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Home Care Financial and Program Support Vital for Success of New Care-Delivery Models

State leaders are looking to home care in new and heightened ways to help drive an agenda of health care improvement and cost-effectiveness for New York.

Home care providers are attempting to respond to this charge, looking to the future with vision, expertise, clinical tools, and a long-established functional role in the health care system that makes them uniquely designed and situated to embrace new and emerging models of care delivery.

They see within these new models a reflection and affirmation of their existing core function: to provide an array of skilled, therapeutic, post-acute, preventive, chronic and supportive care; to provide flexible, cost-effective care; to achieve quality outcomes that prevent needless hospitalizations or nursing-home admissions; to orient care decisions towards the individual and his or her family at the location of the individual's choosing; to navigate new, decentralized, and increasingly integrated payment structures; to coordinate care in an otherwise fragmented system; and more.

Over the past three years, the home care community has undergone a rapid and ground-shifting transition to Managed Long Term Care (MLTC) and Mainstream Medicaid Managed Care plans. While that transition is still happening, other major changes are now in motion. Home care providers are now also working to participate in other new models, such as the Delivery System Reform Incentive Payment (DSRIP) program and Fully Integrated Duals Advantage (FIDA) plans, which seek to further integrate services and payment. Both programs – FIDA and DSRIP – are priority components of the state government's vision for health care going forward. Both are fundamentally reliant on the availability, accessibility and ability of home care to play key care delivery and care management roles within their structures.

While home care is integral to these priority models, its participation requires critical supports commensurate with the state's intended roles and, most importantly, New Yorkers' medical needs. The state's methodologies for financing home care and managed care must be adapted to meet the realities of home care's infrastructure needs; and the state's home care-managed care regulatory structure likewise requires adaptation.

Especially concerning, then, are the results of a recent financial and program analysis conducted by the Home Care Association of New York State (HCA) showing home care to be in a severely compromised financial and regulatory state that is fundamentally challenging home care viability, let alone full and functional participation in these emerging care-delivery models sought by state leaders. A summary of the HCA analysis follows.

HCA's Survey and Financial Analysis

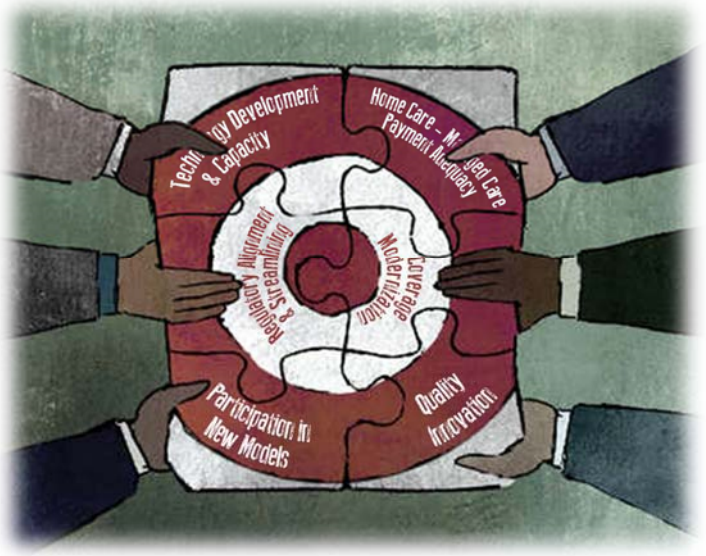
In late 2014, HCA conducted statistical, cost-report and survey-derived analyses of home care providers to assess the financial, programmatic and operational impact of state policies on the home care community and to gauge the home care community's needs and proactive steps in a changing health care landscape.

To gather the most up-to-date statistical data, HCA specifically asked Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs) to report key data elements from their 2013 Medicaid Cost Reports, adding to HCA-compiled data from prior-year 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, HCA asked Licensed Home Care Services Agencies (LHCSAs) to report key elements from their 2012 Statistical Reports. The state Department of Health (DOH) requires LHCSAs to complete these yearly Statistical Reports, which contain demographic information, revenue data from LHCSA contracts with other home care agencies, as well as data on expenses/costs incurred in the provision of home care services.

More than 60 providers responded to HCA's survey, yielding an important set of statistical and descriptive data from a cross-section of providers representing various program types and demographics.

Alongside the survey analysis, HCA also analyzed the 2012 Medicaid Cost Reports submitted by all CHHAs and all LTHHCPs in the state. In addition, HCA examined the key financial elements submitted by managed care plans in their fourth quarter 2013 Medicaid Managed Care Operating Reports (MMCORs).



