

**THE 2010-2011 EXECUTIVE STATE BUDGET**

**A Joint Hearing Before**

**THE SENATE FINANCE AND  
ASSEMBLY WAYS AND MEANS COMMITTEES**

**February 9, 2010**

**Testimony on Behalf of:**

**The Home Care Association of New York State, Inc. (HCA)**

**Delivered By:**

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## Opening Remarks

Good afternoon. My name is Michelle Mazzacco. I am a member of the Board of Directors of the Home Care Association of New York State (HCA), on whose behalf I will be testifying today. I am also the Vice President/Director of the Eddy Visiting Nurse Association.

HCA is a statewide not-for-profit organization representing over 400 home health care providers, allied organizations and individuals involved with the provision of home care in New York State, and approximately 400,000 patients statewide. HCA's mission is to promote and enhance the quality, accessibility and availability of home care by enabling its members to meet the health and assistive needs of frail elderly, chronically ill and disabled New Yorkers.

HCA providers are a core part of the health care system. Our services, through the care provided by visiting nurses, therapists, medical social workers, home health aides and other allied professionals, help patients recuperate and receive rehabilitation safely at home following a hospital stay. We also provide long term home care and management for chronic conditions so that, whenever possible, patients can avoid having to enter or re-enter a hospital or nursing home. By providing care to our patients at home, we are also able to further maximize their functioning, support their quality of life and reduce health care costs.

I come before you today in appreciation of the Legislature's past support for home care and in recognition of the difficult choices that government officials must make to keep the state's fiscal house in order. HCA stands ready to continue to work with the Legislature and

Governor on constructive ideas, including those we have already shared with you – proposals which draw upon home care’s cost-effective design, benefits and advantages as part of the solution to the state’s fiscal management needs.

I welcome the opportunity to testify today and, of course, do so based on the Governor’s January budget submission, not yet knowing what the Governor intends to include among the additional \$750 million dollars in budget cuts and/or actions slated to be announced this day or in other amendments he may propose in his 21-day package.

Among several key messages I hope to leave with you in this testimony are:

- First, home care is not the problem; it is part of the solution, and a part of our system which hundreds of thousands of patients, family members and indeed our state’s health care policies greatly depend upon each and every day.
- Second, enormous Medicaid budget cuts to home care exacted in recent years in an attempt to remedy the state’s fiscal problems have already left many providers on the brink, unable to withstand further erosion, and enormously challenged in their mission to deliver care and buttress the state’s health care infrastructure. You will be greatly alarmed by portions of my testimony today concerning the financial condition of the home care community in this state. Home care needs and merits investment, not further cuts.

- Third, the cuts contained in this new Executive budget – added to the compounded cuts, unfunded mandates and chronic underfunding of services which have left our system so badly damaged – cannot be sustained. These newest cuts undermine the very financial benefit that home care brings to the Medicaid system and otherwise ignore the wisdom it can further bring to the state’s fiscal policies. Please reject the Executive’s proposed, counterproductive cuts, and the further damage to the system they will surely bring,
- And fourth, we offer and look forward to working with you, the Legislature, as well as the Governor, on creative, constructive solutions to Medicaid efficiency that will help in this fiscal year, and in the years beyond.

Together, through cooperation, we can develop sound policies that solve today’s pressing fiscal needs, promote long-term efficiencies rather than prolonged fiscal ruin for our health care system, and continue to care for patients in the most appropriate setting at the right cost. I will be speaking further about our ideas later in my testimony.

### *The Eddy VNA*

I would like tell you a bit about my agency, The Eddy Visiting Nurse Association (VNA), based in Troy, New York. We serve an average of 1,300 patients on any given day in five Capital Region counties through our Certified Home Health Agency (CHHA), Long Term Home Health Care Program (LTHHCP) and Program for All-Inclusive Care for the Elderly (PACE). Most of the services we provide are funded by Medicaid, since most of our patients

are covered by that program. When Medicaid funding is cut, as the Governor's budget again proposes to do, we have little recourse for making up the lost funds.

In the case of such drastic Medicaid cuts, while our options are few, the consequences for patients are innumerable.

For instance, without the Eddy's LTHHCP, also known as "the Nursing Home Without Walls," nearly 500 nursing-home-eligible patients throughout the Capital Region would no longer be able to receive needed care at home. The LTHHCP is a statewide program administered locally by providers like the Eddy that rely substantially on their patients' Medicaid coverage to keep them out of higher-cost nursing home settings through sophisticated case management involving a mix of home health aide, skilled nursing, therapy and other services, as ordered by the patient's physician. Statewide, the "Nursing Home Without Walls" serves approximately 25,000 patients at an average cost that is half of what Medicaid pays for nursing home care, making the LTHHCP a primary and cost-effective cornerstone of our home care system, and our health care system generally. Without this program providing services in the home, where would the Eddy's 500 nursing-home-eligible LTHHCP patients go?

