New York City, the state intends a very rapid expansion to other geographic areas as they hope to expand the number of available MLTC plans. With approximately 34,000 Medicaid recipients currently enrolled in MLTC, that number would have to increase approximately tenfold for the entire LTC population to be covered.

For this transition to be successful, we request your support of the following **recommendations**:

- *Ensure actuarial soundness of rates that are adjusted in real time to reflect the increasing risk that MLTCs are being asked to assume;*

- *Promote efficient growth and expansion of MLTC plans through regulatory streamlining, and clarifying the criteria by which an MLTC can subcontract with "downstream" service providers;*

- *Enable MLTC operators to manage their enrollments in order to make the process as smooth and consumer-friendly as possible. A proposal in the 2012-13 Executive Budget to mandate the use of a single statewide enrollment broker should be clarified to ensure that there is interface and coordination with the actual plans, and that MLTC plans can continue to communicate with and enroll recipients.*

- *Ensure an objective Medicaid fair hearing process that does not undermine the integrity of the managed care model;*

- *Timely reflect the costs associated with the wage parity law in capitated payments to MLTC plans.*

The state Medicaid program is publicly financed with taxpayer dollars. Those dollars should stay with New York-based operators that will reinvest those dollars here at home, as opposed to publicly-traded for-profit corporations that will divert state resources out of New York. An Executive Budget proposal would strike a long-standing provision in statute that requires MLTC sponsors to be well-established organizations that have experience as providers or plans with a history of coordinating services. Without this provision, there is serious concern that the market will open up to inexperienced corporations that will enter the MLTC market seeking to generate quick profits from taxpayer dollars. Our not-for-profit, provider-based MLTC operators have a proven track record of providing efficient, high quality, high consumer satisfaction services to Medicaid clients.

**Recommendation:** *Legislators should reject the Executive Budget proposal to open up sponsorship of MLTC plans to any interested entity. This is a serious consumer protection issue, and the protections afforded under the current statute must be preserved.*

**Nursing Home Services**

To examine the state of nursing home Medicaid financing over the past few years is to observe what can only be described as chaos. The long overdue "rebasing" of Medicaid rates was finally implemented, but simultaneous state budget cutting measures essentially negated any overall benefit from the new system. Delays in rate updates, freezing of trend factors, additional cuts and provider taxes, and now the uncertainty of a new statewide pricing system, a global cap that could result in mid-year rate cuts, and the managed long term care transition, only serve to compound the financial challenges and uncertainty that providers face.

And the financial challenges facing nursing homes are not insignificant. Annual inflationary factors have been eliminated or zeroed out since 2007. Providers are asked to do what they have been doing while they are paid what they were five years ago. Vendors and unions are not willing to accept that deal so costs to the homes continue to increase. Over 75% of nursing home costs are staffing-related, and compensation, largely driven by union contracts, continued to rise over this time period. As a result, DOH now considers 23% of all nursing homes in the state to be "financially challenged."

DOH was given the authority last year to establish a statewide pricing methodology effective January 1, 2012. While the system has some positive features, it has some serious, negative consequences that can't be ignored, specifically the impact it has on certain providers. Many of the most negatively impacted facilities are widely recognized for innovation, resident focus and offering multiple services in their communities. Although a stated goal of the new methodology was to minimize funding disruptions, at the end of the day it will transfer over $200 million among providers and result in double-digit revenue reductions for dozens of facilities.

**Recommendation:** *Address those nursing homes that are being most severely negatively impacted by statewide pricing, and ensure that overall nursing home reimbursement is not further cut as managed care enrollment increases by requiring that nursing home costs be adequately reflected in managed care rates.*

Our membership includes managed care organizations as well as providers across the entire continuum of long term care services. Our members are hard at work learning from each other and forming formal and informal partnerships. Managed

care organizations are playing a crucial role in Medicaid redesign and deserve appropriate premium payments. Inadequate payments will only add to the financial pressure homes are currently facing and undermine the type of partnerships between providers and MCOs that are needed to ensure continuity, stability and quality of care for the vulnerable populations involved. Adequate premiums will not guarantee a smooth transition, but premium levels that fail to reflect care costs will guarantee that the restructuring will be more difficult than necessary.

