February 3, 2014

Dear Members of the Joint Legislative Committee on the Medicaid Budget:

On behalf of the Home Care Association of New York State (HCA) – which represents approximately 400 health care providers, organizations and individuals involved in the delivery of home and community-based care services to hundreds of thousands of patients throughout New York State – I submit this cover letter and three attached documents in support of my oral testimony delivered today, February 3, 2014, before the Joint Legislative Hearing on the 2014-15 Medicaid State Budget.

The purpose of these documents and corresponding recommendations for the 2014-15 State Budget are outlined below.

HCA Legislative Priorities in the 2014-15 State Budget

Chief among the attached documents is *HCA's Legislative Priorities In the 2014-15 State Budget* summary sheet. I draw your attention to this document in particular, as it urges concrete action from the Legislature in **four priority areas** on behalf of New York's home and community based care providers and patients. These four priorities are briefly summarized below:

1. **Regulatory streamlining and alignment are needed to support the efficiency, quality, orderly structure and payment of home care services under managed care.**

2. **Services, including mandated home care wage laws (under the Wage Parity Law) and service delivery regulations, must be appropriately funded and reimbursed.**

3. **Budget language is needed to support innovative hospital-home care models for patient services, system improvement and community health.**

4. **"Essential Personnel" status is vital for supporting home care and hospice personnel during emergency response.**

Urgent Needs

The first two items on the above list reflect areas of extremely urgent need in home care – specifically, regulatory streamlining and funding support to meet the escalating wage levels mandated by the Wage Parity Law for 2014. **These two areas of support are essential for the continued functioning and adaptability of New York's Medicaid home and community based care system.**

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According to a recent HCA provider survey, more than two-thirds of providers said the redundancy or lack of clarity in state regulations has had a "large cost impact" on their organization, especially as the state accelerates its transition of thousands of patients to managed care. In an effort to address this major area of concern during last year's budget process, HCA urged a series of regulatory-relief and realignment measures that would make it possible for home care providers and managed care plans to work together more seamlessly – as the state intends – by eliminating duplication, inconsistency, and confusion about roles, responsibilities and requirements.

In response, the Legislature last year established a workgroup to examine these issues. HCA has since worked with allied associations to advance a joint package of specific regulatory streamlining proposals for the workgroup's consideration. (The workgroup is due to report to the Legislature by March 1.) However, as a whole, this workgroup process is not meeting the scope or immediacy of need. Regulations remain excessive, overlapping, not clearly delineated as to agency/managed care plan roles, inefficient, and underfunded to meet mandates. Unfortunately, this regulatory mismatch continues to add undue costs to the home and community based system – and without any appreciable patient-care rationale. The 2014-15 State Budget offers a proper venue for reform, and HCA, in the strongest terms possible, requests priority legislative remedy in this area.

Indeed, the current Executive Budget proposes an amendment to Public Health Law provisions for the General Powers and Duties of the Commissioner of Health, authorizing rule and regulatory waiver flexibility as necessary to promote quality, integration and efficiency in service delivery for system reforms which I will describe later in this letter. We surely support this proposal, which is needed for true delivery and payment reform; but we will be submitting for your consideration parallel flexibility language for the managed care-home care integrated model which likewise is urgently needed, and we will also include specific areas for streamlining, flexibility and realignment needs.

Meanwhile, as the state's home care wage requirements increase precipitously in March 2014, about 40 percent of home care agencies said they expect they will have to reduce the hours of direct-care staff as a result of these increased labor costs, while 25 percent of agencies plan to lay off agency staff, according to HCA's recent survey of providers. **Funding for the Wage Parity Law is necessary to support a stable home care workforce and ensure continuity of services**. While the Executive has rightly included such funding in the Executive Budget proposal, the current budget language does not indicate the appropriation level, and verbal indications suggest that the level is significantly underfunded. **Adequate funds are vitally and urgently needed for the increased mandate**. These cost increases are effective March 1 – a full month before adoption of the new budget is required.

Additionally, more specificity is needed regarding the anticipated pathway of Wage Parity funds for supporting home care personnel. It is critical that the increased funding not only adequately compensate managed care plans and providers, but that such funding in turn also be definitively channeled to direct care agencies whose staff are providing the direct services. Direct care agency compensation must meet both the agency's operating costs and the home care aide compensation levels required under the Wage Parity Law.

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We look forward to close engagement on these issues with the Legislature and Governor to ensure an adequate and appropriate financing structure for wage parity.

HCA Recommendations in Synch with Legislative/Executive Proposals

In addition to the aforementioned two primary and urgent areas of need, **HCA also seeks action in two other areas which incorporate legislative initiatives supported by the Legislature in prior years and which, additionally, have the benefit of being strongly compatible with core priorities articulated in both the Governor's State of the State and his 2014-15 budget proposal**.

Last year, HCA worked with the Legislature to advance "Essential Personnel" legislation (S.4719/A.6530) for patient access to home care and hospice personnel in emergencies like Superstorm Sandy, Hurricane Irene, ice and snow events in the North Country, emergency flooding and others. We urge the Governor and Legislature to incorporate such provisions of the "Essential Personnel" legislation into this year's budget language as part of the budget's comprehensive approach to emergency preparedness and response.

HCA also has worked with hospital association colleagues and with the Legislature to formulate and introduce home care-hospital-physician collaboration program legislation (S.5258/A.7899). Not only did this concept gain legislative support for introduction in 2013, but it has formed the basis for ongoing discussions with the Legislature and Executive for new ways of integrating the system and supporting communities' health care infrastructures. This concept is entirely in synch with the Governor's health care reinvestment and shared-savings programs in the 2014-15 Executive Budget.

In this regard, the Governor's proposed budget language for collaborative models – particularly through his health care capital or delivery system reform incentive payment pilot proposals (DSRIP), and regulatory flexibility language – provide what appears to be an excellent foundation from which to proceed in the negotiations.

