



NYS Home Care Program and Financial Trends 2017



A report on the financial and program condition of New York's home and community-based providers and managed care plans amid state reform policies and mandates

Background on Data and Analysis Methods

The Home Care Association of New York State (HCA) recently conducted an analysis of Medicaid Cost Reports, Statistical Reports and Medicaid Managed Care Operating Reports for all home care agencies and managed care plans in the state. These reports – independently verified by accounting professionals – provide the most comprehensive data available on the financial picture for home and community-based services in 2014 and 2015. These reports also form the basis for routine state Medicaid reimbursement calculations.

While these reports provide a vast range of data, HCA has also gathered important supplemental information on provider, health plan and worker status through a December 2016/January 2017 survey. **This just-completed survey netted responses from 70 home care entities** of various sizes and service regions across New York State, adding important new data and information for 2015 and 2016 that is not otherwise available in the cost, statistical and operating reports that HCA has obtained from the state.

The purpose of this analysis – reviewing both the public reports and the survey responses – is to inform the Legislature and Administration about some of the program and financial trends occurring in home care and managed care as officials deliberate over the state budget.

HCA has conducted a similar analysis in past years; however, this year's study adds a range of new issues to the profile, from the experience of providers operating in new state-developed models of care to the recent, multiyear implementation of minimum wage increases, beginning December 31, 2016. These increases have an estimated \$2.19 billion impact on home care alone in the multiyear rollout.



Summary of Data Reports and Survey Findings

Consistent with our findings from past years, the state's Managed Long Term Care (MLTC) plans – which manage, authorize and pay for long term care services provided by home care agency contractors – and the home care providers operating substantially in MLTC networks are together shouldering unsustainable negative operating margins.

Though the MLTC and home care connection in Medicaid is a major point of state underfunding, aggregate operating losses are presented across all sources of payment for home care providers. On average, Medicare, all forms of Medicaid, commercial insurance, and other payor sources are reimbursing below margins for home care services (though Medicaid and Medicare account for at least 90% of all home care reimbursement in New York State). These underpayments are unsustainable without compromising patient access, services, workforce and the crucial infrastructure that delivers and manages the care.

Our analysis finds that state 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 results in 2015.

CHHAs and LTHHCPs are Medicare-certified home care provider agencies authorized to receive Medicaid and Medicare coverage for services, though both entity types are reimbursed for most of their services through contracts with MLTCs and other managed care entities. These entities receive their payments from the state, and, in turn, remit payments to network providers for services. Another provider type, Licensed Home Care Service Agencies (LHCSAs), traditionally provides home health aide and personal care aide services, as well as aide training, recruitment and oversight, under contract with Medicare-certified agencies and, increasingly so, under contract with MLTCs and other managed care plans. They, too, face enormous financial stresses, particularly for increasing wage and overtime costs, as well as accumulating state mandates ignored in the state's payment methods. Many LHCSAs each report budgeting millions of dollars for these new cost obligations underfunded by state Medicaid, as explored later in this report.

These system-wide operating losses in managed care and home care are due in large part to inadequate state Medicaid methodologies and rates below the requisite, baseline costs of care delivery; and many of the serious financial findings from our study (in 2015 and 2016) predate the recent increased minimum wage implementation, which suggests that a deeper financial impact is yet to be reported.

Meanwhile, as the state has pumped billions of dollars into efforts like the Delivery System Reform Incentive Payment (DSRIP) program for service projects and reforms, home care providers indicate in our survey that: they are not meaningfully included in the DSRIP decision-making process; they question the return on investment for the cost of strategic planning and implementation of DSRIP projects in home care; and, in many cases, they have yet to receive *any* payments for projects flowing through entities that the state has designated to manage the fund-flows and project designs for achieving DSRIP goals. Those goals include reducing avoidable hospital use by 25% over 5 years. Home care providers have long operated under metrics for reduced hospitalization admission and readmission rates. Thus, they inherently have a vital role to play in the reform effort, to which DSRIP should be better synched.

