



February 8, 2012

Dear Members of the Joint Legislative Budget Committee:

HCA presents to you the attached written testimony, in the form of a document entitled *In the Aftermath of the MRT: Home Care in New York State – at a Crossroads*.

On behalf of approximately 400 HCA home care provider members and the hundreds of thousands of patients they serve, I ask the Joint Legislative Committee, as it considers the Medicaid and health portions of the budget, to carefully consider the unprecedented upheaval which is now occurring in the home care system and which will only be exacerbated by soon-to-be-implemented policies enacted from last year's budget, as documented in HCA's testimony report.

In addition to the damage from massive cuts to home care in last year's budget, which the current-year budget proposal silently continues into 2012-13, home care providers wishing to comply with state-mandated policy changes in the coming weeks desperately need: answers to fundamental questions; more reasonable timetables for phasing-in major new home care mandates, enrollment policies, and reimbursement changes; clear, explicit and non-conflicting guidance from the state for compliance with these imminent new policies; and accommodations that assure continuity of care for patients – all of which are tragically lacking, needlessly putting providers at compliance risk, and, worst of all, risking the quality of care for vulnerable patients who rely on home care services. Our report offers several recommendations for your consideration in all of these areas which we would be pleased to further discuss with you as part of the budget process.

The past year has been one of enormous challenge for the home care system. Even greater challenges lay on the horizon. Home care providers need your immediate action to mitigate the continued onslaught of cuts to home care and the fundamental gaps in state policy development, for the sake of patients and the operational stability of New York's home care infrastructure.

If you have any further questions about these issues, please do not hesitate to contact me at (518) 810-0664 or jcunningham@hcanys.org.

Sincerely,

A handwritten signature in blue ink that reads 'Joanne Cunningham'.

Joanne Cunningham
HCA President

In the Aftermath of the MRT

Home Care in New York State – at a Crossroads

For over three decades, New York State's home care system has been the national leader and the inspiration to other states in setting the models and standards for the preventive, post-acute, rehabilitative and long term care of individuals at home.

New York's Certified Home Health Agencies are among the very first and most community-rooted in the nation. Our Long Term Home Health Care Program (also known as the "Nursing Home Without Walls") has been the country's model for long term care at home, providing a cost-effective, coordinated alternative for individuals who are otherwise eligible for nursing home placement. These programs have combined with Licensed Home Care Services Agencies and consumer-directed models to establish a continuum of community services and options caring for several hundred thousand individuals and families annually, and saving hundreds of millions of dollars in Medicaid expenses.

Over the past year, in the wake of massive policy actions with no planning and no fallback options, this diversified system has been pushed down a path of change for which its future direction, or even sustainability, is greatly uncertain.

Massive change

Major policy changes, advanced by the Governor's Medicaid Redesign Team (MRT) and enacted as part of the State Budget agreement on April 1, 2011, have set in motion massive reimbursement cuts, an unfunded wage mandate, and a series of policy changes that leave New York's home care system in a perilous state.

Reimbursement cuts alone are prompting agency closures and, in many cases, have disrupted and destabilized the care that many of the neediest and most complex home care patients receive. Care delivered by county agencies across the state is in a heightened state of jeopardy, as county governments are increasingly seeking the sale or closure of their agencies, a trend which most profoundly affects service availability in rural areas.

On top of massive cuts that uniquely targeted home care last year, the state budget also set in motion a new policy of mandatorily enrolling all long term home care

patients into managed care plans, including Managed Long Term Care Plans (MLTCs). In addition, home care providers also must adhere to a new, unfunded wage mandate, effective March 1, 2012, that will cost them hundreds of millions of dollars, and will likely result in some agencies closing. A new payment system was also imposed on providers for shorter-term home care patients, starting on April 1, 2012.

In any given year, these policy or reimbursement changes would have an adverse impact on the provider community. But all of these changes, simultaneously enacted, have caused a tsunami-like reaction in the community-based home care arena, challenging these providers to figure out how to stay fiscally viable while they are compelled to plan for a still-undetermined business model in a brand-new system of home care delivery. For many community-based providers, their future is in jeopardy.

