2017-18 State Budget Testimony
HCA Concerns and Recommendations

Joint Legislative Hearing
of the Senate and Assembly on the
Health and Medicaid Budget

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New York State (HCA)

HCA
HOME CARE ASSOCIATION
OF NEW YORK STATE

Introductory Remarks

The Home Care Association of New York State (HCA) appreciates the opportunity to testify before the Legislature today on the Health and Medicaid aspects of the proposed 2017-18 state budget.

I am Al Cardillo, Executive Vice President at HCA. My organization represents home care and hospice providers, as well as Managed Long Term Care (MLTC) plans, throughout every region of New York State. This vital system of home-and-community-based entities serves 375,000 Medicaid recipients annually, as well as 180,000 Medicare beneficiaries and other patients receiving cost-effective services at home.

HCA's membership encompasses the full continuum of home-based services. This includes post-acute, long-term, preventive, end-of-life, and managed care-directed programs, each of which have their own core licensing features, payment and billing structures, clinical and human-resource capabilities, as well as distinct roles in the system.

Collectively, these providers and plans keep patients out of costlier settings (like hospitals and nursing homes); provide maternity-newborn care to assist mothers and children; help aging New Yorkers live independently and safely at home; support patients recuperating from surgery (so individuals aren't readmitted to the hospital due to complications); address clinical risk areas like asthma mitigation, cardiovascular health management and infection control; provide public health services like immunizations; and execute additional functions that are not explicitly health-related but are unique to in-home service delivery, such as emergency-preparedness activities.

I point your attention to all of these features because I think you will see that home care delivers squarely on priority areas that have commanded attention from the state in all of its major policy initiatives intended to reduce costs and provide better care.

As you know, the state has invested billions of dollars into the Delivery System Reform Incentive Payment (DSRIP) program to reduce unnecessary hospital use by 25%. The state has also invested enormous financial and planning resources in an effort to reorient the entire Medicaid system toward value-based payments (VBP). These new risk-sharing and highly integrated system models seek to reduce costs and incentivize outcomes in manners that have long resided in home care's domain of expertise.

If you were to examine any of the specific DSRIP or VBP projects targeted by the state – whether its post-acute joint-replacement care, asthma mitigation, or managing chronic obstructive pulmonary disease, congestive heart failure and diabetes – home care has been addressing these needs in

focused and intensive ways for decades. A robust home care system is requisite for the success of every state Medicaid waiver project and system redesign activity currently in operation, especially those models aimed at the overarching goal of a 25% reduction in hospital use.

I will focus on four areas critical to the support of the community-based sector in which we ask for your help and action in this new state budget.

Payment Adequacy Needed for Home Care Stability in Achieving State Outcome Goals

Home care providers and the MLTC plans they partner with are collectively shouldering operating losses due to long-standing Medicaid rate-setting inadequacies. Our just published financial condition report, attached to my testimony, profiles the data.

The state's premium and rate methodologies are failing to cover the *real* cost of delivering services, particularly with the increasing need for care and constant layering of new provider/health plan mandates. We ask the Legislature to build on last year's budget language requiring actuarially sound payments by further strengthening the methodology language to ensure that critical managed care and provider operating and service expenses are duly covered in the premiums and rates as statutorily intended.

HCA has provided requisite Article VII language for your consideration.

We further ask that cuts to MLTCs that have been proposed by the Executive in this budget, and referenced further in this testimony, be rejected and that this necessary MLTC funding is restored.

Our financial condition report, derived from certified cost reports to the state, finds that state Medicaid underpayments result in 61% of MLTC plans having negative premium incomes in 2015 and 72% of Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs) having negative operating margins for 2014, with similar CHHA/LTHHCP financial results in 2015.

Thirty-one percent of all home care agencies (CHHAs, LTHHCPs and Licensed Home Care Services Agencies, or LHCSAs) have had to use a line of credit or borrow money to pay for operating expenses over the past two years, and another 6% of agencies were unable to establish a line of credit or financing due to various financial factors.

Funding pressures on MLTCs also contribute to a downstream effect on providers experiencing authorization and payment delays, the accumulation

of bad-debt, and constricted revenue flow. I point you to our report, *NYS Home Care Program and Financial Trends 2017*, for further details and elaboration on these financial matters.

Most urgently, as you know, last year's budget adopted a minimum wage hike that disproportionately affects home care providers and MLTC plans. This wage hike alone will have a $2.19 billion cost impact for home care across the full, multi-year implementation of the mandate. It is essential that state-set managed care premiums and provider rates be increased to fully cover these wage requirements, and that the requisite appropriation level be included in the budget for this purpose. We urge the Legislature and Executive to ensure the necessary budget funding.