Some Key Findings at a Glance

- Approximately 70% of CHHAs and LTHHCPs had negative operating margins in 2011 and 2012 based on HCA's Medicaid Cost Report analysis. A similar result (70% of CHHAs/ LTHHCPs having negative margins) was also shown in 2013, based on provider responses to HCA's survey.
- Over 90% of LHCSAs in the survey sample reported negative operating margins in 2012 based on their latest Statistical Report data submitted to DOH.
- 57% of MLTCs had negative premium incomes in 2013, up from 42% in 2012 and 2011 (a 35% difference). MLTC plans are currently the payment source for a vast majority of Medicaid community-based long term care services. In the analysis, HCA found a strong correlation between the compromised financial condition of plans (as shown in their premium income losses) and a reduction in their rates of payment to downstream home care providers who are already coping with the impact of prior-year cuts and mandates like the Wage Parity Law. On average, home care providers who have negotiated MLTC contracts are receiving Medicaid rates 13% below their fee-for-service rates, according to HCA's survey.

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A Worsening Financial Picture in Home Care: Further Details

HCA's survey and cost-report analysis confirms several of the concerning trends that have been identified in prior-year financial reports. The impact of past home care cuts, unfunded mandates, the structure and flow of Medicaid payments under managed care, and other state changes have threatened the financial viability of home care providers and their contracting managed care plans at a time when the health care system relies on vital home care services to support the aims of models like DSRIP, ACOs, Health Homes, FIDA and MLTC.

The data from HCA's analysis clearly show that inadequate premium payments to managed care – coupled with regulatory, payment, billing and other obstacles in the financing and care-authorization structure – all have a compounding effect on cash-flow and the financial viability of home care providers.

More specifically, LTHHCPs continue to face a marked fiscal and viability challenge in this environment resulting from the state's policy to redirect virtually all Medicaid long term care enrollment into managed care plans. The policy change requires LTHHCPs – in order to maintain service to Medicaid patients – to land contracts with health plans and other new models that must recognize the value of LTHHCP's care-management, coordination and service-delivery expertise.

In last year's HCA survey, 12% of home care agencies said they planned to close their doors. In this year's survey, 20% said they plan to do so as a result of recent policy changes, including more than one-third of LTHHCPs pressured to pursue a phase-out of their programs absent supportive actions by the state.

More findings are below.

- In the past several years, home care provider margins have remained consistently in the red, compromising viability. Approximately 70% of home care providers had negative operating margins in 2011 and 2012, according to an analysis of home care cost reports, and over 70% were reporting negative operating margins in 2013 based on our survey respondents.

- 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.

- Financial data confirms that LTHHCPs are experiencing the most severe losses in terms of financial or programmatic viability, despite having served as a linchpin of the state's community based long term care system for decades. Principally, state finance methodologies and lack of transition policy in the move to mandatory managed care enrollment resulted in a 85% of LTHHCPs having negative operating margins in 2012. The median operating margin of LTHHCPs who completed HCA's survey was -12.51 in 2013. Between 2011 and 2012, total operating losses for all LTHHCPs increased from -$47 million to -$75 million – a 60% increase in operating losses over one year. Due to the managed care transition, specifically, 34% of survey respondents have already phased-out or plan to phase out their LTHHCPs, and 62% of all home care survey respondents have already (or will) reduce staff and other expenses to become more efficient.

- As a result of state policies and Medicaid funding reductions in recent years, 21% of LTHHCPs have already closed their program since 2013, with 33% still planning a phase-out.

- A similar financial trend is shown in the CHHA sector where operating margins have only gotten worse in the past year. Over half of all CHHAs had negative operating margins in 2012 and 2013. The median operating margin of CHHAs surveyed in 2013 was approximately -1.3%, worse than the -0.5% median operating margin in the 2012 Cost Reports.

- Home care providers also reported that their revenue (from all payors) remained in Accounts Receivable (AR) for an average of 76 days, with 60 days being the median timeframe for AR, based on all survey respondents. More than 12% of providers indicated that 11% to 20% of their revenue in AR resulted in "bad-debt" or not getting paid.