Unmanageable pace and inadequate communication about change

Because so many policy shifts and reimbursement changes all were enacted simultaneously and with very quick implementation dates, providers are now attempting to manage and navigate this massive array of new system changes, all the while figuring out how to preserve their mission-driven approach to caregiving. Many of these providers serving the chronically ill, elderly and disabled population must figure out how to transition thousands upon thousands of patients into a new managed care system which may or may not want to partner with their organization. These agencies have spent decades creating programs to serve needy patients in their communities. Unfortunately, they may no longer be allowed to continue in that role or in the important role as care coordinator, to assure that patients have the care they need to stay in their homes.

Compounding the policy change is the fact that the state's transition plan has not given guidance to providers to assist them in such a massive transition plan or to help position them to continue to be the health care provider for these patients. Without a state directive that insists on continuity of care, the transition for these patients will be fragmented at best.

Most of these changes will begin implementation in less than two months: on April 1, 2012. Though they were enacted during last year's budget, little was known at that time as to how exactly the changes would affect long-standing provider organizations and their patients. There was no effort by the state to adequately assess the capacity of the existing home care system to meet the state's home care needs and policy goals without moving to this abrupt, massive and arguably unnecessary transition. There was also no effort to determine the system's capacity to adapt to these changes, minimal opportunity made to educate providers about transition issues, or other actions necessary to otherwise ensure an orderly transition process. As a result, the system to date stands in substantial chaos.

In addition, as the state now enters the implementation phase for each of these massive system changes and mandates, policymakers have yet to offer: clear instructions for compliance with statute; a responsible, orderly or detailed transition plan; a reasonable and predictable implementation timetable; safeguards to ensure that the provider infrastructure is not dismantled or does not collapse; a well-defined delineation of compliance, administrative or reporting responsibilities; or, even, an articulation of the most basic rules governing certification, quality reporting, contractual arrangements or patient outreach responsibilities.

Some of the state's policy changes haven't even yet received requisite federal approval, causing additional uncertainty for providers. Home care organizations are thus expected to make major planning decisions today – mere weeks before implementation – for an entirely new system of care delivery that, in many key areas, has yet to even gain final approval from the federal government, much less a clear articulation from the state regarding implementation.

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To achieve state policy goals, home care providers need stability, signals of support, help in adapting, and clear and practical guidance

In the face of a complete realignment of the entire home care system, without guidance, information and concrete assistance to providers, the future of many community-based home care agencies is in jeopardy. State health officials have provided mixed messages to providers. Some policymakers indicate that it is the clear intention of the state to preserve continuity of care through policies that would require the continuation of services being provided by the existing network of providers, such as Long Term Home Health Care Programs, Certified Home Health Agencies and Licensed Home Care Services Agencies. Meanwhile, conflicting guidance and policy is essentially silent on how current providers can continue to serve their patients and communities and to vitally remain in the service delivery arena.

Moreover, the state has recently sent yet another mixed signal to the provider community by allowing for the establishment of new Certified Home Health Agencies to enter into the New York home care marketplace (without regard to state public need regulations), spelling further displacement of the current network of community-based providers.

The lack of consistent, practical and encouraging guidance to New York's home care provider network has left the majority of providers – including their sponsoring hospitals and health systems – uncertain about their future and in a state of significant alarm about how their patients will continue to receive care by their agency. Without this guidance, the organizational planning that home care providers are forced to make in anticipation of changes to come, requires a complete realignment of both their mission and role in the health care system – decisions that could be irreversible and result in the loss of home care capacity needed in New York's health delivery system.

Home care's role saves the health care system, already exceeding state estimates

The state Department of Health's own data shows that home care programs like the Long Term Home Health Care Program (LTHHCP) are already cost-effective and can support the state's cost-efficiency goals if allowed to continue managing and overseeing the care of community-based long term care patients. The LTHHCP, in particular, provides an alternative to institutional care at 50 percent the cost of institutionalization; its cost-savings capacity and programmatic function can be further enhanced through legislation already advanced by HCA and introduced in the Legislature. This program, alongside Managed Long Term Care Plans, can play a vital role in assuring excellent coordination of care for patients with highly intensive needs or health conditions, saving the state Medicaid funds. Additionally, like all other health sectors, home care is subject to a Global Medicaid Spending Cap that is already achieving cost savings and can continue to do so absent system-destabilizing changes and mandates.