HCA asks that the Executive's proposed budget language, which is extensively institutionally-focused, be amended to more explicitly include home care as a participant and eligible core leader in these programs. We commend to the Legislature's and Executive's attention the provisions of S.5258/A.7899 as the basis not only for home care's inclusion but for core hospital-home care-physician program initiatives exemplary for inclusion under the DSRIP and related proposals.

New York's State of Home Care

HCA's second enclosed document, entitled *New York's State of Home Care*, provides a strong rationale for each of HCA's four principal legislative requests using concrete evidence from the home care field.

This report offers an up-to-date briefing on all of the major policy changes occurring in home care. As you know, over the past two years, New York's Medicaid home care program has undergone unprecedented change, which is continuing at a rapid pace. As a result of these changes, home care

providers and managed care plans have had to significantly retool and reformulate. These new policies present fundamental shifts in service delivery, payment and regulation, including the state's reshuffling of billions of dollars in reimbursement, a succession of new regulatory mandates, and the transition of nearly a hundred-thousand patients from their existing community service-arrangements-into-different service settings – with more patients transitioning every day.

While much of the policy background behind these changes may already be familiar, HCA's *State of Home Care* report specifically provides an on-the-ground look at the practical impacts of these changes from the home care provider and plan perspective, including further detailed findings of HCA's aforementioned provider survey coupled with a financial analysis of Medicaid cost reports over the past three years.

In addition to the findings mentioned above, this analysis shows that:

- Based on the Medicaid Managed Care Operating Reports (MMCORs), 42 percent of Managed Long Term Care (MLTC) plans had negative premium incomes in 2012 – a shortfall that financially squeezes both the MLTC plans and their rates of payment to downstream home care providers who are already coping with the impact of prior-year cuts, mandates like the Wage Parity Law, and other issues. On average, providers who have already negotiated MLTC contracts are receiving Medicaid rates 7.45 percent below their fee-for-service rates.

- 12 percent of home care agencies plan to close their doors as a result of recent policy changes; 53 percent of Long Term Home Health Care Programs (LTHHCPs) plan to do so.

- Almost 80 percent of survey respondents have seen an increase in administrative costs due to state and federal audits alone.

We hope these findings and background are instructive as the Legislature works to negotiate key Medicaid budget provisions with the Executive in consideration of HCA's four-point set of budget and legislative priorities previously outlined in this letter.

2014-15 State Budget Provisions Related to Home Care

HCA's previously outlined legislative priorities were initially developed in advance of the Governor's budget. Upon the Governor's budget release, these priority legislative requests were further shaped to also function as a response to the Governor's budget proposals for home care.

When assessed side-by-side with our legislative priorities and recommendations, the Executive Budget proposals contain provisions which HCA can strongly endorse, others which will require further information and assessment, and still others which in present form compel our concern.

To provide a concrete response on the Governor's budget, the third enclosed document – *2014-15 State Budget Provisions Related to Home Care* – is a chart briefly summarizing each of the proposed budget provisions affecting home and community-based providers along with HCA's

analysis and recommended actions. As you can see, many of the Governor's proposals seek to address areas of concern emphasized in HCA's four-part legislative priorities, which I have already addressed in this letter and to which I have offered both analyses and requests for Legislative/Executive action in the negotiations. Some of these areas, such as the Executive's proposal to provide funding for wage parity, require further elaboration and consultation with the home care community to ensure that the proposed appropriations are adequate and are structured in such a way that they reach direct-care workers employed by all affected direct care providers. Please see the attached chart for further response and analysis by HCA on the Executive's budget proposals which I hope will be of assistance in your continued budget review, negotiations and language development.

Conclusion

I thank you for the opportunity to testify today about the many areas of urgent need for funding, regulatory streamlining and program support in home care and managed care. 2014 offers an opportunity to develop policies in the 2014-15 State Budget which provide critical support for home care and health plans to function under and carry out these new state policies, including: providing home care agency and managed care regulatory efficiency; ensuring appropriate funding for services and mandates; and developing new avenues for service delivery innovation and collaboration. HCA looks forward to continuing our discussions with state policymakers on ways to support the home care system with available investment dollars and appropriate regulatory change to ensure a strong infrastructure ready to meet the needs of New York's citizens.

As always, please do not hesitate to reach me for any further input or information.

Sincerely,

Joanne Cunningham
HCA President

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HCA
HOME CARE ASSOCIATION
OF NEW YORK STATE

Updated January 22, 2014

Home Care Priorities in the 2014-15 Budget

Home Care Priorities in the 2014-15 Budget

What can the Legislature and Governor do in this year's budget to support home care?

HCA
HOME CARE ASSOCIATION OF NEW YORK STATE

1

Home Care & Managed Care Regulatory Streamlining & Compatibility

Regulatory streamlining is needed for efficient provision and payment of home care services under managed care.

While the state has transitioned quickly to managed care – and expects to accelerate this process in 2014 – it has not made parallel changes in the regulatory structure of home care providers and managed care plans.

The 2013-14 State Budget required the State Health Department, through a workgroup, to streamline and properly align these regulations; however, this process is not meeting the scope or immediacy of need. Regulations remain excessive, overlapping, not clearly delineated as to agency/managed care plan roles, inefficient, and underfunded to meet mandates.

This regulatory mismatch threatens the operation of health plans, providers and the state's own Medicaid redesign program. Regulatory streamlining is urgently needed and we ask it to be an initiative of this budget to address operations, service contracting and delivery, paperwork, billing/payment procedures, physician orders, and the sorting of health plan/agency responsibilities in this new environment.

2

Funding to Meet the Cost of Care & Regulatory Mandates

Services, including mandated wage laws and regulations, must be appropriately funded and reimbursed.

State Medicaid payments and managed care plan premiums do not adequately support home care wage, service and regulatory mandates. The 2014-15 budget must do so, or else modify or suspend these mandates until funding is procured. Without commensurate funding, agency and health plan services, operations and workforce cannot be sustained under current mandates such as home health agency "Conditions of Participation," the state's home care worker wage parity law, and others.