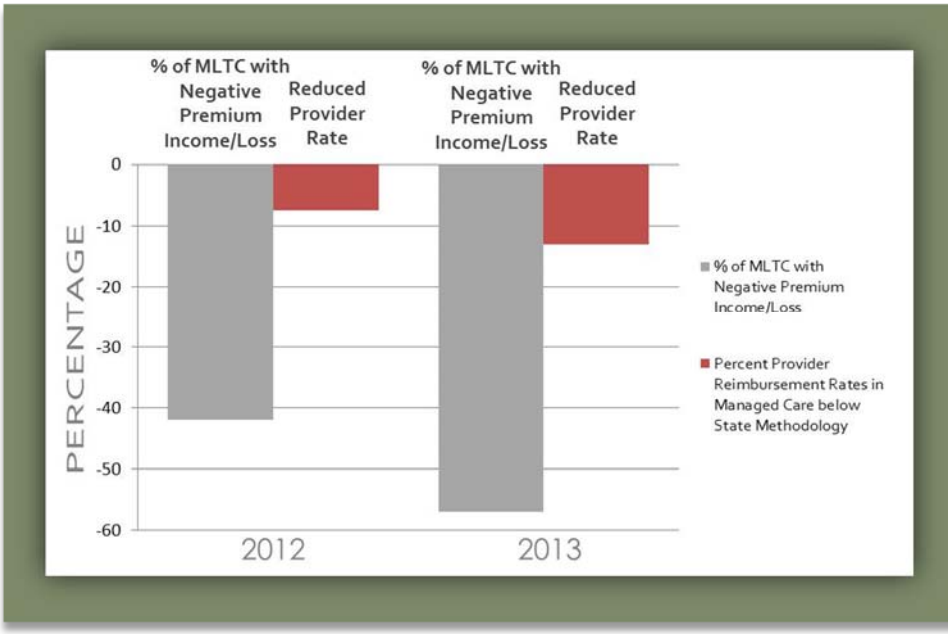
Negative Premium Income for Managed Care Has Downstream Effect on Home Care Provider Financial and Operational Stability

According to MMCOR data, 57% of MLTCs had negative premium incomes in 2013 – up from 42% in 2012 and 2011. As MLTC plans cope with the pressures of negative premium incomes, their downstream providers are seeing costs rise, especially administrative, wage and benefit costs. As a result, a major source of the financial vulnerability occurring system-wide in home care involves inadequate premium levels for managed care and the consequent squeeze this puts on rates to downstream providers who are negotiating from a financially precarious position.

According to HCA survey results, other financial and operational impediments in this working relationship between home care providers and managed care plans include: delays in authorizations and payment; inconsistent billing codes; inadequate rates; and a lack of state policy clarity about regulatory requirements under managed care.

Below are some detailed findings:

- HCA's data analysis finds a correlation between premium income for plans and the negotiated rate that providers receive from plans. As premium incomes get worse, so have the contracted rates to providers. On average, providers with MLTC contracts are receiving Medicaid rates 13% below their fee-for-service (FFS) rates, according to HCA's survey, at a time when 57% of MLTC plans have had negative premium income. Compare that to the prior year: When 42% of MLTCs had negative premium incomes, and the average provider contractual rate was 7.45% below fee-for-service rates.



- Considering that approximately 70% of home care providers were operating in the red in 2012 – at a time when the fee-for-service (FFS) rate was largely still in effect – this 13% variance from the already-inadequate FFS rate suggests that providers will continue to face extreme financial hardship and continued difficulty functioning as they are expected to do under current models.

- Inadequate managed care rates to home care providers ranked among the highest concerns voiced by respondents in HCA's survey. When asked about the overall impact of managed care contracting, more than two-thirds of providers selected "inadequate rates" as having the largest impact, along with "lack of timely authorizations," "lack of timely payment," "inconsistent billing codes," and lack of a clear state policy about regulatory requirements under managed care.

- Approximately 40% of survey respondents reported that their Medicaid Managed Care claims were not paid within the "prompt" pay law timeframe for "clean" claims needing no edits (30 days for electronic claims and 45 days for paper claims), a backlog which leads to significant cash-flow issues and, in some cases, "bad-debt" that contributes to operating losses.

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Wage Parity Law and Other Regulatory Requirements Lead to Staffing Cuts, "Bad-Debt," and Operating Losses

Consistent with last year's findings, wages and benefits costs remain the biggest factor in rising costs for home care providers. Forty-two percent of respondents chose "wage costs" as having the "largest impact," while 35% said "benefits costs" had the "largest impact." Similarly, providers were most concerned about the Affordable Care Act (ACA) health coverage mandates and the elimination of the 'companionship exemption' for home care (now on hold due to court action) – two wage and benefit related mandates that providers ranked highest as having an impact on agencies.

The state's Worker Wage Parity Law continues to impact agency operations and services. Most providers have responded to these increased Worker Wage Parity costs by seeking a higher contractor rate, where possible; however, in an environment of inadequate managed care premium rates and mounting fee-for-service losses, providers have had to increasingly resort to staffing cuts and other measures to remain compliant with the law.

In our survey, HCA asked providers to indicate the current impact of wage parity as well as the expected 2015 impact of wage parity. For every impact of wage parity – whether it was staffing cuts, administrative cuts or changes in caseload – providers indicated that they would have to resort to even stronger remediation measures in 2015 versus 2014.

In addition to growing labor costs, other mandates like physician order issues are having a major impact on providers. As one respondent noted: "The 90-day Medicaid M.D. order requirement is too burdensome and, in some instances, not achievable. It drives high Medicaid bad-debt rates."