Implemented last year, the cap limits state-share Medicaid spending in all areas to \$15.3 billion in 2011-12 and \$15.9 billion in 2012-13. While respecting the state's need for fiscal discipline and expenditure control, HCA has strongly objected to the approach taken in establishing this cap. We contend that the cap policy: places an artificial limit on an open entitlement program, Medicaid, in which enrollment is growing; is connected to broad administrative "super-powers" that allow the Commissioner of Health to unilaterally reduce expenditures through cuts and other means as the Commissioner may deem necessary, without a needed mechanism for legislative input; and jeopardizes the financial viability of home care agencies, 70 percent of which reported operating in the red prior to last year's budget. According to the most recent report on the Global Medicaid Spending Cap, cumulative state-share spending for the months of April through November 2011 was \$10.94 billion compared to an estimated \$10.95 billion, or \$4.4 million below the state's projections.

Home care has been a prime source of Medicaid reductions and savings within the cap. Of all the health sector categories, "Other Long Term Care" (which encompasses home care provider spending) was \$88.9 million less than the state projected – the most successful category of state-share savings under the cap, grossing to a state/federal-share Medicaid savings level of \$177.8 million.

Without stability, practical guidance and support, the role of community-based agencies is in jeopardy

At this critical time of instability and uncertainty, HCA urges the Legislature to take action to send some clear signals of support for New York's community based home care providers. These requests ask for mitigation of damaging reimbursement cuts, clarity about new proposals impacting home care in the Governor's Executive Budget Proposal, assistance in transition plans, and clear guidance and direction about the home care provider community's role in a new system.

HCA Budget Requests

HCA urges the Legislature and Executive to include the following provisions in the amendments to the Executive budget:

- 1. Ensure that the Transition to Managed Care is Provided for in a Responsible Manner and Maintains the State's Landmark Long Term Home Health Care Program (also known as the "Nursing Home Without Walls")**

The implementation plan for the state's policy requiring mandatory enrollment of home care patients into managed care, as adopted in last year's budget language and currently being executed, lacks the necessary guidance, consumer/provider safeguards or appropriate timetable to avoid disruption in the continuity of care or loss of the service infrastructure. As a result, home care services throughout the state are at risk of being disrupted or irreparably diminished. In particular, New York's national landmark program, the Long Term Home Health Care Program (LTHHCP), is especially imperiled.

HCA urges that the budget be amended to incorporate language to provide for a responsible implementation of the state's managed care policy, including: (a) an adequate timetable and orderly progression for transition; (b) continuity of patient care and service provider; (c) consumer and community options for models of care, including the LTHHCP; (d) contract parameters and safeguards for consumers, providers and managed care plans; (e) adequacy of premiums and service payment for managed care/home care enrollees; and (f) continuity of the telehealth program in Certified Home Health Agencies (CHHAs) and LTHHCPs.

The Executive budget language mandates that long term care patients be offered the Consumer Directed Care Program; the LTHHCP should similarly be included as a mandated consumer option, as it is now under the current system.

- 2. Repeal, or at a minimum, delay, the implementation of the Home Care Aide Wage Mandate; ensure Continued Funding of Managed Care Premiums and the Down-streaming of Payment to Providers to Support the Mandated Aide Wages from Prior Local District Contracts; if the mandate is not repealed, then Appropriately Expand Funding to Cover All Applicable Aide Wages**

Last year the state budget imposed an enormous unfunded mandate on home care agencies in New York City, Westchester and Long Island, to pay home care aides wages based on those required of government or government contractors under local wage mandate laws.

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The law is scheduled for implementation in New York City on March 1. There is tremendous instability and uncertainty in the home care community about the ability to comply with this law given the absence of funding as well as the state's massive layers of home care cuts. Providers find an alarming lack of information available to them on aspects of the law – information that is necessary in order to determine compliance. Since last spring, HCA has been appealing to the state Department of Health for clarification of the terms and responsibilities under this law but, thus far, such clarifying information has not been adequately provided.

Providers are unsure of how to implement the law, in addition to being uncertain where the financing will come from to cover this unfunded mandate. The lack of information – and lack of available funds – is also preventing providers from executing timely contract renewals for services as well as interfering in their right to contract discontinuation.

