



January 2013

A Report on the Fiscal Health of Home Care in New York State

Provider survey and analysis of the most up-to-date cost-report data show that plunging negative margins, coupled with a lack of transition support, jeopardize provider efforts to participate in new long term care environment



A Report on the Fiscal Health of Home Care in New York State



Key Findings

- **Home care provider margins plunge further into the red, threatening viability.** The percentage of home care providers with negative operating margins increased by an alarming 22% between 2010 and 2011, the most recent year of data available. In 2011, 79% of surveyed home care providers had negative operating margins.
- **CHHA operating margins drive deeper into the red.** The median operating margin of surveyed Certified Home Health Agencies (CHHAs) was -13.94% in 2011, a precipitous drop from 2010 when the median operating margin was -0.31% for survey respondents.
- **LTHHCPs face a unique threat to their financial and programmatic viability.** The median operating margin of surveyed Long Term Home Health Care Programs (LTHHCPs) was -11.47% in 2011. Between 2009 and 2010, total operating losses for all LTHHCPs increased from -\$21.2 million to -\$38 million, a 79% increase in operating losses.
- **Wide variances in contract rates and a lack of transition support are further jeopardizing provider sustainability even as home care agencies work to meet the state's mandatory managed care enrollment policy.** HCA's survey finds that the vast majority of home care providers are working in good-faith to establish contract partnerships with Managed Long Term Care (MLTC) plans and Managed Care Organizations (MCOs). **Yet in 2011, when the Medicaid fee-for-service (FFS) rate has historically proven inadequate, two-thirds of survey respondents indicated they are receiving MLTC and MCO rates well below the already insufficient FFS rates.** For those providers who receive rates below FFS, their MLTC rates are on average 8% below FFS and their MCO rates are on average 20% below FFS, further compromising the fiscal stability of home care providers, 79% of whom are already operating in the red under FFS. These results speak to the need for adequate payments to providers as well as adequate premium payments to plans for the provision of home care services. Meanwhile, when asked which supports are needed to contract with MLTCs/MCOs, "stronger continuity-of-service/transition policies" ranked second only to concerns about adequate payment.

Why These Findings Matter

Home care providers deliver cost-effective services to patients at home in the community, helping to keep individuals out of institutions and other higher-cost settings. However, in an increasingly worsening pattern, rates of reimbursement have not kept pace with the already economical cost of delivering these services to patients at home, threatening access to home care services and potentially causing hospitalization or higher-cost services for vulnerable patients whose health status may spiral downward without the needed in-home support.

Meanwhile, the state is embarking on a policy of mandatory enrollment in MCOs and MLTCs for the financing and authorization of home care services. To ensure success, this policy depends on a strong network of home care providers to deliver home care services. Continued erosion of the home care provider financial base seriously jeopardizes the success of this policy.

Executive Summary

A financial data and survey analysis conducted by the Home Care Association of New York State (HCA) using the most recent data available from independently certified and state-required cost reports finds that home care financial margins have plunged alarmingly into the red due to chronic reimbursement cuts and state policy changes that have eroded the financial base of home care providers in an environment where costs continue to increase.

These findings were most dramatic in 2011 when an already consistent trend of declining home care operating margins plunged sharply into negative territory. 2011 was also a year of unprecedented state budget cuts for home care combined with continuing new cost burdens – especially for wages and benefits – that are likewise tied to state budget policies.

Continued on next page



Executive Summary - continued

To put this in perspective, while the percentage of home care providers with negative operating margins grew from **63% to 65%** between 2009 and 2010 (a 3% increase), this percentage rocketed to **79%** in 2011 (a 22% increase), according to conservative estimates culled from an analysis of providers completing HCA's *2012-13 Financial Condition Survey* late last year and early this year.

In the case of surveyed CHHAs, median operating margins dropped from +0.3% in 2009 to -0.31% in 2010 and then dove to -13.94% in 2011.