Let me describe for you a couple of the Eddy's patients who come to mind when I think of what further budget cuts will mean for those who rely on home care.

Ms. K is a 55-year-old woman with diagnoses of Guillain-Barré syndrome (a disorder in which the immune system attacks part of the peripheral nervous system causing severe muscle weakness, paralysis and sometimes death), chronic obstructive pulmonary disease, type 2 diabetes, hypothyroidism, and sleep apnea. Ms. K also has a tracheotomy and an IV port, is on continuous oxygen and is morbidly obese. Ms. K has been an Eddy home care patient for three years and has had just one hospitalization, for pneumonia. She receives home telehealth monitoring on a daily basis, combined with nursing visits one to two times per month for skilled care, assessment and patient teaching and monitoring. She is clearly a highly needy and medically unstable patient who would lose her ability to remain at home without the care and support of the home care agency, resulting in a severe impact to her personally and enormous additional cost to the system.

Another patient, Ms. M, is a 58-year-old woman with a diagnosis of Pyoderma Gangrenosm (open leg wounds which will never heal), a history of strokes and osteoarthritis. She lives with her elderly father and has been receiving Eddy home care services for over 20 years. The agency provides Ms. M with nursing visits two to four times per week and a home health aide to assist with her personal care needs. Despite the intensity and complexity of her condition, Ms. M has had just one hospitalization in all this time. When Ms. M's father became ill, the agency provided him with services as well, delivering care in a way that was both efficient and critical to the support of his role as his daughter's caregiver. The agency similarly supported Ms. M's mother prior to her passing in 2003. This is a great example of not only what home care can do to keep an extremely ill person at home, but to also incorporate and support the assistance of family caregivers in this effort.

I hope these stories – among countless others I could tell – impress upon you the potential effect of the Executive budget cuts on these individuals, let alone the cumulative effect of budget cuts and other actions over just the past several years alone.

### *Home Care Today*

In order to understand the full effect of state policies on home care, one must recognize that the home care system has evolved into a highly skilled, pivotal part of the overall health care delivery system, as the cases I've just described help portray. As the expectations about home care's role in the health system have changed over time, so has the cost of delivering care.

Today, my agency serves patients with increasingly complex clinical needs at home – many of whom, not so long ago, would have certainly resided in a nursing home. Without home care, most of these patients would be hospitalized more often, experience much longer acute care stays should they be admitted, and would be more likely to eventually need nursing home care as their health, cognitive, or physical condition deteriorated – all at a much higher cost to Medicaid.

In addition to serving patients with more sophisticated needs, both our CHHA and LTHHCP employ leading-edge disease-management programs to combat chronic illnesses among young disabled and elderly patients as well as high-tech medical equipment to care for medically fragile children at home at far less cost than in institutions. We also use technology, such as home telehealth, to monitor patients' vital signs in between nursing visits, leading to substantial reductions in unnecessary emergency room use, doctor visits and hospital stays.

These are just some of the vital improvements and savings opportunities brought about

through home care and its incorporation of technology and professional skill. The Eddy's telehealth program, for instance, monitors an average of 230 patients daily, extending the clinical encounter beyond scheduled face-to-face home visits and increasing collaboration with the physician.

This shift to providing complex care at home, as well as the cost-effectiveness of this trend on a national level, has been well chronicled. For instance, a study by Avalere (2009) found that early intervention post-acute home care services for patients with diabetes, chronic obstructive pulmonary disease or congestive heart failure saved Medicare \$1.71 billion and would have saved \$1.77 billion more with wider use. (References to other studies on the cost effectiveness of home care are included in Appendix 2.)

### **Precarious Fiscal Condition of Home Care**

In spite of home care's proven cost-effectiveness and its success in managing an increasingly elderly patient population with more complex health conditions, a legion of past Medicaid cuts has left many providers in dire economic distress, as reimbursement levels fail to keep pace with the increased cost of delivering care. Not only have home care providers been inflicted with over \$320 million in Medicaid cuts during the past two years, but their operations have been further sidelined by new unfunded mandates and taxes that wield an impact amounting to \$65 million per year. To put this in perspective, consider the effect of \$65 million on agencies whose costs are largely personnel-related. Under the streamlined home care operating model, our core cost is the service itself provided by home health caregivers. Given this profile, when \$65 million is factored as a share of home care's overall operating cost

picture, then the toll of unfunded mandates and taxes alone is equivalent to a 3.6-percent Medicaid cut in just one year, packing an enormous blow on top of more explicitly defined reimbursement cuts.