HCA urges the Executive and the Legislature to either repeal or to amend the wage mandate law to delay implementation for at least another year while the system adjusts to the profound series of cuts and changes – by which time there may also be a clear delineation of provider responsibilities under this law.

In the partial transition of the personal care program from contracts with local districts to contracts with managed care plans, which began on August 1, 2011, the state Department of Health required that managed care payments to home care providers continue at the reimbursement levels necessary to permit the home care agencies to pay wage mandates effective under local laws in the New York City, Westchester County, Nassau County and Suffolk County personal care programs. The state's mandate for these managed care payment levels was made effective only through February 29, 2012; there has been no stated commitment at this time by the Department of Health to fund either the existing personal care wage mandates from March 1 on, or the new broader wage mandate that will be applicable in these same regions starting March 1.

HCA urges that the Legislature and Executive require the Department to continue managed care plan reimbursement at levels that permit the mandated wage payments to home care workers under the personal care program, and that this payment obligation be appropriately reflected in the premiums paid to managed care plans, down-streamed to the contracted home care agencies.

If the broader mandated wage law is neither delayed nor repealed, HCA urges that the Legislature and Executive require the Department to similarly mandate that payment to home care agencies – either through managed care, through episodic payments or residual fee-for-service payments – also reflect the increases in funding necessary to permit compliance with the wage mandate law.

3. Restore the Medicaid Trend Factor and Provide for Health Community Input into Performance Based Price Adjustments

The 2012-13 Executive budget proposes to permanently eliminate the trend factor in the establishment of Medicaid reimbursement rates, after the Legislature last year limited the Executive's trend factor elimination to just the 2011 and 2012 years.

The budget further proposes very general language authorizing the state agency commissioners to establish rate adjustments, not based on a trend factor, but based on "performance metrics" that would be developed by the commissioners of health and other state agencies. Few details are provided and there is no requirement for input from or consultation with the health care community or the Legislature.

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HCA Budget Requests - continued

Medicaid reimbursement methodologies, which are calculated on an "historic cost" or expenditure base, require, by principle, a trend factor to correct for the difference between the historical base year and current costs. Trend factors are core components to the accuracy of the state's reimbursement formulas; they are not "inflaters," as they have been characterized. The elimination of the trend factor amounts to a cut, not the elimination of a "raise."

HCA respectfully urges rejection of this proposal and the restoration of the trend factor authority for future years. In addition, HCA requests that any language under consideration which would index future rate adjustments to performance metrics be amended to require consultation with the representatives of the affected provider sectors and the Legislature in the determination of such metrics and in any other parameters that would guide such adjustments.

4. Place Fair, Practicable and Financially Feasible Parameters on the Governor's Proposals Limiting Executive Compensation and Administrative Reimbursement to Providers

The Executive budget proposes arbitrary limitations on agencies' or organizations' executive compensation eligible for reimbursement under state financed or state authorized public funds.

The Executive also proposes parameters on the proportion of public funds used to reimburse direct-service versus administrative expenses. In this proposal, the Executive seeks to require that an entity allocate no less than 75 percent of its state public funds for direct-service expenses this year, 80 percent next year and 85 percent the following year.

The budget language, which has since been succeeded by an Executive order directing the state agency commissioners and directors to implement the limitations by regulation, is extremely general and vague as to the method and identification of costs for the calculation. Of particular concern is the fact that the definitions of "administrative" and "direct-service" expenses are left up to the commissioners, as are the parameters for exceptions to the rule and for an entity's termination from public programs for failure to comply.

In the case of home care, the Department of Health currently requires many costs to be allocated on provider cost reports as "administrative," when these costs (like care management) are actually patient care/direct-service related. Home care agencies and other health care providers are already capped for their allowable administrative expenses and suffer from the Department's inclusion of patient-care-related expenses under the agency's "administrative" cap. If, for example, the current definition of administrative costs were applied to home care under this new Executive proposal, the viability of most agencies would be significantly compromised, particularly as the allowable administrative share is gradually reduced to 15 percent. Additionally, providers serving high proportions of Medicaid and other publicly supported patients would be unfairly and inequitably affected by these limitations.