In the case of surveyed LTHHCPs, median operating margins had a similar negative trend line: -6.3% in 2009, -7.21% in 2010 and -11.47% in 2011 at a time when long term care policy changes have just begun to squeeze the referral base of LTHHCPs and will continue to do so as long term care policy changes take hold.

Meanwhile, variances in negotiated contract rates and a lack of transition support continue to jeopardize the standing of providers in their efforts to meet state-initiated changes in the long term care system – changes that home care providers are striving to

meet in good faith. These findings make clear the need for more adequate FFS payments to providers as well as premium payments to plans for the provision of home care services.

At present, New York's home care system is operating under three payment models during this time of transition. The first and primary of these is a FFS system that has been in place for decades, although subject to budget cuts slashing reimbursement to levels which have not kept pace with the cost of providing care, as is evident from prior-year financial studies in home care and in the findings of this report.

More recently, the state has embarked on two additional payment models: an episodic payment system for CHHA cases up to 120 days in duration; and enrollment of certain patient populations in managed care and managed long term care for the provision of services, with the ultimate goal of near-universal mandatory enrollment. Given that HCA's 2009, 2010 and 2011 cost report analyses largely reflect a FFS world, HCA focused much of our provider survey on the current experiences of providers as they begin feeling the effect of the

movement toward mandatory enrollment, which is expected to be the dominant payment model for the long term care system in the future.

At a time when the vast majority of home care providers were already operating at a loss under FFS rates that were largely still in place from 2009 to 2011, HCA's survey finds that the negotiated rates between home care programs and MLTCs/MCOs were substantially lower than this already inadequate FFS payment in the vast majority of cases. Two-thirds of survey respondents indicated they are receiving MLTC and MCO rates below their FFS rates. For rates that are below the FFS rate – a rate of payment which is already contributing to negative margins for 79% of providers – MLTC rates are on average 8% below FFS, and MCO rates are on average 20% below FFS, further compromising the fiscal stability of home care providers.

What follows below are further details on the data-collection process and survey methods used in this study as well as further elaboration of these key findings.

Background on HCA's Data and Survey Analysis Methods

In late 2012, HCA conducted a survey of our home care provider members to assess the financial impact of prior-year reimbursement cuts and to find out what actions providers are taking as a consequence of these cuts and other Medicaid redesign initiatives that are dramatically changing the delivery of home care services in New York State.

HCA had also previously obtained from the state Department of Health (via a Freedom of Information Act request), the 2009 and 2010 cost report data for all CHHAs and LTHHCPs in the state, comprising a statewide universe of financial data in home care for these years.

Continued on next page

Background - continued

In home care, all CHHA and LTHHCP providers are required to submit cost reports annually to the state as a financial basis for the state's Medicaid rate-setting process. These cost reports provide official, independently certified financial and statistical data related to all categories of an organization's revenues and expenses (not just for Medicaid, but for all payors). Given this array of reliable data, these documents are a fundamental instrument for gauging an organization's financial health, especially in the context of discussions about Medicaid policy.

To obtain more recent data – which is not yet publicly available from the Department of Health – HCA used our 2012-13 financial condition survey of providers to specifically ask CHHA and LTHHCP member agencies to submit an array of 2011 financial data based on their just-submitted 2011 Medicaid Cost Reports.

HCA's collection of 2009 and 2010 cost report data for all 250 CHHAs and LTHHCPs, coupled with the survey respondent data in 2011, offered HCA the most up-to-date set of data practicable for assessing the financial health of New York's home care industry. (Since the state uses two-year-old cost reports as a base for setting provider reimbursement rates, the 2011 cost report data – which providers submitted to the state during the summer of 2012 – are the most current data available.)

Licensed Home Care Services Agencies (LHCSAs) also participated in HCA's survey. These agencies provide vital training, recruitment, employment, oversight and direction predominately of paraprofessional caregivers who meet the needs of thousands of elderly, chronically ill and disabled patients in the home under contract with LTHHCPs, CHHAs, MLTC and MCO plans and local social service districts. Only LHCSAs that have personal care contracts submit cost reports. Therefore, LHCSA cost report data was not included in HCA's financial analysis. However, HCA did capture other important financial data and survey responses for LHCSAs based on separate measures further detailed later in this study.