The state is also fast moving to shift its multibillion-dollar Medicaid payment infrastructure to operate through new models, like New York's Value Based Payment project. Value Based Payments involve performance and/or risk-bearing arrangements for services, covering all or subsets of services, conditions and populations, from primary, to acute, to long term care. Home care enters this new frontier of reimbursement shouldering major underpayments, as earlier described. They also have no state-invested working capital funds to help integrate their functions, operations and data. **Fewer than 7% of home care providers responding in our survey reported engagement in Value Based Payments thus far from payors or network partners.** Movement from current payment models to Value Based Payments will have major impacts. State support is crucial for providers and managed care plans in this transition.

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Home care workforce shortages, recruitment and retention are another area of urgent concern shown in our analysis. The state has, in the past, filtered rate add-ons in various places of its payment methods targeted to staff recruitment and wage payment. However, the payments – whether through managed care plans to providers, or directly from the state – are not in line with real infrastructure needs, nor is the state's response capturing (and enabling support of) the nonwage factors uniquely at play in home care.

According to HCA's survey, **a 24% turnover rate is reported for home care aides and a 21% turnover rate for nurses and other professional staff.** As the population ages, and the care delivery reforms continue to depend on home care to keep patients in the community longer, the state must move the home care workforce and capacity infrastructure into the forefront of planning efforts.

Below is a more detailed description of our analysis, with corresponding background to contextualize the data.

Inadequate State Medicaid Reimbursements to MLTCs and Home Care Produce System-wide Red Ink



New York's home care system is primarily partnered with managed care. This means that MLTC plans and other Medicaid Managed Care insurance payors receive "per-member-per-month" (PMPM) lump payments from the state to authorize and pay for services to enrollees. Managed care plans, in turn, contract with home care providers to provide and work with the plan to manage services.

Approximately **70%** of a home care provider's Medicaid revenue in New York State comes from Medicaid Managed Care (MLTCs and mainstream managed care) contracts, while **30%** comes directly from the state. This latter portion is primarily reimbursed through a reimbursement structure called the Episodic Payment System, discussed later in this report.

The state is required by law to produce actuarially sound rates that are sufficient for managed care plans to pay for quality care by their network providers. But our analysis finds that MLTC plans are operating with substantial losses, due to inadequate payment from the state, and these losses squeeze the contracted amounts available for home care providers in the plans' networks. This condition results in accumulating losses producing negative operating margins for plans and providers alike. It further produces service-authorization delays, cash-flow issues, and increasing debt loads across the spectrum of service entities.

According to our analysis:

- **61% of all MLTC plans had negative premium incomes in 2015**, up from 42% in 2012 (a 46% increase since 2012). A negative premium income means that the state's payment to the plan is less than the plan's costs.
- Approximately **43% of all MLTCs had medical expense ratios over 90%**, which indicates that PMPM revenues from the state are not sufficient to meet overall plan medical expenses.
- **72% of CHHAs and LTHHCPs had negative operating margins in 2014, with similar results for 2015.** For 2015, the average operating margin for CHHAs and LTHHCPs was -4.42%.
- **Thirty-one percent of all home care agencies (CHHAs, LTHHCPs and 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.

Inadequate State Medicaid Reimbursement Leads to Service and Payment Delays for Home Care

If a managed care plan is not adequately paid to cover the costs of contractor services, the plan faces major operational pressures that flow downstream to home care providers in the form of billing and care-authorization delays for enrollees, as plans and providers manage a dwindling revenue flow.

This effect on CHHA, LTHHCP and LHCSA providers means that:

- On average, **only two-thirds (62%) of Medicaid Managed Care or MLTC claims are paid to home care providers within the prompt-pay timeframe**, our survey finds. Furthermore, home care providers report that their Medicaid Managed Care revenue was in accounts-receivable for an average of 85.6 days, and approximately 4% of Medicaid Managed Care revenue to home care resulted in bad-debt (meaning providers are not getting paid for 4% of their claims).
- Home care survey respondents indicate that nearly **20% of their managed care cases are affected by a lack of timely authorizations or reauthorizations**. More than 37% of agencies report that it takes up to 7 days to receive service authorizations or reauthorizations in cases where the authorizations and reauthorizations are late; an equal number of agencies report that it takes up to two weeks; and 21% said it takes up to four weeks. These delays lead agencies to commit valuable resources for obtaining such authorizations/reauthorizations.
- Approximately **77% of home care contracts with managed care plans do not cover the home care agency's costs**, with an average 18% difference between the amount providers are paid and their expenses in such cases.