One crucial part of this is the capital cost component of Medicaid nursing home rates. Capital projects require long range planning and major investments, and many homes have made these decisions and entered into debt obligations and credit enhancement arrangements based on the state's assurances of Medicaid reimbursement for these costs. Furthermore, state policy should promote and not discourage existing nursing homes from investing funds to upgrade their physical plants.

**Recommendation:** *For these reasons, nursing home capital costs should be "carved out" of managed care benefit packages and reimbursed directly to providers by Medicaid so that providers can meet their existing debt obligations – which are predicated on current reimbursement provisions – and can continue to invest in necessary facility improvements. Otherwise, existing debts and access to additional capital for construction could be threatened.*

Related to this is the issue of automatic sprinkler systems in nursing homes. Federal regulations require all nursing homes to be fully sprinklered by August 2013. While we have been working with DOH on this issue since it was announced, there remain a number of homes that are unable to obtain capital funding for the costs of these projects.

**Recommendation:** *Through legislative and/or administrative actions, the state should assist nursing homes that are having difficulty obtaining financing for needed sprinkler upgrades.*

Nursing home residents who need to be hospitalized should be able to return to their room in the nursing home upon discharge. Homes with high occupancy qualify for Medicaid bed-hold payments to compensate for holding an empty bed while a resident is in the hospital. The state has limited these bed-hold payments in recent years and proposes to give DOH unilateral authority to further reduce these payments by $40 million. What is unclear is the proportion of total payments that $40 million represents, and how this provision would be implemented. We believe that the total amount of bed-hold payments has already fallen significantly, and will

further decline without further state budget action as initiatives aimed at reducing re-hospitalizations are implemented.

**Recommendation:** *Given the recent significant cuts in the Medicaid bed-hold benefit and the increasing acuity of nursing home residents, it is important to preserve an adequate bed-hold benefit so residents do not have to worry about losing their home because of a temporary transfer to the hospital.*

Finally, as the state transforms how LTC is funded and organized, onerous and unnecessary state regulations need to be addressed. One such change includes authorizing facilities to use specially trained technicians to assist in administering medications. This practice has been successful over a long time period in the developmental disabilities field, and could allow better use of direct care staff in nursing homes.

**Recommendation:** *State lawmakers should support the proposal to allow nursing homes to utilize specially trained aides to assist in medication administration.*

**Home and Community-based Services**

Home and community-based services are vitally important to enabling seniors to stay at home safer and for a longer period of time, and must be a key partner in the current transition to managed care. Unfortunately, more so than any other provider group, home care agencies are dealing with an untenable level of operational uncertainty. In addition, across-the-board cuts, provider taxes, the elimination of the trend factors and unfunded mandates which have been in effect for years, were only exacerbated in last year's budget and continue to impact the system today.

LeadingAge NY remains particularly concerned with two MRT initiatives, mandatory managed long term care and the wage parity law. Under mandatory MLTC, enrollment is effective and slated to begin sometime after April 2012 in New York City, once federal approval is received.

Continuity of care provided by community-based programs is jeopardized because of the continued uncertainty and the timing of enrollments. For example, nearly 50 LTHHCPs that are sponsored by nursing homes and hospitals may lose their ability to provide nursing and therapy services in patients' homes. This is because DOH has concluded that these agencies, unlike other LTHHCPs that are considered "freestanding" agencies, must apply to become certified home health agencies (CHHAs) under a new process. There is no way of knowing how many of these 50

or so LTHHCPs would be granted CHHA licenses, or how many recipients would have their care disrupted if they needed to switch agencies.