Because the Medicaid Cost Report includes various revenue and expenditure data, HCA was able to use these reports as a basis for calculating aggregate provider operating margins (calculated as the difference between revenue and expenses) and median operating margins. The operating margin is a benchmark indicator of an agency's financial health.

Of the nearly 80 home care providers that answered HCA's survey, 45 CHHAs and LTHHCPs submitted detailed information from their 2011 cost reports. This 2011 data was then compared to: 1) the 2009 and 2010 cost report data HCA had obtained for all 250 CHHAs and LTHHCPs statewide as well as 2) the 2009 and 2010 cost report data for those providers answering HCA's survey.

In employing this method, HCA found that the 2011 cost report data from surveyed providers was not only consistent with the financial trends globally in home care, but the 2011 survey data actually provided a *conservative* reflection of the margins for all home care providers in 2011 since the providers answering HCA's survey tended to have more positive operating margins than the industry as a whole.

In addition to compiling cost report data, HCA also used our 2012 - 2013 survey to ask providers about other financial, operational, programmatic and strategic experiences occurring in the field as a consequence of prior-year reimbursement cuts and policy changes.

These questions focused on a few key policy and fiscal areas, including: the state's ongoing transition of Medicaid cases to MLTC and MCO plans; unfunded mandates and new administrative costs such as the Home Care Worker Wage Parity Law; and the impact of nearly \$1 billion in Medicaid cuts during the past two years as part of the state's Medicaid Redesign Team (MRT) and state budget process.

Background on MLTC Enrollment Transition

In order to appreciate the information found in our survey analysis, one needs to understand the policy framework driving these outcomes.

The 2011-12 State Budget began a process of requiring that dually-eligible patients 21 and older needing more than 120 days of Medicaid community based long term care services must enroll in an MLTC plan. This process, also known as “mandatory enrollment,” has already gone into effect for specific populations in New York City, and it has or is about to go into effect for Long Island and Westchester. The policy is expected to be systematically implemented statewide under a fluid timetable that depends on the state Department of Health’s determination of MLTC services in a county, federal waiver authorizations, and other determinations, eventually redirecting thousands upon thousands of patients and the providers that serve them.

For home care providers, this policy means that many agencies (including those with long-established care-management experience and

well-established roots in the community) will increasingly expect to operate in a subcontracting role, providing services to this patient population under contract with MLTCs or MCOs rather than directly functioning as the care managers for these patients and the Medicaid program.

As the state’s own policy objectives make clear, home care providers are instrumental to the success of this endeavor because they form the core infrastructure and expertise needed to deliver and care manage the services to patients under contract with MLTCs and MCOs. Their capacity to serve patients – and, thus, their financial viability – is paramount.

Mindful of these trends, several of HCA’s survey questions attempted to gauge the current and future financial impact of mandatory MLTC/MCO enrollment on vital front-line home care providers who are only now starting to feel the effect of this policy change – a change that will become even more profound as New York State progresses to statewide “mandatory enrollment” implementation.

Thus, in an environment where prior-year cost reports show that the vast majority of home care providers are *already* operating in the red when directly billing under Medicaid FFS – due to reimbursement rates reduced below provider costs, as otherwise found in our report – some of HCA’s survey questions attempted to determine how providers’ negotiated contract rates with MLTCs/MCOs compared with the rates that providers have been receiving under Medicaid FFS.

This comparison – married with cost report data otherwise obtained in HCA’s analysis – provides a sense of: 1) home care provider financial experiences under Medicaid FFS and 2) how this experience may be further challenged under market conditions where negotiated rates fall even further below the FFS rates that have already proven inadequate in meeting provider costs.

Starting on the next page is a summary of four key findings from HCA’s cost report and survey analysis overall.