In late 2009, HCA and the New York Association of Homes & Services for the Aging conducted a multi-tier analysis of the financial stability of the home care industry. Our study, entitled *Lethal Doses: Chronic Cuts and New Mandates Threaten Home Care in New York State*, involved a statewide survey of home care providers in conjunction with an analysis of Medicaid cost reports, which providers must file each year with the state. The cost report is an independently certified financial statement that is the basis for Medicaid rate setting policies. It also tells us a lot about the financial condition of the home care industry. Among the report's key findings:

- 67 percent of all home care agencies that are required to file cost reports were operating in the red in 2007, as a result of underpayment by the state, budget cuts and unfunded mandates;
- 75 percent of county-operated agencies and 76 percent of LTHHCPs were operating in the red in 2007, as a result of underpayment by the state, budget cuts and unfunded mandates;
- 44 percent of agencies surveyed by HCA and NYAHSAs reported that they must borrow money to meet their operating expenses;

- 44 percent of agencies surveyed by HCA and NYAHSA indicated they are either “likely” or “very likely” to close their doors if hit with an additional five-percent cut; and
- In response to already enacted cuts, 51 percent of agencies have cut direct-care staff, 41 percent have reduced services, 90 percent have delayed filling staff vacancies, and 66 percent have delayed technology initiatives, according to the HCA/NYAHSA survey.

These findings paint a grim picture, revealing how chronic disinvestment in the home care industry threatens home care’s role as a safety net that averts the need for costlier hospitalization, the incidence of hospital readmissions, repeat emergency room visits, and premature nursing home entry. Earlier in my testimony I mentioned the Eddy’s LTHHCP, which serves an average of 475 nursing-home-eligible patients on a given day. The fact that 76 percent of LTHHCPs are operating in the red is a grave sign for the future of home-based long term care in New York State, as a program that has proven its value to patients, the state, and the health care system teeters financially on the edge.

One of the most alarming trends revealed by the HCA/NYAHSA report is the fact that 44 percent of home care agencies that participated in our survey are borrowing money to stay afloat. It has become clear that while the state applies cuts as a remedy to balance its budget, those very same cuts force providers to essentially mortgage their operation, spiraling deeper into the red in order to continue providing services to Medicaid patients. The 67 percent of home care providers now operating in the red have clearly made the difficult choice of risking

financial insolvency for the sake of continuing their mission to serving New York's most vulnerable patients.

This financial picture is clearly rooted in the chronic underfunding of home care. In just two years, home care agencies have had to endure across-the-board funding eliminations; a new gross receipts tax (GRT) on their revenues and other taxes; premium reductions; new regulations and unfunded mandates; and the elimination of vital workforce investment monies for upstate New York – all measures that, ominous enough on paper, in reality rock the very foundation of an infrastructure already faced with the rising cost of patient care and operations, staff shortages, overreaching government audit activities, and other pressures.

These prior-year cuts, coupled with proposals in the 2010-11 Executive Budget to further reduce home care by nearly **\$155 million**, would bring the overall toll to almost a **half billion dollars in cuts to home care**, just since April 2008. (See Appendix 4.) Given the current financial precariousness of home care, further home care cuts of this size will cripple a delivery system already on the brink of collapse.

In addition to recent destructive home care cuts, home care agencies have been dealt a litany of unfunded mandates and taxes that are costing them an additional estimated **\$65 million** per year – itself the equivalent of a 3.6-percent Medicaid cut. This unprecedented level of new mandates has caused an enormous dislocation of home care agency staff and resources, as personnel are pulled away from core tasks related to service delivery and are instead dedicated

to administrative functions. A number of these new mandates are described in Appendix 3 of this testimony.

## **2010-11 Executive State Budget Proposals**

Against this backdrop of severe home care agency financial instability and a succession of newly imposed unfunded mandates, the Governor has proposed a 2010-11 Executive State Budget that includes Medicaid home care cuts estimated by the Administration at **\$73.9 million** (state share). However, these cuts have a compounding adverse effect on patient services in that Medicaid reductions at the state level also result in the loss of federal matching dollars. Therefore, \$73.9 million in state-share cuts increase to approximately **\$155.2 million** when the federal matching share is applied in 2010-11. (See Appendix 1.)

### *Elimination of the Medicaid Trend Factor*

A major cut proposed by the Executive is the elimination of the Medicaid trend factor for all of 2010 and the first quarter of 2011 (from January 1 to March 31) for CHHAs, LTHHCPs and Personal Care providers. The Administration estimates these actions would result in over \$25.8 million in state-share cuts. HCA estimates the trend factor elimination would result in \$62.9 million in state/federal-share cuts for 2010-11.

This new trend factor cut is on the heels of prior budget actions which eliminated the 2009 trend factor and greatly slashed the trend factor for 2008. Please be aware that these legislated cuts, as well as the current 2010-11 budget proposal, are not only imposed in these specific years, but are rolled into perpetuity in all future years, eliminating necessary payment to

providers for services that patients need and for activities – *and mandates* – the state expects. These cuts exacerbate an already woefully inadequate trend factor that, even when funded at its intended percentage, fails to generate state rates that meet the cost of delivering services and maintaining a proper infrastructure. The results of our *Lethal Doses* fiscal-conditions report bear out the consequences and perilous forecast of such chronic underfunding and methodological cuts.