The Governor has proposed amendments in the 2014-15 Executive Budget to adjust Medicaid rates for Wage Parity. However, it is unclear whether the proposal truly covers the mandated costs, how contracting LHCSAs and other providers will be paid, how managed care plans will be covered and pay contractors, and how other elements will be met. The negotiated budget must ensure adequate funding and channels of payment. Payments must cover both wages and service/operating mandates.

HCA supports the Governor's proposal to rescind the 2 percent across-the-board rate cut to providers and health plans. We also support this year's Executive proposal to reinvest, at the provider and plan level, savings achieved under the Medicaid Global Spending Cap.

3

New Avenues for Service Innovation & Collaboration

Insert budget language to support innovative hospital-home care models for patient services, system improvement and community health.

Home care agencies and hospitals are developing new ways of collaborating to improve patient care and management, prevent avoidable hospital readmissions and emergency room/institutional care, support infrastructure, make the system more cost-effective and help meet overall community health needs and goals.

A supportive state policy and financing structure is essential to promote these cutting-edge models, which are consistent with state and federal policies, including the state's health care redesign policies, state/federal waivers and amendments, and trends in the health care system (see S.5258 Hannon/A.7899 Gunther).

We are encouraged to see that the federal reinvestment waiver is a big focus of the Administration's efforts to support New York's Medicaid program, as highlighted in the Governor's budget message. We are also encouraged to see that the Governor has included in his budget a capital initiative that appears to also allow for collaborative models. It is critical that home care providers have an equal role in this initiative – and that the budget supports collaborative home care models, as envisioned by S.5258/A.7899.

4

"Essential Personnel" Status for Home Care in Emergency Response

Adopt legislation extending 'Essential Personnel Status" to home care and hospice personnel during emergencies.

A major focus of the Governor's 2014 State of the State Address was emergency preparedness and response. HCA applauds this important focus and the recognition that regulatory changes can assist in the overall response effort to disasters like Hurricane Irene and Superstorm Sandy. Home care has a critical role in these events.

The Executive has proposed changes in the designation of "essential personnel" for purposes of access to restricted zones during an emergency.

This proposal is much needed, but it must include home health and hospice personnel in such categorization, given the vital role that these providers play in assisting vulnerable patients who may be unable to evacuate and require care (see S.4719 Lanza /A.6530 Cusick).

New York's State of Home Care

Huge Changes & Vital Needs Amid State Policy Transition

A Special HCA Report

Over the past two years, New York State's Medicaid program has undergone unprecedented change, which is continuing at a rapid pace. In particular, the change has presented extraordinary challenge to the state's home and community-based care system, and to managed care plans, both of which must significantly retool and reformulate under this new policy.

The new policy requires all long term Medicaid home care services to now be provided through home care agency contracts as part of managed care. The change presents a fundamental shift in service delivery, payment and regulation. It has included the state's reshuffling of billions of dollars in reimbursement, a succession of new regulatory mandates, and transitioning nearly a hundred-thousand patients from their existing community service arrangements into different service settings – with more patients transitioning every day.

The vast majority of these changes emanated from the state's Medicaid Redesign Team (MRT), authorized by the 2011-12 State Budget, and later implemented, on a rolling basis, under a policy framework overseen by the state Department of Health (DOH).

If viewed as a two-cycle process, the first stage of these changes has mostly resulted in constrictions to the existing home care system through a series of reimbursement cuts. This was followed by a second phase of structural changes to the system: its flow of reimbursement dollars, the management and authorization of home care services, the placement of patients in new service models, and more.

As New York's home and community-based providers work to adapt to the magnitude of these changes, they face major impacts on their infrastructure and patients, as revealed in a new HCA financial analysis and survey of home care providers conducted over the past several months. Those findings, summarized later in this report, are best understood in the context of recent changes to New York's home care system, as outlined in the policy briefing on the next few pages of this document.

JANUARY 2014

Major Changes in Home Care

Home Care Cuts

In 2011-12, home care providers received approximately $700 million in direct Medicaid reimbursement cuts over two years, including: a 2% across-the-board rate cut; a gross-receipts tax, elimination of the Medicaid trend factor adjustment; and the imposition of the Medicaid Global Cap, which affects virtually all Medicaid outlays by restricting levels of spending to a state-forecasted trend. The Global Cap additionally exposed providers to the possibility of further cuts in the event that spending exceeds the state's forecasted trend at some future time. To date, according to monthly reports from the state, spending on the Medicaid program as a whole – and home care especially – has remained well below the cap.

In addition to across-the-board home care cuts, a specific type of home care provider, Certified Home Health Agencies (CHHAs), was uniquely hit with an agency-specific per-patient cap on spending in the 2011-12 State Budget. This cap alone amounted to a $200 million state-and-federal-share reduction in reimbursement.

These CHHA ceilings were applied as a first-year spending control measure as the state completed its design work and implementation of a new CHHA reimbursement system, which ultimately went live on May 1, 2012. This new system, now in effect for patients needing 120 days or fewer of care, is called the episodic payment system, or EPS. It functions similar to the way Medicare pays for home health services; rather than reimburse a CHHA for each unit of service (i.e. each service provided in a patient's home), EPS pays the provider a single risk-adjusted rate that covers an entire 60-day 'episode' of care, regardless of how many times the provider visits a patient or how much care the patient ultimately requires.

This transition from CHHA spending caps to a risk-based model of payment, through EPS, is emblematic of the state's effort, as a whole, to approach its Medicaid reforms in home care by first cutting Medicaid payments and then overhauling the overall method of payment and finance incentives. While CHHAs have now moved to a risk-based system – for patients needing less than 120 days of care – a separate, sweeping change continues to be rolled-out for programs serving 'longer-term' Medicaid populations (i.e. patients needing more than 120 days of care). The vast majority of these patients are now being moved to managed care plans under a process called "mandatory enrollment," which is perhaps the biggest overhaul to home care in decades, affecting all of the principal types of home care programs, including CHHAs, Long Term Home Health Care Programs (LTHHCPs) and Licensed Home Care Services Agencies (LHCSAs).