Finding 1: Home Care Provider Margins Plunge Further into the Red, Threatening Viability

Home care providers are experiencing continued erosion in their operating margins due to a combination of reimbursement cuts and increased costs – a condition which is only expected to intensify with the continuation of these trends alongside the continuing, broad state Medicaid cuts and the application of the global Medicaid cap cuts, and the state’s sweeping process of transitioning home care cases into mandatory MLTC/MCO enrollment.

An organization’s operating margin is calculated based on the difference between revenue and expenses. HCA’s membership survey found that the two highest-ranked impacts on provider Medicaid revenue are: 1) the “Effect of Payment Changes/Reimbursement Cuts” and 2) the “Transition to Managed Care.” On the expenditure side, the biggest cost increases were for wages, benefits and unfunded mandates.

Wrote one survey respondent: “Salaries, benefits, contractual and other expenses are increasing. Federal and state mandates have been exponentially added. Reimbursement has constantly eroded over the past few years. Counties are leaving home health. Other providers will too. New York State will be left with large, multi-area entities who drive the services provided, likely without the same local interactions, quality and outcomes.”

These and other findings are detailed below.

Operating Margins

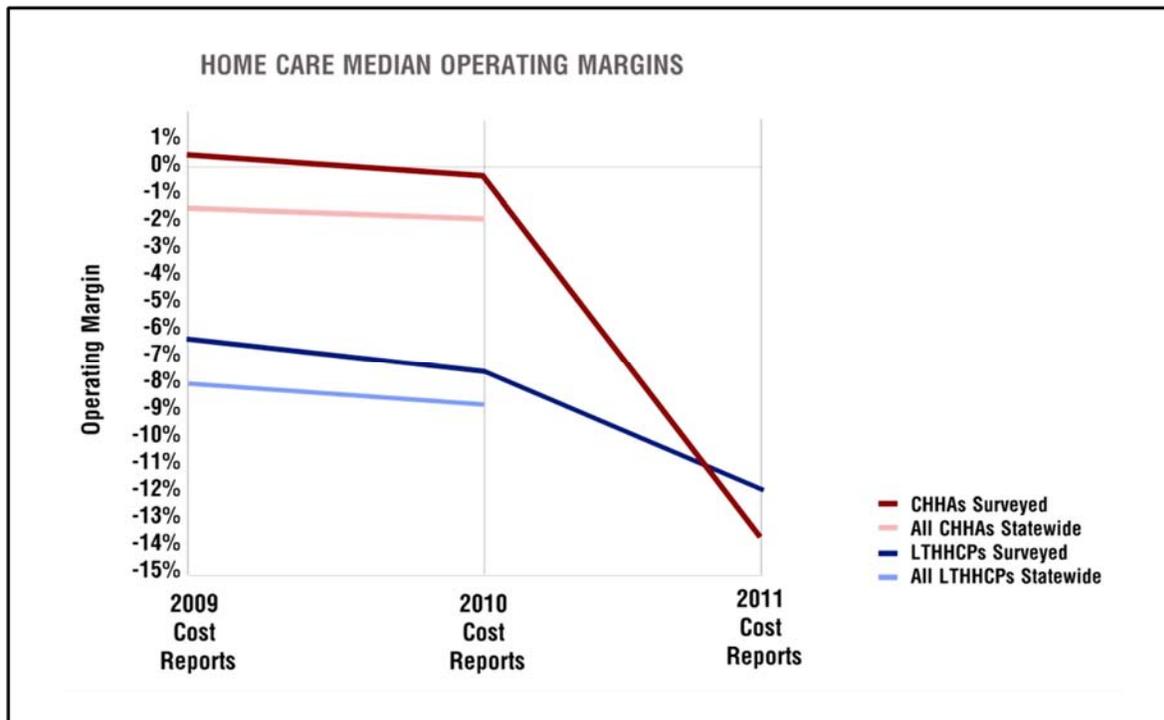
- HCA examined the 2009 and 2010 cost reports submitted by 45 providers that reported their 2011 data in our survey.