The trend factor is often misleadingly viewed as an “equitable” form of cut in the budget process because of its applicability across all sectors of care. However, unlike other services, home care is not a service with embedded “bricks-and-mortar” costs, major medical equipment, the operation of physical plants and the like. Virtually all of home care’s costs are concentrated in direct-care personnel, along with the activities that support the delivery and management of patient care and the transport of staff and equipment to and from patients’ homes. Therefore, the trend factor elimination in home care slices right into the heart of service delivery and the core of our agencies’ operations. There is no other place to turn when these funds are cut.

In addition, the rising level of patient acuity, growing complexity of patient care demands, challenges with the recruitment and retention of direct-care staff, need for investment in home care technology and infrastructure, and constantly mounting state and federal mandates, are unavoidably reflected in provider costs. These real costs in home care can’t just be “zeroed-out,” as if a “zero” inserted into the trend factor statute will make such costs disappear. The costs can’t be ignored and there are no places for home care to shift or make them up, and no

compensatory or mitigating actions taken by government to insulate home care providers against these losses.

As there is always justifiable alarm in the legislative process for the effect of such Medicaid cuts on “high-need” / “high-Medicaid” providers in other health sectors, the impact on home care merits a commensurate level of alarm. A substantial part of home care is covered primarily by Medicaid, including care to special needs populations, medically fragile children and chronically ill elderly who receive long term care at home as an alternative to institutionalization. These services are hit disproportionately hard by such Medicaid cuts. Witness the devastating effects that Medicaid underpayments and cuts are having on the state’s LTHHCP, with 76 percent of these providers experiencing operating losses as of 2007, and with a 65-percent increase in the amount of LTHHCP operating loss between 2004 and 2007. A program that cares for patients at home at an average of about 50 percent of the cost of institutional placement, serving both the patients’ and the state’s goals, is in jeopardy because of the disproportionate effect of such cuts and such chronic underfunding.

### *Increased Gross Receipts Tax (GRT)*

Last year’s budget included the levy of a 0.35-percent gross receipts tax (GRT) on CHHAs, LTHHCPs, Licensed Home Care Services Agencies (LHCSAs), and Personal Care programs (at a then-estimated cost of \$14 million per year). This tax is imposed on all streams of revenue and penalizes those agencies that try to bring in non-Medicaid business. Patients already attempting to pay privately for services face surcharges on their payments as a result of the GRT – in essence, the GRT taxes the uninsured home care patient.

The home care GRT is also disproportionately applied to home care in that it is not reimbursable (as is the nursing home GRT) and is applied to Medicare payments, which the Legislature has explicitly excluded under the GRT applied to nursing homes.

The proposed 2010-11 budget would increase the GRT on home care to 0.70-percent, which would result in approximately \$17.6 million in new home care provider taxes for 2010-11 – on top of a GRT of similar impact that was newly inserted in last year’s state budget.

### *Cap on Personal Care Services*

HCA supports efforts to align patients with programs which are most able to appropriately manage the intensity and complexity of their care needs. In fact, we have offered several proposals designed to enhance quality and efficiency through more refined assessment, better flow of patients into services, improved opportunities for provider collaboration and other innovations to support care management service delivery.

Though seemingly complementary to some of these principles, one of the Executive’s main home care proposals raises many concerns as to its structure, effect and workability. HCA recommends that the Legislature and Governor instead work with approaches which we have offered and that we would continue to collaboratively develop with our peers in the home care community.

The Executive proposes to place an average 12-hour-per-day cap on personal care services, and to concurrently redirect affected personal care program patients to other community-based programs such as the LTHHCP and Managed Long Term Care (MLTC) on the basis that the care management capacity of these programs is more appropriate to the needs of these patients. The proposal is projected to have a state-share impact of \$30 million and an HCA-estimated state/federal-share impact of \$73.17 million.

The proposal as crafted raises serious concerns about its workability and effects, and has the potential to disrupt patient access and care for an estimated 5,000-plus beneficiaries.

The content of the current proposal offers little insight into the application of the cap or the process for redirecting patients to these other programs. While seeking to establish a threshold for the review and referral of high need patients to appropriate programs of care, the proposal seems devoid of flexibility in relation to personal care in cases where flexibility would be vital for the consumer, and the proposal makes no corresponding adjustments in the programs to which patients would be redirected in order to ensure the ability of these programs to enroll this high-need population. For example, current expenditure constraints applicable to both the LTHHCP (i.e., an individual care plan cost cap) and MLTC (i.e., rate capitation) would have to be concurrently addressed in order for these programs to properly enroll such patients – an action HCA suggests the Legislature consider independent of the Governor’s proposal, considering the value of these programs in delivering cost-effective services.

As stated throughout this testimony, HCA has presented the Legislature and Executive with positive alternatives to cuts and ideas for system improvements, including ideas related to the screening and care of high need patients in ways we feel are preferable to those advanced in the Governor's proposal. We look forward to working with the Legislature and the Governor on the establishment of supportive methods of improving patient care access and care management.