Finally, providers have made financial, operational and staffing decisions based upon the state's draft phase-in schedule. To allow a county to implement mandatory enrollment months or years ahead of schedule would put local providers at risk of being locked out of contracts by larger and/or commercial managed plans that are not familiar with the fabric of their communities.

**Recommendation:** *Home care providers need predictability in order to manage operations and continue providing care and employment during the transition to managed care. The Legislature should help to ensure that this transition is managed effectively by deeming LTHHCPs that are nursing home or hospital-sponsored as CHHAs.*

A provision in the enacted 2011-12 budget requires CHHAs, LTHHCPs and MLTC plans to comply with the state wage parity law in the NYC boroughs and surrounding counties beginning in April 2012.

**Recommendation:** *This unfunded mandate still needs to be clarified before it is implemented. Absent additional funding, this will put providers at greater risk to have to reduce their staffing and may undermine the transition to managed care.*

LeadingAge NY supports the 2012-13 Executive Budget proposal that would allow Licensed Home Care Service Agencies (LHCSAs) that have contracts with MLTCs to receive fee-for-service Medicaid payments for recipients who are temporarily transitioning to fee-for-service status for a variety of reasons. We hope that as payment issues like this arise, they can be resolved quickly so continuity of care is not undermined.

We appreciate that the Executive budget keeps most State Office of the Aging programs level-funded, but we are seriously concerned to see $457,000 cut from the Naturally Occurring Retirement Communities (NORCs) and Neighborhood NORCs. These critical programs bridge medical and social issues for seniors who are otherwise at risk for needing Medicaid-covered services. They also minimize the silo effect, and are in and of themselves important care coordination models.

**Recommendation:** *The Legislature should restore funding for the NORC and neighborhood NORC programs.*

**Adult Day Health Care**

In anticipation of the statewide expansion of MLTC, LeadingAge NY's affiliate, the Adult Day Health Care Council, has developed a proposal for a new model of adult day health care.

Adult day health care (ADHC) is a community-based long term care program that provides comprehensive health care to the frail elderly, disabled and chronically ill in a congregate day-center setting. ADHC centers provide all the services that a nursing home provides, but individuals who attend them can remain in their own homes and communities while receiving care. Currently, approximately 13,500 New Yorkers annually receive ADHC services in 160 centers.

MLTC plans must offer coverage for both ADHC and social day care to their enrollees. Social day care services include a meal, socialization, and personal care, but do not include skilled services such as nursing, physical therapy and medication management, which are routinely provided in ADHC centers. Currently, individuals receiving ADHC and social adult day care must receive these services in separate centers. In addition, ADHC is reimbursed through an all-inclusive visit rate. This means that within each ADHC program, the same rate is paid per visit for each individual regardless of the number and type of skilled services the individual receives.

Our proposal would allow ADHC and social adult day services to be provided to individuals in the same physical location and during the same time period. ADHC programs would be permitted to unbundle their services thus allowing MLTC plans to purchase only the services they feel their clients need and to negotiate the price of these services with the ADHC program. This proposal: (1) allows the ADHC model to be flexible as MLTC expands; (2) reduces the possibility of disruption of the 13,500 ADHC registrants since they will be able to receive both ADHC services and social adult day services provided by MLTC plans in the same place; and (3) addresses the shortage of social adult day capacity throughout the state.

This change can be made by amending regulations at 10 NYCRR Section 425, which govern ADHC programs. Timing is a critical factor since ADHC programs must be allowed to change in advance of, or at least at the same time as, MLTC is expanded. We have had numerous conversations with DOH and they are supportive of the concept.

**Recommendation:** *We are working with DOH to ensure this regulation change is made, and will seek legislative support for implementation of this new model as quickly as possible.*

**Adult Care Facilities and the Assisted Living Program**

Adult Care Facilities (ACFs) and the Assisted Living Program (ALP) remain critical components of our senior care delivery system and are extremely well positioned to support the current transition to managed care. ACFs and ALPs are cost-effective alternatives to more expensive forms of institutional care and are efficient delivery models that combine services with housing.