The findings for these reported 2011 data are consistent with the trends globally in home care. For these survey respondents, the median operating margins dropped dramatically in 2011. In the case of CHHAs, the margins dipped from +0.3% in 2009 to -0.31% in 2010 to -13.94% in 2011. For LTHHCPs, the margins dropped from -6.3% in 2009 to -7.21% in 2010 to -11.47% in 2011.

The table below and chart on page 6 illustrate these findings by comparing the median operating margins of surveyed CHHAs and LTHHCPs with the median operating margins from statewide cost report data.

Home Care Median Operating Margins

Provider	2009 Cost Report	2010 Cost Report	2011 Cost Report
All CHHAs statewide	-1.71%	-1.81%	
All LTHHCPs statewide	-8.1%	-8.771%	
CHHAs that completed HCA survey	+0.3%	-0.31%	-13.94%
LTHHCPs that completed HCA Survey	-6.3%	-7.21%	-11.47%
% of providers with negative operating margins	63%	65%	79%



- While 63% of CHHAs and LTHHCPS had negative operating margins in 2009 and 65% had negative operating margins in 2010, 79% of survey respondents had negative operating margins in 2011 – a sharp increase during a year of unprecedented budget cuts and policy changes.
- The number of all CHHAs and LTHHCPS experiencing operating losses greater than \$500,000 increased 18% from 2009 to 2010.

Revenue and Cost Impacts

- According to HCA’s survey results, the top three factors having the “largest impact” on an agency’s rising costs were: wages (66% of providers ranked it as “largest impact”); benefits (52%) and unfunded mandates (40%).
- Eighty-five percent of providers reported an increase in administrative costs due to state and federal audits alone.
- In response to the Wage Parity Law, in particular, 57% of providers have laid-off non-direct-care staff, 50% have stopped accepting cases where the contractor rate is inadequate to meet the costs of the unfunded mandate, 36% have reduced hours and overtime of direct-care staff and 7% of providers have laid off direct-care staff.
- Over the past two years, almost half of respondents had to use a line of credit or borrow money to meet expenses.



Finding 2: CHHA Operating Margins Driven Deeper into the Red

Cuts enacted in the 2011-12 State Budget have taken an enormous toll on CHHA operating margins at the same time that state policies ostensibly, and ironically, view CHHAs as critical components of the state's mandatory enrollment policy, as demonstrated in the state's recent request for applications (RFA) to open up the CHHA licensure process.

- The median operating margin of CHHAs was -13.94% in 2011. For the CHHAs that completed HCA's financial condition survey, the drop in median operating margins went from 0.3% to -0.31% in 2009 and 2010, consistent with historic trends, but then dropped precipitously to -13.94% in 2011 at a time when CHHAs were hit with unprecedented cuts, including the CHHA-specific expenditure cap.

Finding 3: LTHHCPs Face a Unique Threat to their Financial and Programmatic Viability

At the time of this writing, the state is seeking a 1915(c) waiver amendment to discontinue LTHHCP enrollment in areas where the "mandatory enrollment" policy is going into effect. LTHHCPs already report a substantial drop in referrals due to this policy which is further eroding their financial stability.

LTHHCPs have a long history of care management expertise of enormous value to partners in an evolving long term care system; these already efficient programs serve nursing-home-eligible patients at an average of 50% the cost of nursing home care. However, LTHHCP providers are facing what may be insurmountable hurdles to viability in this context of both inadequate payments and the mandatory enrollment paradigm.

While the policy trends initiated in 2011 are already affecting the LTHHCP, the Department of Health's latest plan to eliminate enrollment of the program's core patient population without securing the program's role and providing for effective transition support will have an exponentially greater impact in the immediate future if the Department's LTHHCP waiver/policy intentions become a reality.

HCA's findings are detailed below.

- Between 2009 and 2010, total operating losses for all LTHHCPs increased from -\$21.2 million to -\$38 million, a 79% increase in operating losses during this period.
- The percentage of LTHHCPs reporting negative operating margins was 74% in 2009, 75% in 2010 and 77% in 2011.
- When providers were asked what changes they have made or expect will occur in order to prepare for subcontracting, 41% of respondents said they will phase-out or alter the use of their LTHHCP.