### *Prospective Payment System (PPS) for CHHAs*

Last year, the state budget included a proposal to change the reimbursement system for CHHAs from its current fee-for-service structure to a prospective payment system (PPS) under which home health agencies would receive a bundled rate (episodic payment) for delivering care to a patient over a 60-day period, with payment varying according to health severity. The change would have applied to new cases starting in January 1, 2010 and would have assumed built-in reductions of \$200 million (state/federal Medicaid shares).

HCA argued against the imposition of a reform of this magnitude without thorough analysis, statistical modeling, piloting, transitioning and full vetting with providers, consumers and other stakeholders. The proposal lacked responsiveness to certain basic goals – most importantly, the stability of the home care agency safety net in providing accessible, high quality home care services. The proposed methodology was designed to drastically reduce reimbursement for the care of “high-cost” patients who would face limited access to home care services or whose providers would be financially destabilized in attempting to provide the necessary care. Concern was also especially voiced for vulnerable agencies, many of which are

sole community providers, who might not be able to withstand the transition or the reductions in payment associated with the new system. Further concerns were raised regarding the effects of the proposal on direct-care staff and the likelihood that the proposed system could worsen already serious recruitment and retention problems that plague providers in maintaining the needed level of essential health personnel.

As a result of the concerns raised by HCA, consumer representatives and allied health associations, the Legislature rejected the Executive's PPS proposal but instead established a Home Health Reimbursement Work Group for the purposes of studying the home health reimbursement system. The Work Group has been studying the methodology since last July with no resolution on most of the fundamental issues and concerns associated with the Executive's proposal.

Despite the breadth and severity of outstanding issues, this year's budget again proposes a PPS model for CHHAs, starting in January 2012, and contemplates the continuation of the Work Group. As with the concerns voiced by the Work Group, HCA's fundamental concerns regarding the proposed PPS remain outstanding in relation to both the providers and patients.

Other than to postpone the date of implementation, this year's budget proposal, which would essentially lock the Legislature two years hence into an unknown model with unknown effects on providers or consumers, offers no further assurances of a stable, responsive system than that offered last year. We see only unnecessary risk in the adoption of any mandated budget language at this time, considering that: there is no relationship between this proposal and any

savings this fiscal year or even the following year; the proposed transition would result in unknown and major implications on patients and providers; and the Legislatively-established Work Group is expected to further study these issues.

### ***Provision of Home Care by County Health Departments***

County-sponsored home care agencies are a vital part of the service delivery system in many communities and provide an array of public health services such as maternal and child health care. While all home care agencies across the state face the challenges of rising costs, as well as difficulties attracting and retaining adequate staff, these challenges are even more severe in rural areas where agencies serve patients dispersed across vast geographical areas and few other community services are available to sustain the health and support needs of residents.

This year's proposed budget would discontinue state reimbursement for local public health expenses attributable to certain services, including home health and hospice programs – a reduction of about \$5.1 million (state share). This proposal would further endanger one of the most fragile parts of the home care system. As previously mentioned, the HCA/NYAHSA *Lethal Doses* fiscal-conditions report found that 75 percent of county-operated home care agencies shouldered operating losses. Such an integral part of the health care system cannot sustain further cuts, which are certain to eliminate services in large stretches of rural New York and add to the growing number of health departments that have had to close their CHHAs. One county agency estimates that its losses would approximate an unsustainable half a million dollars under this cut.

Last year, the Legislature rejected a similar Executive proposal to eliminate local public health funding for home care. However, this year the state Department of Health (DOH) is asserting its intention to effectuate the cut administratively. We urge the Legislature's intervention in preventing DOH from instituting this damaging action.

### ***Increased Medicaid Fraud Targets***

This year's budget proposes to increase Medicaid fraud targets by an additional \$300 million to reach levels of \$1.17 billion.

HCA supports efforts to safeguard the integrity of our Medicaid system. Fraudulent activity adds costs to the health care system and diverts resources from patient care. We have actively promoted health provider compliance efforts and initiated programs and proposals to improve system transparency and integrity.

While HCA continues to work with the Office of Medicaid Inspector General (OMIG) on draft audit protocols that set standards, guidelines and parameters for the auditing of CHHAs and LTHHCPs, we nevertheless have serious concerns about the nature of OMIG audits.

We are concerned that everything from billing errors to legitimate compliance questions, technical mistakes and departures from standard practice are often lumped together with real instances of fraud under the elastic definition of "fraud and abuse."

The current scope and processes of state Medicaid audits have extended far beyond fraud and system integrity investigation. The situation is unfair, wasteful and oppressive to providers and patient care. We appreciate Senator Craig Johnson's January hearing on Medicaid audits

and the opportunity to have testified jointly with the Healthcare Association of New York State (HANYYS) and many others who share these concerns. We would be pleased to also share directly with you the testimony we provided to Senator Johnson.