Mandatory Enrollment

Traditionally, patients at or above the 120-day threshold for care duration were served by a provider-led program of care-management and services (e.g. a CHHA, LTHHCP, LHCSA, or some combination); or, they were enrolled in a Managed Long Term Care (MLTC) plan which functioned as the vehicle for care management and Medicaid payment but established contracts with a network of home care providers to do the actual service delivery to patients. With some variation, these models (along with a "consumer directed personal assistance program" model) were the options for patients. These options depended on the level of services needed, the type of program overseeing the patient's care, decisions made by local social service districts, and other factors.

At the same time that the state began transitioning to a new CHHA payment system, it also initiated an ambitious project to move over 100,000 longer-term home care patients from direct home care program enrollment (e.g. CHHAs, LTHHCPs and LHCSAs) to enrollment in managed care insurance plans, and to enroll all new such patients into managed care.

This transition from CHHA spending caps to a risk-based model of payment, through EPS, is emblematic of the state's effort, as a whole, to approach its Medicaid reforms in home care by first cutting Medicaid reimbursement and then overhauling the overall method of payment and finance incentives.

For patients who are enrolled in managed care, the plans authorize and (directly or through contract) coordinate home care and certain other services; the plans receive a monthly premium payment from the state for doing so; and the home care provider operates as a subcontractor, delivering and/or coordinating in-home services to managed care enrollees under contract with – and paid by – the MLTC or Managed Care Organization (MCO).

Therefore, to participate in this system and continue serving the Medicaid long term care population, home care providers (be they a CHHA, LHCSA or LTHHCP) must negotiate a service or care management contract, as well as rates of payment, from the MLTC or MCO; and these rates can vary significantly from the amount a provider would have traditionally received when it was directly billing the state under fee-for-service.

Evolution of the Mandatory Enrollment Requirement

The mandatory enrollment process began in New York City in 2012 and is being extended to other regions of the state on a phased-in basis. Under this policy, many patients in the downstate region have already been enrolled in managed care plans. Mandatory enrollment into MLTCs has begun upstate as well for some patients, but not yet for the vast majority of upstate populations. (The state's original schedule called for mandatory enrollment to commence in the balance of the upstate regions by June 2014.)

This change alters service delivery for certain eligible patient populations served by virtually all types of home care agencies and programs, especially patients in programs like the LTHHCP and Personal Care Program which serve the elderly and persons with disabilities.

Enrollment Numbers to Date

Date	Partial Cap & PACE Enrollment	Medicaid Advantage Plus Enrollment
January 2010	28,951	426
June 2010	30,407	583
January 2011	32,602	1,207
June 2011	34,929	1,420
December 2011	43,523	1,671
January 2012	45,487	1,720
June 2012	52,479	2,000
Sept 2012	58,375	2,442
December 2012	71,170	2,956
January 2013	78,222	3,094
March 2013	87,419	3,263
August 2013	102,084	4,299
Sept 2013	110,401	4,414
October 2013	113,577	4,544
Nov 2013	116,171	4,665
December 2013	118,615	4,826

Timeline of Events to Date

September 2012	Personal Care goes into MLTCs (NYC).
January 2013	CHHAs go into MLTCs (NYC) and all programs in L.I. & Westchester go into MLTC.
May 2013	LTHHCPs go into MLTCs (NYC).
September 2013	All programs go into MLTCs in Rockland & Orange.
December 2013	All programs go into MLTCs in Albany, Erie, Onondaga & Monroe.

At present, the Personal Care program has been entirely transitioned over to managed care, a process which began in September 2012 for those patients who are dually-eligible for Medicare and Medicaid. This means that LHCSAs who previously received a fee-for-service rate for Personal Care services provided to these patients are now operating in a negotiated contract arrangement with the managed care plan to deliver services for those patients.

The transition of Personal Care also means that integral components of the program which were formerly handled by local departments of social services (e.g. assessments, authorization of services) are now the purview of the managed care plan. However, the specific handling of assessments and various other core program tasks (i.e. supervision, reassessments), vary from plan to plan, and these tasks may be fulfilled by the contracting home care providers.

LTHHCPs have been uniquely affected by this mandatory enrollment policy. LTHHCPs, also known as "the nursing home without walls," are specially licensed by the state to provide a nursing-home-level of care to nursing-home-eligible patients in their own homes. These agencies have traditionally served 25,000 to 30,000 patients, many of them dual-eligible, at half the cost of nursing-home care, although program costs are statutorily capped at 75% of the nursing-home rate.

As of today, these programs may no longer enroll new Medicaid patients in mandatory managed care counties, and may only continue to serve their patients in these areas if they are able to contract with a managed care plan in that region.

Meanwhile, thousands of existing LTHHCP patients have also been required to transition to managed care in a rapid migration of services. Starting May 2013, all dually-eligible New York City LTHHCP patients were required to enroll into MLTCs, and the process is continuing statewide.

Ironically, the MRT had declared the LTHHCP to be a vital part of the new infrastructure and the new managed care policy. However, faced with an uncertain future, due to process issues in the managed care transition, LTHHCP providers are already beginning to discontinue or substantially downsize these programs, as revealed later in HCA's survey.

Meanwhile, important specialty services like home telehealth are also substantially impacted by the managed care transition. Home telehealth involves the use of technologies in the home which allow patients to receive education and daily monitoring of vital signs and/or video visits from a registered nurse or therapist, bringing medical monitoring to people who need it, as a supplement to in-person home visits. Many home care agencies have adopted these technologies and clinical protocols in ways that have greatly enhanced patient care and reduced unnecessary hospitalizations.

In 2007 and 2008, the state Medicaid program, with advocacy from HCA, adopted a special program structure and Medicaid rate for telehealth under the fee-for-service system. However, as the state now moves enrollments and payments to managed care, it has yet to migrate this home telehealth program so that it is continued under the managed care structure. As a result, providers are already reporting that they plan to discontinue their home telehealth programs; without a carryover of structure, funding or aligned incentives, most managed care plans are not paying for home telehealth services.

Faced with an uncertain future due to process issues in the managed care transition, LTHHCP providers are already beginning to discontinue or substantially downsize these programs, as revealed later in HCA's survey.