Finding 4: Wide Variances in Contract Rates and a Lack of Transition Support are Jeopardizing Providers in their Efforts to Meet the State's Mandatory Managed Care Enrollment Policy

Home Care providers are striving to participate in the state's plan for mandatory managed care enrollment. When asked several different ways about actions they have already taken or are planning as a result of past payment cuts or Medicaid redesign initiatives, the vast majority of providers answering HCA's survey said they had finalized or were pursuing MLTC/MCO contracting, but this process – for providers and plans alike – has been hobbled by a lack of transition guidance, lack of necessary regulatory changes, and already inadequate Medicaid payment rates from which contract negotiations are based.

Continued on next page

Finding 4 - continued

Despite providers' good-faith efforts to support the state's mandatory enrollment policy, our survey reveals that contracted rates of payment under managed care are most often significantly lower than the FFS rate, which is already so inadequate that 79% of providers were operating in the red in 2011. Meanwhile, more than half of respondents have, or expect to, "reduce[d] staff and other expenses to become more efficient" as a means of participating in a mandatory enrollment contract arrangement.

Beyond the need for consistent rates of payment, providers seek additional transition supports to make contracting work for their organizations. Wrote one respondent to HCA's survey: "LTHHCPs need clear operating guidelines and possible changes in regulation to be able to compete in this new care environment."

These and other findings are detailed below.

- Providers are working to pursue contracts with MLTCs/MCOs. When asked "Have you, or are you planning to, contract with an MLTC/MCO to provide home care services?" almost 90% of providers answered "Yes".
- Yet, a state policy of chronic Medicaid under-payment and unclear transition guidelines nevertheless puts home care providers at risk even in cases where they are able to contract for services. Two-thirds of survey respondents indicated they are receiving MLTC and MCO rates below a FFS rate that is already inadequate; in many cases, the variance in contracted rates is substantial and inconsistent. For those rates below FFS Medicaid – under which nearly 80% of providers are operating in the red in 2011 – the MLTC rate is on average 8% below FFS Medicaid and the MCO rate is on average 20% below FFS Medicaid, with one respondent experiencing a rate difference as high as 50% below FFS.
- Overall, the transition to mandatory enrollment has affected agency finances at a time when the vast majority of providers were already operating at a loss: While most providers ranked "payment cuts/reimbursement changes" as the number 1 reason for a recent decrease in Medicaid revenues, "transition to managed care" ranked as the number 2 reason affecting most providers' Medicaid revenues.
- When asked which transition supports are needed to make it possible for providers to contract with an MLTC/MCO, the need for payment adequacy was rated highest by respondents, followed by "stronger continuity-of-service/transition policies" and then "staff retraining funds or support."



Conclusion

HCA's 2012-2013 cost report and survey analysis provide the most current information to date on the financial standing of New York's home care industry. While previous studies have shown a trend of under-reimbursement resulting in a consistent decline in home care provider operating margins, the data for 2011 reveals the starkest decline yet in the overall financial health of home care agencies at a time when the state has enacted unprecedented cuts and changes to the delivery of home care services.

Even while home care providers are clearly striving to work as partners in the state's effort to redesign the long term care system, past funding cuts, new and increasingly onerous mandates, an overall lack of transition and funding support or clear operating guidelines in the state's move to mandatory enrollment, and other factors have all worked in a counter-productive way to greatly hinder the efforts of home care providers in navigating this new system of care management on behalf of patients in the community.

HCA urges state policymakers to work with the home care community on a comprehensive set of transition supports, regulatory reforms, operating guidelines and funding assistance to ensure the sustainability of New York's vital home care infrastructure, which has been cultivated over time to: effectively manage long term care, help patients avoid higher-cost care, support care transitions, assist family caregivers and maintain the patient's quality of life.



HOME CARE ASSOCIATION
OF NEW YORK STATE

388 Broadway
Fourth Floor
Albany, New York 12207
Phone: (518) 426-8764