Given that this year's budget proposes to increase Medicaid fraud recoveries up to a \$1.17-billion-dollar level, we urge you to consider actions that will afford more appropriate treatment of the health care community and ensure that OMIG recovery efforts are aimed at the truly bad actors in our system. We will be joining with our colleagues throughout the continuum of care to recommend a series of important statutory safeguards for your consideration and we respectfully request the adoption of these safeguards along with this budget.

***Additional Proposals of Interest and Concern***

The Executive budget contains or omits many additional proposals of both interest and concern to home care, such as: a proposal that is included in the budget to consolidate all of the authority for MLTC in DOH while eliminating the State Insurance Department's role, which is a concern to our MLTC members; a proposal contained in the budget to convert county nursing homes to expanded home care capacity; and a past program that is omitted in this budget, but should be funded, to continue targeted support for the home care infrastructure in rural, small city and suburban areas, also referred to as the accessibility, quality and efficiency rate adjustment. HCA and the membership will be providing further information and recommendations to the Legislature and Governor on these additional aspects of the budget.

### *HCA Proposals in the Budget*

Over the past year-and-a-half, HCA has worked closely with its membership in identifying and crafting policy proposals that would generate significant savings for the Medicaid system by instituting home care program enhancements, regulatory reforms, workforce flexibility measures, quality and performance standards, and initiatives to realign health care financial incentives. We developed these proposals knowing that the home care industry is well positioned to apply its knowledge from the field in offering proactive, constructive and creative solutions – rooted in policy – for achieving Medicaid efficiencies during a time of undeniable financial duress. The result of these efforts is HCA’s “Home Care Accessibility and Efficiency Improvement Act” (HCA-EIA, S.5179, introduced by Senator Craig Johnson), a comprehensive package of proposals that draws upon the cost-effectiveness of the home care system in achieving further Medicaid savings. These proposals would achieve significant savings, enhance patient access to services, and encourage lasting system reforms at the same time.

A main focus of our advocacy efforts in recent months has been to encourage the Governor and Legislature to embrace these proposals in place of blunt Medicaid cuts. We were pleased and appreciative that Governor Paterson, as a result of HCA’s advocacy efforts, incorporated at least three HCA-developed proposals from S.5179 in his proposed budget, including the following:

- A proposal to enhance program efficiency and provide flexibility by changing the minimum reassessment interval for LTHHCP patients from every 120 days to 180 days (resulting in a state-share savings of \$600,000 and a state/federal-share savings of approximately \$1.5 million);
- Another proposal to allow patients to be collaboratively served by the LTHHCP and other waiver or case management programs that together meet a fuller complement of patient needs, as long as the programs “maintain distinct yet coordinated services and case management responsibilities” and don’t duplicate benefits. This provision is not only taken from our HCA-EIA legislation, but has been a policy change for which HCA has advocated directly with the U.S. Centers for Medicare and Medicaid Services, New York’s Congressional Delegation and DOH.
- A third and especially innovative proposal to establish a Federal-State Medicare Shared Savings Partnership Program. This program would provide health care financing revenue to the state from shared federal Medicare savings. The shared federal savings would be derived from state initiatives in the care and management of Medicaid/Medicare beneficiaries resulting in reduced expenditures for hospital, long-term care and other medical care. It would provide for a reinvestment of a portion of the federal savings into the state’s health care system. Provider care-management innovations are demonstrating very favorable outcomes in home care, and this proposal presents opportunities for cutting-edge developments that assist the patients, the system, the state and the federal government. This proposal is not only

substantially taken from our HCA-EIA bill, but HCA has also secured sponsorship of our legislation at the federal level, where it is being prepared for introduction.

These are the kinds of constructive proposals that are possible with the joint effort of those in the field and state policymakers. As another recent example, HCA's proactive work with the Legislature and Governor during the December deficit-reduction plan (DRP) negotiations led to the incorporation within the DRP of another of HCA's proposals from S.5179, which changed the state's policy with regard to medication pre-fills for patients, and is set to save the state nearly \$20 million in state-share savings this fiscal year. We ask you to consider our efforts in contributing such real solutions to the process during your deliberations over the new cuts that the Executive budget proposes to hoist upon the home care community.

Unfortunately, this budget is very disproportionately weighed with proposals seeking to slash rather than to create or change. We urge you to reject these new cuts in favor of continued work with our Association and our members in the field.

HCA stands ready to offer additional creative ways to generate efficiencies in home care and in the Medicaid system generally, and to save home care programs from unnecessary financial ruin by substituting constructive proposals in place of draconian budget cuts. We look forward to further working with you and the Executive on these ideas and on making revisions to the proposed 2010-11 budget that reflect positive changes to further enhance the effectiveness and efficiency of the home care system while recognizing the vital role that home care plays in the entire health delivery system.

Thank you.