Wage and Labor Costs Have the Biggest Impact on Providers

Wage and overtime costs have created enormous stresses across the system. This includes changes to the federal Fair Labor Standards Act (FLSA), in October 2015, which requires home health aide overtime to be paid at time-and-a-half of the aide's actual wage, as opposed to time-and-a-half of the minimum wage. On December 31, 2016, the state began requiring new minimum wage levels for regions of the state in a process that is expected to cost \$2.19 billion for home care across the multiyear phase-in.

The state has included Medicaid payment adjustments for these new costs. However, for both the new overtime and minimum wage changes, the amounts have been insufficient. Also, especially in the case of minimum wage, the state's payment adjustments have been directed to MLTC plans as a required pass-through to their network providers who employ – and directly pay – the workforce. Yet the state's guidelines for directing

the flow of payments have been vague and, in cases, contradictory, leading to a vast array of interpretations for how much a provider is ultimately paid. Meanwhile, providers face wage-related cost increases for their Medicare cases that have not been addressed by the state or federal government.

- Over 60% of survey respondents indicated that wage and overtime costs, along with the cost of worker benefits, has had a "large" or "largest impact" on their overall costs increasing.
- The minimum wage mandate has inundated providers with new costs. Larger LHCSA and CHHA programs report that **they have budgeted cost increases as high as \$1.5 million to \$11.9 million for the cost of minimum wage** just for the December 31, 2016 to December 31, 2017 period, with smaller and mid-size agencies budgeting between \$10,000 and \$450,000.

Rebasing Cuts Further Erode CHHA Operating Margins

As previously noted, 72% of CHHAs had negative operating margins in 2014 and 2015. One factor is the implementation of rebasing cuts under the CHHA Episodic Payment System (EPS).

While 70% of Medicaid home care payments are processed through managed care, the remaining 30% are still paid by the state through EPS. This payment system provides a base rate to providers, which is adjusted for acuity, regional wage differences and other factors. With this rate, providers deliver as much care as is needed for a patient during 60-day incremental periods (called episodes). In 2015, the state implemented a process called rebasing, which is essentially a series of adjustments intended to update the EPS rates for CHHAs to a “newer” (but not “cost-reflective”) base year. However, for most providers, the rebasing process was simply another payment cut, contributing further to the operational losses experience by CHHAs, as reported in our survey:

- The average percentage cut attributable to CHHA Medicaid EPS rebasing is a **19.6% reduction between 2015 and 2016**, according to survey respondents.
- Nearly **half of CHHAs** actually reported that they experienced **a rebasing cut of more than 30%** during this period.

Workforce Turnover and Shortages Jeopardize Home Care Capacity for Patient Care

HCA has proposed legislative language to address the long-standing recruitment, retention and workforce shortage issues in New York State, which affect various regions of the state differently. This includes unique supply and geographic service spreads in the upstate region, and distinct competitive pressures in the downstate region.

In some instances, providers report that workforce shortages limit their ability to accept new cases or fully fill service hours, jeopardizing access to care. According to our survey:

- Home care agencies must contend with high staff turnover rates, with 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.

Home Care Providers Report High Costs, Low ROI, and Little Meaningful PPS Understanding of Their Role in DSRIP

New York State has initiated multibillion-dollar payment changes creating entirely new models of care, such as DSRIP and Value Based Payments. The intent of these changes is laudable; but the practical design and mechanics are obstacle-ridden for most of the community based system, including home care.