As part of this whole transition process, the state has developed requirements intended to ensure that a patient's caregivers and level of home care service remain in effect during a defined 90-day transition period for patients already receiving services before the transition. However, once this continuity-of-care period ends, a patient will receive services only from those specific home care providers who are under contract with the plan and in the health plan's network. Those network providers may – or may not be – different from the ones who were previously serving the patient; and the level of services may also change depending on the reassessment of the patient by the plan.

As each month passes, more and more patients are being transitioned from fee-for-service, or direct provider enrollment, to Managed Long Term Care. The state's Medicaid expenditure and enrollment data reveal the magnitude of this shift in such a short period of time: Between January 2011 and December 2013, MLTC enrollment has grown 264%, from 32,602 to 118,615. In this same period, the state's expenditures on capitated payments to managed care increased from $1.7 billion to $4.7 billion in 2013 – a 176% percent increase. Meanwhile fee-for-service Medicaid revenue for home health (CHHAs and LTHHCPs) has decreased by 64%.

This monumental transition is just one step among even bigger changes yet to come. The state is right now working with the federal government on a special demonstration project to enroll dual-eligible Medicaid/Medicare patients into special managed care plans for the coordination of both their Medicaid *and* Medicare services.

To date, the state's mandatory managed care initiatives have been restricted to Medicaid services, even in cases where a patient is eligible for both Medicaid and Medicare. However, under the Fully Integrated Duals Advantage demonstration, or FIDA, the state expects to enroll 170,000 dual-eligible recipients – many of them having just enrolled into MLTC plans under the aforementioned transition – into specially approved managed care FIDA plans that will coordinate services paid both by Medicare and Medicaid.

Individuals will have the option of enrolling into a FIDA plan of their choice; however, eligible beneficiaries who do not actively enroll into a plan or indicate that they don't want to enroll will be "passively enrolled" at a later time. For passive enrollment selection, the state has said it will rely on a process called "conversion in place," under which dual-eligibles already in MLTC plans will see the Medicare benefit added to their MLTC coverage in cases where the individual's MLTC plan is FIDA-approved.

Preparing for this Shift

The expectation is that a monumental transition – such as is occurring in home care – would require: a well-thought-out system of regulatory adjustments, where appropriate; detailed guidance to providers and plans; communication to Medicaid recipients about the enrollment process and appeal rights; quality oversight and measurement; and more.

During last year's budget process, HCA urged a series of regulatory-relief measures that would make it possible for home care providers and managed care plans to work together more seamlessly, as the state's policy intends, by eliminating duplication, inconsistency, and confusion about roles, responsibilities and requirements. In response, the Legislature set up a workgroup to examine these issues. HCA has worked with other associations to advance specific proposals for the workgroup's consideration; the workgroup is due to report to the Legislature by March 1.

One of the biggest and unforeseen regulatory changes to occur in the lead-up to mandatory enrollment was the state's effort to open up the home care certification application process for the express purpose of meeting the needs of a transitioning system – ostensibly, to ensure that enough CHHA capacity existed to contract with managed care plans in serving patients.

Between January 2011 and December 2013, MLTC enrollment has grown 264%, from 32,602 to 118,615.

To that end, in December 2011, the state issued an emergency rule lifting the moratorium that had barred any new CHHAs in the state. It also set up a Request for Applications (RFA) process that would allow: existing CHHAs to apply for more capacity; new CHHAs to enter the Medicaid market; and other existing providers (LHCSAs and LTHHCPs) to establish or convert to a CHHA. So far, about 66 applicants for new CHHA capacity have been approved by the state's Public Health and Health Planning Council – a process that has brought forth new players and market dynamics in an infrastructure already otherwise undergoing major transitions.

So far, about 66 applicants for new CHHA capacity have been approved by the state's Public Health and Health Planning Council – a process that has brought forth new players and market dynamics in an infrastructure already otherwise undergoing major market transitions.

Wage Parity and other Mandates

In addition to the succession of payment cuts, structural changes, and major market dynamics, a third enormous change to the home care system over the past two years has been the state's imposition of a Home Care Worker Wage Parity Law. This law establishes a minimum rate of home care aide compensation in the New York metropolitan area.

Wage Parity began in March 2012 for New York City and March 2013 for Long Island and Westchester. It includes a timetable of mandated wage increases for home care personnel, with no new funding support from the state, thus far, in the form of premium payments to managed care plans or rate adjustments to providers.

These state-mandated wage parity levels are tied to local living wage laws and, in some scenarios, individual collective bargaining agreements. As interpreted by the state Department of Health, the mandated levels for New York City will accelerate significantly in 2014.

Starting March 1, New York City's wage requirement will be $14.09 in total compensation. For Long Island and Westchester, the wage amount increases to $9.50 per hour, if health benefits are included, or $10.93 without health benefits.

The Wage Parity Law has additional implications now that the U.S. Department of Labor has eliminated the "companionship exemption" for home care agencies. This federal change in the labor law means that, starting January 1, 2015, home care aides will have to be paid overtime at time-and-a-half of their regular pay, not time-and-a-half of the minimum wage, in New York State. In many cases, this new federally required base wage for calculating overtime will be substantially higher, due to the higher baseline compensation levels set forth in the Wage Parity provisions.

These major new mandates are just a few of the increasing pressures on providers who also are additionally subject to administrative cost limitations under the Governor's Executive Order 38, new flu vaccination and reporting requirements, state and federal audits and third-party appeals processes, as well as major new paperwork and enrollment procedures for physician-ordered home care services that have a direct impact on home care billing under Medicare and Medicaid.

Survey and Financial Analysis Reveal Major Impact of Policy Changes in Home Care

To assess the impact of these enormous and multi-layered changes to New York's Medicaid home care system, HCA, in November of 2013, issued a survey to be completed by our home care provider members asking them to answer important questions about their experiences with the MRT changes impacting the home care community.

We also asked providers to give us a sense of the financial condition of their agencies by reporting key elements from their 2012 Medicaid Cost Reports. The Medicaid Cost Report provides official, independently certified financial and statistical data related to all categories of an organization's revenues and expenses.