Appendix 1

**PROPOSED 2010-11 EXECUTIVE STATE BUDGET**

<b>TREND FACTOR CUT</b>		
	State Share April 1, 2010 to March 31, 2011	Weighted Enhanced Federal Match April 1, 2010 to March 31, 2011
Home Care (LTHHCP, CHHA)	\$11,500,000	\$28,048,780
Personal Care	\$14,300,000	\$34,878,049
<b>Total</b>	<b>\$25,800,000</b>	<b>\$62,926,829</b>

<b>PERSONAL CARE CAP</b>		
	State Share April 1, 2010 to March 31, 2011	Weighted Enhanced Federal Match April 1, 2010 to March 31, 2011
Personal Care	<b>\$30,000,000</b>	<b>\$73,170,732</b>

<b>INCREASED ASSESSMENT</b>		
	State Share April 1, 2010 to March 31, 2011	No Federal Match April 1, 2010 to March 31, 2011
Home Care & Personal Care	<b>\$17,600,000</b>	<b>\$17,600,000</b>

<b>Total Impact</b>	<b>\$73,400,000</b>	<b>\$153,697,561</b>
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**Note:** the total impact in the chart above does not include an estimated \$600,000 in state-share savings (approximately \$1.5 million total state/federal share) attributed to HCA's proposed change in the LTHHCP minimum reassessment period and a provision to permit LTHHCPs and other waiver programs to collaborate and jointly serve patients.

## Appendix 2 Cost Effectiveness of Home Care

1. A Congressional Joint Economic Committee study in 2004 found the costs of an average 60-day home care episode (\$4,000) were less than receiving such care in skilled nursing facilities (\$8,300), inpatient rehabilitation facilities (\$12,500) or long term care hospitals (\$35,700).
2. Avalere found that if patients use home care services for post-acute care at an early time (defined as “in the same quarter as the first hospitalization stay that initiated the period of care”), the costs of caring for individuals with a primary or secondary diagnosis of diabetes, chronic obstructive pulmonary disease (COPD), or coronary heart failure (CHF) were much lower than the costs for patients who received post-acute care in other post-acute care settings – a total savings of \$1.77 billion for Medicare over 2005-2006 (Avalere Health LLC, 2009). In addition, an estimated 24,000 fewer hospital readmissions over 2005-2006 associated with early home health would save another \$216 million for Medicare.
3. A study by Kaye, LaPlante, & Harrington, 2009 (*Health Affairs*) found that states offering well-established noninstitutional services experienced less growth in long term care spending than states with limited noninstitutional programs.

4. Buntin & Kaplan found that when hip and knee replacement patients received care at home for rehabilitation, the total medical expenditure for acute stays plus 120 days of post acute care was \$3,500 and \$8,000 less than in skilled nursing facilities and inpatient rehabilitation facilities, respectively (Buntin & Kaplan, Comparison of Medicare spending and outcomes for beneficiaries with lower extremity joint replacements 2005).

5. A study of New York's Traumatic Brain Injury program found that the program saved \$30,832 for each of its recipients compared with services provided in nursing homes, hospitals, and other institutions, which resulted in a total annual savings of \$60 million (Hendrickson & Blume, Issue brief: a survey of Medicaid brain injury program. 2008). Nationally, the waiver saved a total of almost \$273 million annually (an average of \$30,000 for each patient) compared with institutional care in 17 states in 2006.