Below are some further findings about the impact of wage parity and other regulatory requirements.

- In 2014, 35% of providers (survey respondents) have reduced the hours of direct-care staff, due to wage parity, while 50% expect to do so in 2015.
- In 2014, 39% of providers have stopped accepting cases where the contractor rate was inadequate to meet wage parity expenses, while 62% expect to do so in 2015.
- Forty-eight percent of providers affected by wage parity have reduced staff overtime – an option (overtime hours) that agencies, workers and patients will likely find increasingly less available as the federal government looks to implement changes in the calculation of overtime under the Fair Labor Standards Act.
- The lack of receiving timely physician orders has adversely affected agency finances in terms of administrative expenses, delayed billing and unrecovered expenses. According to HCA's survey, almost 40% of respondents said that timely physician orders had a 'large' financial impact (defined as affecting between 6% and 10% of their Medicaid revenue).

Home Care Providers are Adjusting to New Models but Need Substantive Support to Participate Effectively

Home care agencies are working to retool their operations and adjust to the changes in the health care delivery system.

According to our survey, more than three-quarters of respondents have been recognized as safety-net providers for DSRIP and over half are participating as network providers in a DSRIP Performing Provider System (PPS).

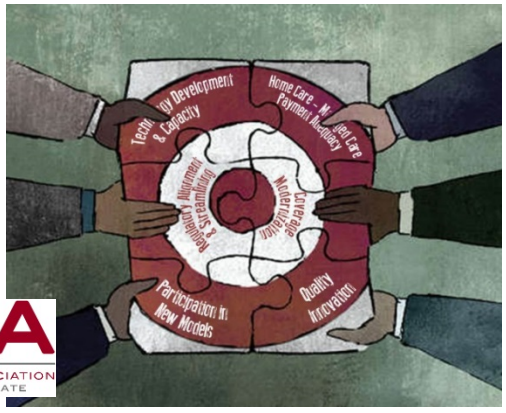
However, the role of home care in the DSRIP structure remains inadequately supported for home care providers – even as the DSRIP model, and home care's charged role, represents a central, multi-billion-dollar component of the state's plan to integrate New York's health care system.

For instance, 82% of home care providers already involved in a PPS under DSRIP have not yet been able to determine, fundamentally, how they would be paid under such a system. Moreover, to date, little to no support has been targeted to home care for its health information technology capacity and interoperability – both vital to functionality under DSRIP, FIDA, managed care or any integrated system.

New and emerging models of care also have not adequately supported care-management tools and functions in home care that could be of benefit to the new system. This includes home telehealth, which is an important and cost-effective disease-management technology that allows for remote monitoring of patients, prompting interventions that reduce the rate of hospital admissions.

In the current fiscal, regulatory and program environment, home care agencies indicate they need: greater state clarity on the role and regulatory responsibilities for agencies; regulatory relief; and capital and technology funding support.

- Only 27 percent of survey respondents answered that they have contracted with MLTCs/MCOs for telehealth services. Many providers have separately reported erosion of over 50 percent of their Medicaid home telehealth enrollment coinciding with the state's redirection of patients to managed care. The home telehealth program, created in 2007 by the State Legislature and Governor, has been a national leader. Telehealth viability under the state's policy changes is an area that requires major attention. MLTCs report that their current premium structure has not included costs for telehealth, and thus many do not yet regard it as a truly "covered" service. Telehealth "seems to fluctuate too much between authorized one time and then not authorized another time," writes one survey respondent about the inconsistency in home telehealth coverage, echoing the concerns of several respondents in HCA's survey.
- Home care providers have been, in large part, bypassed in state and federal efforts to promote Health Information Technology. Having systems that are interoperable with hospitals, Health Homes, ACOs, DSRIP partners and others is a vital but unrealized goal. Providers reported the need for IT funding to align with health policy directives such as: "becoming interoperable with local providers"; "interoperability to advance initiatives such as bundling and DSRIP"; "community portals to hospitals, managed care plans and patients"; "expand and upgrade the use and availability of mobile devices for all field staff."



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Conclusion

To maintain viability, to meet home care's burgeoning role in meeting patients' health care needs across the continuum, and to participate in the changing health care system as sought by government leaders, home care providers need support measures that: ensure adequate and effective managed care-provider payment structures; better align and streamline the regulations governing home care and managed care; promote innovations in Health Information Technology; and other infrastructure investment. Home care is uniquely designed and suited to help drive state and federal policy goals of better care for individuals, better care for health populations and cost effective service utilization. However, targeted relief and support measures are first needed to address chronic and emerging financial, operational and regulatory issues that compromise its abilities and the state's goals.

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