In addition to the HCA provider survey sample (85 respondents), HCA also separately analyzed 2011 Medicaid Cost Reports submitted by all CHHAs and LTHHCPs in the state as well as managed care operating and finance data submitted by managed care plans in their Medicaid Managed Care Operating Reports (MMCOR).

Key findings and related background on this analysis are detailed on the next few pages. A summary of these key findings is provided in the sidebar at right.

Key Findings at a Glance

- Over 70% of home care providers had negative operating margins in 2011 and 2012.
- 12% of home care agencies plan to close their doors as a result of recent policy changes; 53% of LTHHCPs plan to do so.
- 42% of MLTCs had negative premium incomes in 2012 – a shortfall that financially squeezes both the plans and their rates of payment to downstream home care providers who are already coping with the impact of prior-year cuts, mandates like the Wage Parity Law, and other issues. On average, providers who have already negotiated MLTC contracts are receiving Medicaid rates 7.45% below their fee-for-service rates.
- More than two-thirds of providers said the redundancy or lack of clarity in state regulations has had a "large cost impact" on their organization in the managed care contracting environment.
- In 2014, when Wage Parity requirements increase dramatically, about 40% of agencies in HCA's survey expect to reduce the hours of direct-care staff and a similar percentage expect to reduce direct-care staff overtime, while 25% of agencies plan to lay off other agency staff.
- Almost 80% of survey respondents have seen an increase in administrative costs due to state and federal audits alone.

1. Home Care Program Viability in Jeopardy

Massive home care cuts and state changes have threatened the financial viability of home care providers. Meanwhile, as managed care plans continue to receive inadequate rates of payment from the state, downstream home care providers are experiencing a ripple effect on their contracted rates with managed care plans. This is a growing concern as the state continues its shift from direct provider payment to capitated payments, and as providers move past the 90-day continuity-of-care period (which temporarily preserves their fee-for-service rates and existing plans of care).

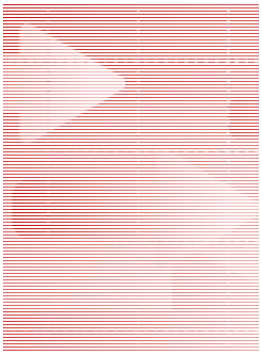
Specific programs like the LTHHCP are acutely affected. The state has effectively shut-off Medicaid patient enrollment into the LTHHCP in mandatory managed care counties throughout the state, and LTHHCPs have encountered an uncertain regulatory environment under managed care that does not offer a clear pathway for these important programs to function as contract providers under managed care in the new paradigm.

Astonishingly, 12% of home care agencies in HCA's survey plan to close their doors as a result of recent policy changes; 53% of LTHHCPs plan to do so. More findings are below.

- In the past several years, home care provider margins have remained consistently in the red, compromising viability. Over 70% of home care providers had negative operating margins in 2011 and 2012, according to an analysis of home care cost reports.
- LTHHCPs have been especially affected by cuts and the uncertain transition to mandatory managed care enrollment. Over 80% of LTHHCPs had negative operating margins in 2011 and 2012; the median operating margin of LTHHCPs who completed HCA's survey was -9.07% in 2012. Between 2009 and 2011, total operating losses for all LTHHCPs increased from -$21.2 million to -$47 million, a 122% increase in operating losses. Due to the state's unsupported managed care transition specifically, 53% of survey respondents have or say that they will phase-out their LTHHCP, and 58% of all home care survey respondents have or will reduce staff and other expenses to become more efficient.
- CHHA operating margins continue to plummet as well. Approximately, two-thirds of all CHHAs had negative operating margins in 2011 and 2012. The median operating margin of CHHAs surveyed in 2012 was approximately -5.0%.
- Almost half of all survey respondents have had to use a line of credit or borrow money over the past two years to pay for operating expenses.
- As a result of MRT actions and Medicaid funding reductions in recent years, 12% of survey respondents plan to close their home care service organizations.
- Another casualty is the diminishing capacity of New York's existing home care provider network to utilize its professional-services and care-management expertise in this new paradigm. According to HCA's survey, only 3% of LTHHCPs, 12% of CHHAs and 13% of LHCSAs have contracted with an MCO for care management; 19% of LTHHCPs are delivering professional services to MCOs; and 22% of all agencies that responded to the survey are providing supervision services.

2. Inadequate Premiums and Contracted Rates to Plans and Providers Erode Financial Support for Home Care

The transition to managed care has increasingly relied on a system of negotiated payments between managed care plans and their network home care providers. But according to MMCOR data, 42% of MLTCs had negative premium incomes in 2012 – a shortfall that squeezes MLTCs and, in turn, the rates of payment to downstream home care providers who are already coping with the impact of prior-year cuts, mandates like the Wage Parity Law, and other issues. More findings are below.



- Inadequate managed care rates ranked highest among the concerns voiced by home care providers in HCA's survey. When asked about the overall impact of managed care contracting, about half of providers selected "inadequate rates" as having the largest impact, followed by "lack of timely authorizations," and "lack of timely payment."

- On average, providers who have already negotiated MLTC contracts are receiving Medicaid rates 7.45% below their fee-for-service rates, according to HCA's survey. Given that 70% of providers were operating in the red in 2011 – at a time when the fee-for-service rate was largely still in effect – this 7.45% reduction from the already inadequate fee-for-service rate suggests further peril for downstream providers.

3. Regulatory Clarity and Streamlining in Managed Care Transition are Urgently Needed

At the same time that tens of thousands of patients have transitioned to managed care, providers and plans continue to seek clarity and answers on basic questions regarding contract and licensing requirements, as well as the division of regulatory responsibilities between plans and providers for supervision, assessments, obtaining physician orders and more.

This overall lack of clarity and redundancy is costly for providers, plans and the Medicaid system as a whole.

Meanwhile, innovative programs recognized under the fee-for-service rate structure, like home telehealth, have no clear line of program continuity or financing support in managed care, threatening the extinction of these innovative technologies and clinical protocols which have proven to decrease costs and improve patient outcomes. More findings are below.