The Governor's budget includes some allocations for home care minimum wage impacts, starting in April. However, both the final adopted funding amount and the distribution methods must be adequate to meet the huge need created by both the wage increase and the growing number of elderly and medically-fragile patients requiring care at home. Home care providers and MLTC plans agree that the state's year-to-date efforts to fund minimum wage costs in the first quarter of 2017 have been uneven, disproportionate, inadequate and, frankly, confusing in regards to the required flow of payments across the continuum of services.

As earlier noted, we also call on the Legislature to reject the Executive's proposed MLTC cuts and adverse actions proposed in the Executive budget. These include the proposed carve-out of patient medical transportation, cuts in the MLTC quality incentive payment, and MLTC eligibility changes that would further compromise MLTC service capability and stability.

HCA also asks that the Legislature reject the budget proposal that precludes MLTCs from marketing. This prohibition creates an un-level playing field for provider-based MLTCs in the market with commercial health plans, whose portfolio of plan services includes MLTCs. By disallowing marketing across the entire field of MLTCs, provider-based plans will be at a disadvantage with commercial plans who can continue to market their other non-MLTC health plans to consumers.

Home Care Regulatory Flexibility for Participation in the State's New Care and Coverage Models, and Strengthened Enforcement of Unlicensed Entities Providing Sanctioned Home Care & Hospice Services

As previously noted, billions of dollars have flowed to other sectors through new models of care, like DSRIP and the Performing Provider Systems (PPSs) functioning under DSRIP. Key to the success of these and other new

integrated models (e.g., advanced primary care, ACOs, value based payment, hospital-physician-home care collaborative) models is available, accessible and well-designed and integrated home care participation.

Home care participation in – and its benefits produced through – these new models can be substantially advanced by a well-matched regulatory structure that would align more specifically to these models. This is particularly so in the case of focused roles and tasks that home care can expertly perform as partners in these models, distinct from home care's more encompassing role in traditional cases where home care is the only or the primary provider. Examples include partnering with physicians in: asthma mitigation through home assessment and recommended remediation; immunization; support in high-risk/high-need maternal and post-partum care; sepsis screening and others. I have attached a background document that provides further explanation and detail.

HCA has submitted Article VII language to create a specific section within Article 36 of the public health law (the governing statute for home care) that would authorize a more flexible and lean regulatory approach, providing a more quickly accessible and efficient structure specifically for home care's participation in the new models.

Meanwhile, DSRIP is witnessing an increase in potential "scoff-law" practices by which non-home-care providers are incentivized to enter the home care field of practice, but through 'unregulated' channels, contrary to state laws and standards.

HCA's members report that hospitals, group practices and others throughout the state are seeking to bypass licensed Article 36 home care providers (as well as Article 40 hospice providers) in an effort to deploy their own nurses or staff to the homes of patients as a way of fulfilling the goals of DSRIP and other system reform projects. These activities escape the strict state and federal laws and regulations that Article 36 home care agencies and hospices must abide as part of their basic state/federal certification and licensure, and participation in the Medicaid program, including patient safety and quality protections specific to in-home providers, such as assessments, documentation, and other requirements.

The Governor's budget proposes a Heath Care Regulation Modernization Team to examine regulations, with an intensive focus on community care. Our concern is that such a venue could exacerbate already problematic jurisdictional crossovers occurring in the field, and we urge the Legislature to guard against this "free-for-all" outcome. HCA wholly supports regulatory relief throughout the continuum, and specifically within home care, as we have proposed in our own language provided to you. But we do not support the construction of a process which could violate the basic integrity of

provider/practitioner licensure and the fundamental organization of the system. We ask the Legislature to ensure strict parameters targeting regulatory flexibility within licensed sectors, and not across sectors; and if such a Modernization Team is authorized, stakeholder representation (including home care), safeguards, and legislative control must be incorporated. Further, specific to home care, such a process must take care to recognize the important provider relationships that exist in Article 36 for meeting very specific competencies and roles, be it: recruitment, training and retention activities; workforce supply and oversight of various disciplines of care care-management; and more.

As noted, HCA has already advanced proposed budget language for home care regulatory flexibility in ways that respect the intentions of agency licensure and jurisdiction on behalf of system integrity. HCA's proposal aims to allow home care to be a nimble participant in new models of service delivery that would optimize community providers in DSRIP models, which was a core goal and intention of DSRIP.