To date, the project management teams and hospital leads in DSRIP have received over 70% of the promised federal funds across all of DSRIP's Performing Providers Systems (PPSs). These PPSs are orchestrating DSRIP network projects and facilitating the payments to downstream providers, like home care, for fulfilling health reform goals.

Home care providers are eager and have the expertise to participate in these and other new models but they report barriers to their participation in integrated systems, which include: funding issues; a perceived shortage of opportunities for LHCSAs in DSRIP; and a general lack of recognition and knowledge on the part of DSRIP networks to understand how home care can participate in reaching DSRIP goals.

(continued)



According to HCA's Provider Survey:

The state's own independent assessor for DSRIP (Public Consulting Group) compiled a midpoint DSRIP assessment. It recommends that over two-thirds of the PPSs should implement midpoint assessment action plans related to financial stability/sustainability and application of Value Based Payments for its provider network; generally, the IA found that many PPSs have not focused on detailed arrangements for sustainability. It also found that:

- PPSs need to work to **educate their partners** on their role with Value Based Payments in New York Medicaid.
- Most PPSs need to **focus their attention and funding to engage key partners**; a majority of the PPSs are behind on their Partner Engagement goals at this point in DSRIP.
- The PPSs **must execute their plans for contracts with their downstream partners** to ensure that they maximize engagement across the networks as soon as possible.
- To date, while the project management offices and hospitals have received over 70% of DSRIP funds across all PPSs, the **PPSs will need to fund their network partners at a meaningful level going forward**.
- **Thirty-eight percent of home care agencies have not yet received any funds from DSRIP PPSs**, despite many months of strategic planning work, DSRIP committee discussions, and preparation for project implementation. Meanwhile, **only 6.9% of home care agencies have yet entered into contracts for Value Based Payment**, which is fast becoming the overarching state Medicaid financing paradigm. Sixty-five percent have not entered into Value Based Payment contracts and 28% indicate that agreements are in progress or they are exploring their Value Based Payment options for the future. Those contracts which have been initiated are still just at Level 0 or Level 1.
- Of those providers who have received money from their PPSs, the amounts have varied between \$1,500 and \$138,000, for anything from meeting participation and attendance, to workforce recruitment, to specific project metric measures, as well as other training and implementation cost reimbursements. This varies substantially across PPS networks and regions, and speaks to the disjointed nature of the DSRIP program implementation. Agencies in multiple PPSs are dealing with these inconsistencies in status, expectation, reimbursement, and timelines. This exacerbates the already large administrative burden of DSRIP participation with little certainty of return on investment (ROI).
- Agencies report significant staff time and activity costs related to DSRIP planning, with some agencies reporting costs as high as \$200,000. Costs of functional DSRIP implementation activities average \$127,829.
- While nearly half of respondents expect money through Year 3 of the DSRIP implementation schedule, **these funds are not expected to cover costs for 43% of respondents**. Furthermore, over 35% of responding agencies are still unsure about whether they will receive future DSRIP payments, let alone whether those amounts would cover costs of expended time and resources.
- **Only around 28% of respondents feel that DSRIP's PPS leads understand home care's role** and have actively taken that into consideration/involved them in the design of payment systems and the flow of funds to downstream providers. Forty-eight percent feel somewhat involved and **24% do not feel involved at all**.
- According to home care providers, the majority of their current or future Value Based Payment participation centers on their work to manage chronic obstructive pulmonary disease, congestive heart failure, and post-acute joint replacement care. Additional areas of widespread interest are to manage diabetes, asthma, and coronary artery disease. Home care providers have long succeeded in addressing these core areas of public health through therapies, medical interventions, and assessments that make them singularly effective entities for reducing the rate of hospitalizations.

Conclusion

State Medicaid policies have in many ways exhibited laudable and impressive goals. Home care providers strongly support reforms promoting the triple aim of "better care, better quality and lower costs." They are eager to collaborate with government and all health sectors to ensure success for New York's citizens.

However, in the progression toward reform, many important and fundamental facets are being overlooked, to the serious detriment of system and reform goals. The Legislature and Governor can, and must, address these issues and needs in the 2017-18 State Budget.

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