



# RISK FACTORS

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

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



FEBRUARY 2016





# RISK FACTORS

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

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

### Background

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

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

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

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

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

*Continued on next page...*

### Data Summary

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

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

*Continued on next page...*

*Background - continued*

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

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

*Data Summary Continued...*

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

*Continued on next page...*

*The Current Financial Landscape for Home Care*

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

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

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

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

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

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

### *Data Summary Continued...*

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

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

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

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

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

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

*Continued on next page...*

- Of the managed care plans which do not remit payment on time, **the average length of time to receive payment is 61 to 180 days for about half of the home care respondents to HCA's 2015 managed care survey.**<sup>17</sup>
- 45% of agencies indicate that **over 15% of their revenue is affected by a lack of timely payment.**<sup>18</sup>

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

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

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

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

#### ***Rebasing***

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

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

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

### ***New Overtime Mandate and Proposed \$15 Wage Impact***

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

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

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

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

*Continued on next page...*





Home care providers have reason to be concerned.

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

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

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

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

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

the premiums they receive are adequate to cover costs.

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

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

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

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

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



## Conclusion

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

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

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

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

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

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

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

<sup>5</sup>Source: HCA's 2015-16 financial survey.

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

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

<sup>8</sup>Source: HCA's 2015-16 financial survey.

<sup>9</sup>Source: HCA's 2015-16 financial survey.

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

*Continued on next page...*

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

<sup>12</sup>Source: 2013 and 2014 MMCOR data received from the state Department of Health.

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

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

<sup>15</sup>Source: HCA's 2015-16 financial survey.

<sup>16</sup>Source: HCA's 2015-16 financial survey.

<sup>17</sup>Source: HCA's 2015 managed care payment survey.

<sup>18</sup>Source: HCA's 2015 managed care payment survey.

<sup>19</sup>Source: HCA's 2015-16 financial survey.

<sup>20</sup>Source: HCA's 2015-16 financial survey.

<sup>21</sup>CHHA rate rebasing was implemented in October 2015. Rebasing essentially means the resetting of the rates, in this

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

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

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

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