- More than two-thirds of survey respondents said the redundancy or lack of clarity in state regulations has had a "large cost impact" on their organization in the managed care contracting environment, while 25% said this lack of clarity and redundancy has had a "medium cost impact." This includes confusion over the responsibilities for obtaining physician orders, plans of care and supervision requirements.

- Eighty-five percent of respondents in HCA's survey indicated that greater state clarity on the roles and regulatory responsibilities of agencies is "very important."

- More than 78% of agencies in HCA's survey said they are unable to contract with managed care plans for telehealth services. Only 21% have contracted for telehealth. Nine percent of providers said they already had to discontinue their telehealth program as a result of the transition to managed care.

4. Wage Parity Law has Led to Staffing Cuts and Financial Vulnerability

Along with payment cuts and changes, providers and plans have also seen major new costs resulting from state mandates such as the Wage Parity Law. While HCA and the home care community have long called for improved Medicaid payment for home care aide compensation, this Wage Parity law imposed wage mandates without commensurate funding. As a result, this law has cost the system hundreds of millions of dollars with no financing support from the state in its managed care premium payments or rates to providers.

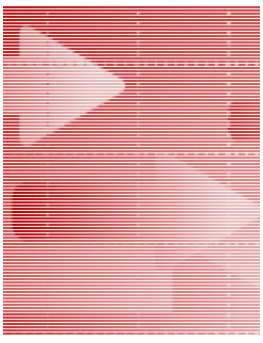
Not only has the Wage Parity Law affected the financial viability of home care providers but it has also led to staffing cuts which undermine the goal of supporting dedicated home care personnel. These mandated wage levels will increase precipitously in 2014, leading to further erosion in home care financial stability, especially as additional federal and other state employer mandates also go into effect. More findings are below.

- Wages and benefits had the biggest impact on the rising cost trend for providers. Forty-one percent of respondents chose wage costs as having the "largest impact" on their rising costs, while 47% chose benefit costs as having the "largest impact."
- As a result of the Wage Parity Law in NYC, Westchester and Long Island, about half of survey respondents have already reduced direct-care staff hours and a similar percentage of providers have already reduced direct-care staff overtime. Nineteen percent have laid off direct-care staff and 23% have laid off other agency staff as a result of the Wage Parity Law.
- In 2014, when the wage parity requirements increase dramatically, without commensurate funding from the state, about 40% of agencies who were surveyed expect to reduce the hours of direct-care staff and a similar percentage expect to reduce direct-care staff overtime, while 25% of agencies plan to lay off other agency staff.

5. Administrative Hurdles Continue to Strain the Home Care System

In the past few years, home care agencies have been hit with unfunded mandates that require staff time and resources and take away from the delivery of patient services. These include influenza vaccine and reporting responsibilities, continued onerous Medicare billing requirements for patients whose home care was covered by Medicaid, new physician enrollment requirements that have a direct effect on home care billing, the physician face-to-face mandate for Medicare home care patients, a multitude of compliance responsibilities, and time spent responding to numerous federal and state audits. Meanwhile, the state has imposed stringent and mismatched limits on administrative expense reimbursement under Executive Order No. 38, threatening the operation of agencies.

Providers also continue to face hurdles in obtaining signed physician orders on a timely basis and are not allowed to utilize an "exception code" to obtain reimbursement for late physician orders that are beyond their control. More key findings are below.



- Almost 80% of survey respondents have seen an increase in administrative costs due to state and federal audits alone.
- Fifty-three percent of survey respondents said that unfunded mandates had a "large impact" on the rising cost trend at their agency. Another 41% reported that other administrative costs had a large impact.
- Forty-three percent of survey respondents said the lack of timely physician orders has had a "large impact" financially on their organization and 40% said it has had a "medium impact."

Conclusion

In the span of just two years, the home care system has witnessed the transition of tens of thousands of patients to new forms of care, dramatic changes in rates of reimbursement and overall provider financial viability, further payment erosion for plans and providers alike in the transition to and financing of managed care, $700 million in direct cuts and unfunded mandates, and an urgent need for regulatory streamlining.

Without state action and support, entire programs like the LTHHCP and specialized services like home telehealth – despite proven success in clinical and cost outcomes – face, at best, an uncertain and limited future. Meanwhile, all home care providers who have developed years of specialized expertise in professional care-management find that this expertise is increasingly underutilized in the new home care marketplace at the same time that the state has had a hand in altering this marketplace to encourage more certified home health capacity.

New wage, regulatory and employer mandates have saddled providers with increasing costs at the same time that the state has imposed new restrictions on the amount a provider can spend on administrative activities while simultaneously shrinking the home care revenue base with payment cuts.

Yet, despite facing myriad policy challenges and increasingly precarious financial conditions, home care agencies are nevertheless planning positive actions to adapt to this changing delivery system. In fact, our survey shows that 64% of providers are retraining their workforce to adapt to a changing home care paradigm, 56% of providers are expecting to enter new partnerships, and 34% are already collaborating as part of a health home or other health system.

Meanwhile, as the state's policies intend, providers are diligently seeking to join managed care networks through contract arrangements with MLTCs and/or MCOs. When asked about actions already taken, 74% of respondents to HCA's survey had already contracted with MLTCs and 43% had already contracted with MCOs, with more expecting to do so as the transition extends to other areas of the state.

Even as this process is now already substantially underway, 2014 offers an opportunity to learn from recent history and develop policies in the 2014-15 State Budget which provide for critical support for home care and health plans to function under and carry out these new state policies, including: providing home care agency and managed care regulatory efficiency; ensuring appropriate funding for services and mandates; and developing new avenues for service delivery innovation and collaboration.

One important vehicle for support is the state's waiver application with the federal government to invest $10 billion of the $17 billion in MRT savings back into the health system and Medicaid reform. Considering home care's well-established clinical and cost-savings track record coupled with the big – but not insurmountable – policy challenges that need to be addressed, HCA looks forward to continuing our discussions with state policymakers on ways to support the home care system with available investment dollars and appropriate regulatory change to ensure a strong infrastructure ready to meet the needs of New York's citizens.