## Appendix 3

### Examples of Recent Unfunded Mandates on Imposed Home Care Providers

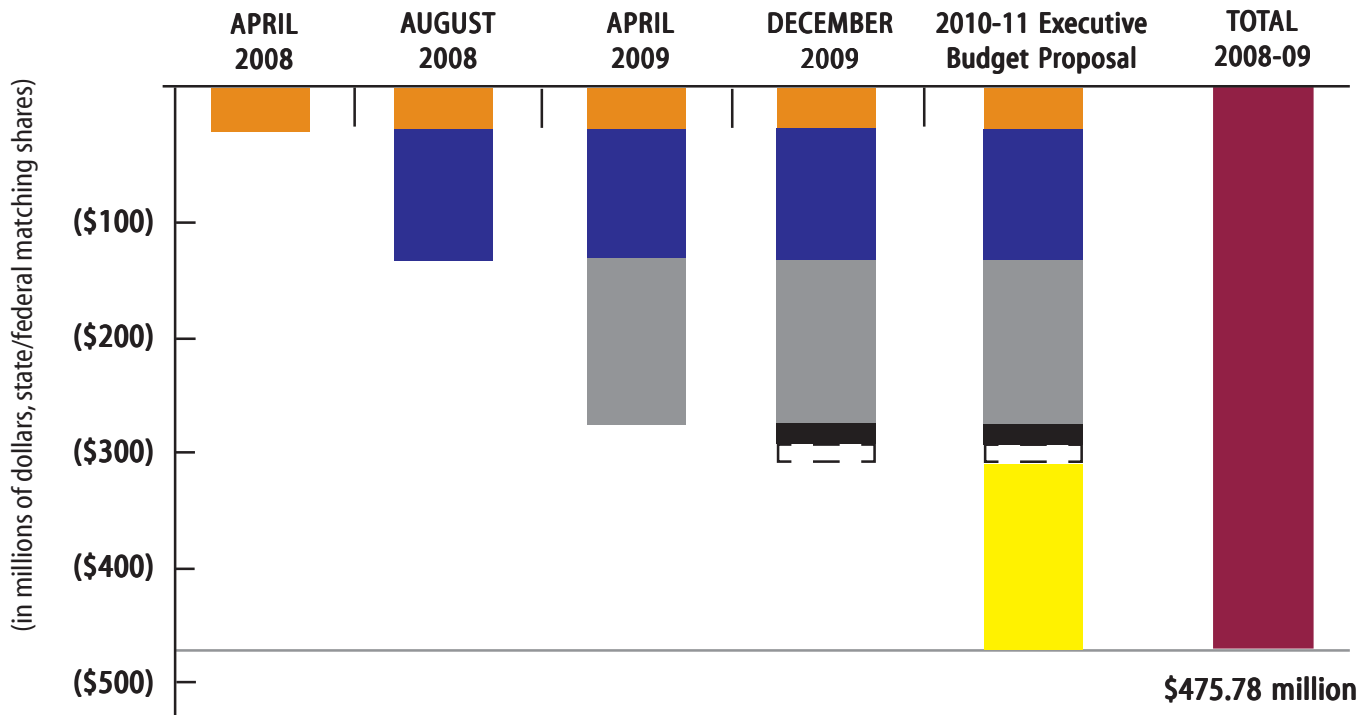
- Participation by home care providers in a massive and costly statewide demand-billing audit following the expiration of a federal program – known as the Third Party Liability (TPL) Demonstration project – for determining whether Medicare or Medicaid is responsible when a patient is covered by both. In essence, the expiration of this program has been an administrative nightmare for providers who now must perform a function previously borne by the federal and state governments for reconciling coverage determinations for dual-eligible patients. The cost of this effort for home care agencies in 2009 has been between tens of thousands of dollars to millions of dollars for larger agencies.
- A new home care registry that agencies must use to verify the credentials of home health staff as well as enter information for new aide trainees. The registry imposes new and costly administrative demands on agencies, including costs related to operational and technical problems that have beleaguered the registry and hampered the program's overall navigability and effectiveness.
- Countless hours of administrative and professional staff time to compile case records in answer to ongoing audits by federal and state officials, often during investigations that concern mere technical errors unrelated to the issue of health care quality.

- Development of corporate compliance policies so that agencies can proactively confront overreaching anti-fraud efforts by federal and state governments and private contractors; and
- Administration of seasonal and H1N1 flu vaccine, and related reporting requirements. Though this requirement was rescinded last year, many agencies have expended resources to meet the then-existing compliance deadline. DOH has indicated that this requirement will be reinstated later this year.

# State Budget Medicaid Cuts and Reduction Actions to Home Care



Governor Paterson's 2010-11 Executive State Budget proposal includes approximately \$155.2 million in new state and federal share Medicaid cuts to home care. If enacted, this would bring the total to **\$475.78 million** in cuts and reduction actions since April 2008. (See chart.)



- April 2008 – Enacted 2008-09 State Budget (\$28 million, state/federal)**  
 35% reduction to Trend Factor (CHHA, LTHHCP, Personal Care)
- August 2008 – Enacted Deficit Reduction Plan (\$107.5 million, state/federal)**  
 1.3-percentage point reduction to 2008 Trend Factor (CHHA, LTHHCP, Personal Care); 1% premium reduction for Managed Long Term Care (MLTC) plans; Upstate workforce money cut by \$960,000
- April 2009 – Enacted 2009-10 State Budget (\$145.08 million, state/federal)**  
 Elimination of remaining 2008 & 2009 Trend Factors and Trend Banking Factors (CHHA, LTHHCP, Personal Care); 0.35% Gross Receipt Tax (all home care); MLTC premium reduction; non-renewal of \$16 million Upstate workforce monies; \$5 million Medicare Maximization targets
- December 2009 – Enacted Deficit Reduction Plan (\$17.4 million, state/federal)**  
 Elimination of 2010 Trend Factor for final quarter of current state fiscal year (Jan. 1 to March 31, 2010)
- December 2009 – Enacted Deficit Reduction Plan (\$22.6 million, state/federal)**  
 Inclusion of HCA-developed medication pre-fill provision that will further reduce Medicaid spending, though constructively and voluntarily, by an anticipated \$2.7 million in the final quarter of the 2009-10 state fiscal year and by \$19.9 million for the 2010-11 state fiscal year
- PROPOSED 2010-11 Executive State Budget (\$155.2 million, state/federal)**  
 Elimination of the Trend Factor (CHHA, LTHHCP, Personal Care); 12-hour-per-day cap on Personal Care Services; Increase in the existing home care Gross Receipts Tax – from 0.35% to 0.7%