Another problem with the administrative-to-direct-service limitation is that providers would have no fiscal room to accommodate the ever burgeoning unfunded mandates heaped upon them by state and federal rule changes. This proposal would permit the state to add mandates that would never filter back to the reimbursement system as well as limit providers' ability to otherwise address these costs.

While the Executive Order already places these limitations in motion via regulation, the existence of the budget language hopefully at least offers an opportunity for revision.

In this regard, HCA respectfully urges the Legislature and Executive to negotiate a practicable and bearable approach to meeting the Executive's concerns, including language that both circumscribes the commissioners' authority and requires consultation with representatives of the various health sectors in the establishment of criteria and parameters for these limitations. Special consideration must be given in the criteria for providers with high Medicaid and other publicly supported financing.

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5. Mitigate the Effects of the Medicaid Reimbursement Cuts on Home Care Providers and Amend the Global Medicaid Spending Cap Provisions to Ensure Proper Legislative Control

The fiscal plan incorporates a continuation of what last year was projected at over \$500 million in cuts to home care. These cuts included the elimination of the trend factor, adoption of a 2 percent across-the-board payment reduction, continuation of a gross receipts tax on providers, personal care reform, Certified Home Health Agency expenditure caps, implementation of a preclaim review mandate, and other actions.

Given the tremendous financial and programmatic instability in the home care sector, HCA recommends that the Legislature and Executive consider a range of possible areas for mitigation of these cuts or their effects, including:

- Eliminate unfair provider interest penalties on retroactive recoupments that are the result of the state's inability to have procured timely federal approval of Medicaid plan amendments necessary to have instituted previous budget cuts (especially since the state is not similarly obligated to pay interest to providers when the state lags in payment increases).
- Allow the reduction or suspension of these cuts when aggregate spending in the home care category is below the projected Medicaid cap level (home care spending continues to be substantially below the cap, arguing for relief of the cuts).
- Allow for a reduction or staggering in the amount of the cuts or recoupment levels in order to assist agencies with the burden of absorbing multiple, simultaneous cuts, particularly for those agencies with hardship.
- Provide relief from excessive regulatory costs, including repeal of the state Office of the Medicaid Inspector General (OMIG) preclaim review mandate – which will require home care providers of a certain size to have their Medicaid claims cleared with an outside contractor before billing. This is a huge unfunded mandate that is yet to be implemented, and, though in process, could be modified or repealed. It is substantially obsolete already, and within the fiscal year will be almost entirely so, due to the other Medicaid Redesign Team payment reforms in home care, including the episodic system and payment of home care claims through managed care plans rather than on a fee-for-service claim to the state.
- Rejection of or amendment to the proposed continuation of the Global Medicaid Spending Cap provisions as well as the blanket authority of the Commissioner of Health to unilaterally reduce reimbursements for services or to otherwise alter programs or benefits to conform to the cap. If the authority is continued, it should be heavily circumscribed by legislative involvement and oversight, as well as limitations on what the Commissioner could do without an act of law.

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HCA Budget Requests - continued

6. Amend the "Episodic" Reimbursement Methodology for Certified Home Health Agencies (CHHAs) to Ensure Patient/Provider Safeguards, Including for Special Needs Patients

The state fiscal plan includes in the Medicaid base a planned April 1 Department of Health implementation date for an episodic reimbursement methodology for CHHAs. This methodology will provide Medicaid reimbursement to CHHAs for every 60-day patient episode, instead of on an individual fee-for-service basis. The methodology is authorized based on minimal statutory provisions, leaving especially high need patients and providers exposed to potentially under-reimbursed care, impaired access and other adversity.

A 2009 workgroup established by the Legislature urged safeguards within the episodic system which were never adopted as part of the episodic statute that is scheduled to take effect with this budget. To date, many questions remain about the workings, adequacy and safeguards of the methodology, particularly given the vagaries of the underlying statute and service compensation problems associated with an interim system of CHHA expenditure ceilings in place for the 2011-12 fiscal year.

HCA respectfully requests that the budget include amendments to the episodic statute to ensure its workability and the fulfillment of its goals, and to ensure that high need and other special need patients – and the agencies that care for them – are not disadvantaged.