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2014-15 State Budget Provisions Related to Home Care

See below HCA's analysis of key proposals in the Governor's 2014-15 Executive Budget.
***Note**: this analysis does not include cost-containment actions rolled forward from prior years (e.g. elimination of the trend factor, Medicare Maximization targets, A&G caps, etc.) This chart focuses on the principal new items affecting home care.*

Article VII Budget Provision S.6358/A.8558 Heath & Mental Hygiene Bill	HCA Analysis
Wage Parity Rate Adjustments Incorporates PHL amendments to adjust rates for CHHAs and LTHHCPs for wage parity costs. Executive states that MLTC rate adjustments will be made administratively. There are no specific line appropriations in the budget showing or detailing the funding increases.	The budget proposal is a positive response to urgent funding needs. However, further analysis is required to see if the adjustment level and payment methods allow for Wage Parity compliance. No detail is provided on: the amount of funding; whether funding meets statutory levels and associated new provider expenses; how the funds would be channeled to LHCSAs and other providers; whether and how managed care plan rate adjustments are made; and whether other elements are adequately met.
Lump Sum/Vital Access Program for LHCSAs The Health Commissioner would be authorized to make "temporary periodic lump-sum Medicaid payments" to LHCSAs that are: undergoing closure; impacted by closure of other providers; subject to mergers, acquisitions, consolidations or restructuring; impacted by mergers, acquisitions, consolidations or restructuring of other providers; or seeking to ensure access to care is maintained.	HCA strongly supports financing opportunities for LHCSAs. However, HCA is concerned about the qualifying criteria for this funding and will be seeking details. HCA is also concerned that such supplemental or "essential community provider" financing may also be needed by other home care provider types.
Discontinuation of 2% Cut & Additional LTHHCP GRT The budget's Global Cap provisions propose ending the 2% across-the-board cut to Medicaid providers and any cuts made in lieu of the 2% (such as the additional GRT imposed on LTHHCPs), terminating March 31, 2014.	HCA strongly supports this action. HCA was part of the Executive's Global Cap Advisory Workgroup where this initiative was formulated.
Repeal of HCRA Support for RTR Article VII would repeal the longstanding HCRA $100 million investment for home care, hospice and MLTC direct care worker recruitment, training and retention (RTR) rate adjustments. The $340 million adjustment for NYC personal care RTR and $28.5 million for upstate personal care RTR are continued.	The proposed budget memorandum indicates that existing RTR funding levels would be maintained within providers' base rates and MLTC premiums. However, the bill itself is silent in this regard. Regardless, HCA urges that HCRA funding investment for home care, hospice and MLTC be maintained, even if repurposed toward home care, hospice and MLTC infrastructure.
Global Cap Shared Savings Reinvestment Plan Article VII includes an initiative to reinvest back into the provider system savings achieved under the global cap.	HCA strongly supports. HCA was part of the Executive's Global Cap Advisory Group where this initiative was formulated.
DSRIP/Waiver Initiatives The budget proposes a capital fund and pilot projects to support system integration, infrastructure and improvement through the "Delivery System Reform Incentive Payment" (DSRIP) program as part of the state's Medicaid waiver plan. Regulatory waivers would be authorized for participating providers.	HCA strongly endorses and has been engaged with the Executive on this concept. HCA has also engaged with the Legislature to introduce a hospital, home care and physician collaboration measure (S.5258 Hannon/A.7899 Gunther) which should be considered with the budget. HCA is concerned that the Executive's language contains no capital finance provisions for home care and only peripheral mention of home care as part of integrated programs. This appears inconsistent with the strong desire, otherwise signaled by DOH, for home care-hospital-primary care partnerships. HCA urges the Executive and Legislature to equally include home care within these opportunities.

Article VII Budget Provision S.6358/A.8558 Heath & Mental Hygiene Bill	HCA Analysis
Adds Managed Care to Home Care Pre-claim Review	HCA strongly opposes this OMIG provision. Pre-claim review was created as an "addition" to the 2011 MRT package as a front-end "fee-for-service" review of all home care claims prior to submission and adjudication. The statute did ***not*** apply this process to managed care payments because managed care plans do not bill, and hence are not paid, based on individual service claims, but instead are reimbursed "per member per month" as an insurance form of payment. The existing pre-claim review was imposed as an unfunded mandate and has been very costly to home care providers at the same time as providers are subject to a host of still-further unfunded mandates. Not only does expansion of the mandate not make sense in a managed care environment, it **adds** to the cost burden of already burgeoning and unmanageable unfunded mandates on home care.
OPWDD Direct Care Worker Scope of Practice Would extend current exception to the Nurse Practice Act for OPWDD direct care workers to cover these workers in new community based (i.e., "noncertified") OPWDD settings.	Home care workers do not appear to be directly affected by this change. However, HCA has sought and urged flexibility for home care workers under the existing Nurse Practice Act exception for home care, which does not include ***certified or licensed*** home care settings, but is limited to services paid for under the consumer directed personal assistance stream only, which, now, along with all other long term Medicaid paid home care, is under managed care.
Removal of LTHHCP Slot Limits The budget proposes amendments to the public health law removing slot limits on LTHHCPs	HCA has advocated removal of LTHHCP slot limits both historically and more recently in connection with the managed care transition. Slot limits have also been identified by HCA and other state health associations as a potential regulatory misalignment between LTHHCP and MLTC that should be removed.
Certificate of Need/Ownership Transfer Reforms Proposed changes include: (i) reduction in the period used to review an entity's "character and competence" from 10 to 7 years under the Public Health and Health Planning Council (PHHPC) approval process; (ii) an expedited review process for approval of up to 9 additional beds, up from the current 5, in existing enhanced assisted living residences and special needs assisted living residences; and (iii) broader inclusion of ownership/interest changes or transfers for PHHPC approval.	HCA supports reductions in the character and competence review period, and supports an expedited review for assisted living residence bed approvals. Further information and assessment are necessary in relation to the proposal triggering broader review of ownership/interest changes or transfers.