The Executive Budget proposal seeks to repeal the section of social services law that expanded the ALP by 6,000 beds, contingent on the decertification of 6,000 nursing home beds, as part of the state's "rightsizing" initiative. The MRT Affordable Housing Workgroup recommended that the ALP be expanded, but no longer be contingent on nursing home de-certifications. We question whether this will have a negative impact on the ability to expand the program.

**Recommendation:** *The Executive Budget proposal should be clarified to eliminate only the part of the existing law that requires nursing home bed decertification, while preserving the ALP expansion.*

Another Executive Budget proposal seems to require that ALPs conduct their own resident assessments. The MRT Affordable Housing Workgroup recommended that ALPs be allowed to conduct their own assessments, but not be required to do so. The intent of the proposed budget language needs clarification.

**Recommendation:** *Existing law should be amended to allow, but not require, ALPs to conduct assessments. There are some ALPs that will find it most efficient to continue to contract with a CHHA or LTHHCP to conduct assessments. This flexibility is essential.*

The Executive Budget does not appear to authorize Medicaid reimbursement to ALPs for pre-admission resident assessments; however the MRT Affordable Housing Workgroup recommended this in conjunction with the aforementioned ability to conduct assessments.

**Recommendation:** *We recommend the final budget include a provision authorizing Medicaid reimbursement to ALPs for conducting pre-admission assessments. If ALPs will be required to conduct pre-admission assessments, this is particularly important. While the cost of ongoing assessments will be captured in the Medicaid capitated rate, there is no way to capture the cost of a service provided to someone who is not yet a resident of the ALP.*

The Executive Budget proposal includes language authorizing an ALP to contract with more than one CHHA or LTHHCP and/or other qualified provider for the provision of certain services. However, it is unclear what is meant by "and/or other qualified provider" (i.e., which types of providers are "qualified" and for which services).

**Recommendation:** *ALPs should be able to contract with nursing homes and outpatient therapy providers in addition to CHHAs and LTHHCPs for those services they are responsible for, and pay for within their set rate. Qualification could entail being licensed by DOH. The statute should allow flexibility to enable the ALP to arrange the services in the most resident-centered and efficient manner possible.*

The MRT Affordable Housing Workgroup also recommended expedited enrollment into the ALP. However, there does not appear to be any language implementing it in the Executive Budget proposal. Given that the current assessment process is outlined in statute, we believe that a statutory change would be required to implement the recommendation.

**Recommendation:** *State law should be amended to facilitate expedited ALP enrollment by allowing individuals to be admitted without an assessment conducted by the local department of social services (LDSS) or HRA prior to admission. Rather, the LDSS can conduct post-admission audits to ensure appropriate admissions. Currently, an ALP resident must go through a "triple screen" before being admitted to the ALP: being evaluated by the ALP, CHHA or LTHHCP and local district. This means that admissions rarely happen quickly. The goal of this provision is to speed up this process and prevent unnecessary nursing home placement. This change is consistent with recent changes in managed care; MLTC plans are subject to a retroactive review.*

**Conclusion**

Again, while overall we support the current efforts at reform, imposing these reforms on a system that is struggling to survive, in a manner that seems almost dismissive of the impact on current providers, is not in the best interests of consumers.

LeadingAge NY encourages the administration and Legislature to work in partnership with providers, consumers and other stakeholders to implement Medicaid redesign initiatives. Such a partnership, however, requires that we strike a balance between the needs of the state to implement the transition, and the needs of current providers who are actually providing the care and services our Medicaid consumers depend upon. To disregard the latter in favor of meeting arbitrarily

established, bureaucratic timelines will ultimately be a disservice to our vulnerable Medicaid population and to the ultimate goals of reform.

As always, LeadingAge NY and its member organizations stand ready to assist lawmakers in developing a budget and policies that will best serve the needs of our state. Thank you for the opportunity to testify today.