A related HCA proposal seeks to amend Article 28 of the public health law to ensure that DSRIP/PPS implementation optimizes the incorporation of community based network partners, rather than duplication by the PPS leads of services that community providers now already expertly provide. Findings from the state Health Department's Mid-point Assessment of DSRIP, by an independent evaluator, point to the lack of downstream funding by most PPS leads to community based partners and the need for more effective and robust incorporation of community providers and plans for the stability of these providers in the next DSRIP phase. HCA's proposal offers the Legislature with language to address these findings.

Infrastructure Investment Needed for Home Care's Participation in New Models

Home care is currently one of the only sectors without a dedicated working infrastructure fund, at the same time that other entities enjoy long-established working capital pools for clinical and Health Information Technology, and other infrastructure needs.

The Governor's budget includes a renewed commitment of $500 million in infrastructure funding for all health care sectors, but a much greater funding apportionment is needed for community care, as well as a commitment for urgently needed infrastructure investment in home care specifically.

Home care providers have a wealth of clinical condition and encounter data on hundreds of thousands of patients. Better technological integration of home care would have a profound, game-changing impact on the system's operating intelligence and vital patient health information exchange with

partners (i.e., physicians, hospitals, managed care) when it comes to patient care conditions and transitions across the system. This is especially vital in connection with reforms such as DSRIP, Value Based Payments, and other Medicaid Redesign efforts.

HCA is urging the legislature to press for more robust home care infrastructure support in this year's budget, including a stronger commitment of investments in home care specifically. This commitment must go beyond the Governor's proposal of $30 million in Health Facility Transformation funds as a floor for community care – which includes all (very needy) community health settings, not just home care – out of a total $500 million allotment for all sectors.

HCA is specifically calling for a $125 million minimum sub-allocation for community care and home care providers. This is consistent with the state's index goal of a 25% reduction in hospital services, which requires community care to shoulder a more substantial role in driving down costs, thus necessitating a more robust level of infrastructure investment. In addition, HCA asks that the program language in the Governor's proposal must also be made somewhat more flexible to ensure its responsiveness to home and community health system needs.

HCA has also provided separate Article VII language specifically related to home care infrastructure programing (described in the attached documents) and urges the Legislature's support.

Comprehensive Assessment and Action Plan Needed to Address Workforce Shortages, Recruitment and Retention in Home Care

I want to take a moment to commend Assembly Health Committee Chairman Richard Gottfried for sponsoring upcoming hearings on workforce issues in home care. The home care community appreciates this commitment to addressing what our partners in the senior advocacy community are calling a "crisis" in access, driven especially by issues in home care workforce retention, recruitment, and capacity to meet the needs of health reform broadly and the growing reliance on home care for our state's elderly and chronic-care population.

We hope these hearings, and the budget process, will culminate in a comprehensive plan to address home care workforce shortages, which affect access to services, create provider cost burdens, and limit the achievement of system goals to rebalance health care toward cost-effective community settings.

According to our provider survey and accompanying report on financial and program trends in the industry, home care agencies contend with high staff turnover rates, including a 24% turnover rate for aides and a 21% turnover rate for nurses and other professional staff.

Approximately 14% of home health aide positions, 17% of personal care aide positions, 13.51% of registered nurse positions, and 10.6% of therapist positions are unfilled due to shortages. On average, agencies are unable to accept 37.3 cases due to staff shortages, with at least three agencies reporting in our survey that over 100 cases can't be accepted because of shortages.

HCA has proposed legislative language to establish a comprehensive policy and set of initiatives to address these longstanding recruitment, retention and workforce shortage issues, as well as home care capacity needs for communities in New York State. This issue affects various regions of the state differently, including unique supply and geographic service spreads in the upstate region, as well as access and service capacity pressures in the downstate region.

Given the increased reliance on community-based services for vulnerable populations, it is long past time for the state to conduct a comprehensive needs-assessment and action plan regarding the home care workforce, especially with the state's newly imposed minimum wage requirement, which adds new competitive pressures that are likely to exacerbate long-standing concerns for workforce capacity and readiness.

Conclusion

I again thank you for the opportunity to testify before this hearing and urge each of you to engage with the home care providers in your legislative districts who can provide more locally specific details on these issues and pressures in the industry affecting not only the hundreds of thousands of home health beneficiaries in New York State but the workforce who serves them.

I also encourage you to read our attached reports, which provide a further summary of home care industry experiences as well as a concise statement of our state budget recommendations. As always, I am happy to answer any of your questions related to these matters. Thank you.