

2018-19 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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**Joanne Cunningham
President,
Home Care Association
of New York State (HCA)**



Introductory Remarks

My name is Joanne Cunningham, President of the Home Care Association of New York State (HCA). Thank you for the opportunity to testify today.

HCA's members are state- and federally-licensed home care provider, hospice and Managed Long Term Care (MLTC) entities that meet rigorous requirements for coordinating and delivering medical, social, therapy and aide services to patients in their homes.

These services are matched to meet the patient's individual needs and the physician's plan of care, whether it's chronic-care management, assistance with activities of daily living, medication management, wound care, post-acute therapies, maternal-newborn care, nutrition, infection control, public-health-oriented interventions, palliative and end-of-life care, or a range of additional services.

Annually, 400,000 patients receive home care services in New York State. All of these services aim to support the entire health care system and the state's overarching health care cost-containment goals by: preventing hospitalizations; providing an alternative to nursing homes; improving the health and safety of frail-elderly citizens; fostering a patient's adherence to his or her physician's plan of care; and more.

Home care nurses, aides and therapists are specially trained by home care provider clinician managers under an established set of state and federal oversight rules, as well as patient assessment and credentialing requirements, to conduct care at home in a way that peer-level clinicians in other settings are not similarly equipped to do.

I mention all of these important factors because New York's legislature has deliberately structured a system of licensure and certification of home care providers under Article 36 of the Public Health Law in order to protect the health, safety and welfare of individuals receiving care in the home setting. Often serving a frail and elderly population, licensed and certified home care providers are required to abide by rigorous, but important standards, for the benefit of the patients they serve. However, finance and policy decisions relevant to the current budget discussion, as well initiatives related to healthcare delivery system transformation, have the potential to significantly harm and disrupt an experienced system of quality home care providers that is vital New York's health care continuum.

Accompanying my testimony are two documents which provide a succinct guide for HCA's requests and concerns stated here today, as well as some additional recommendations on behalf of HCA's home care, hospice and MLTC membership that are not fully described in my testimony.

The first document, our *2018 Budget and Legislative Asks*, is a one-page statement of HCA's platform for budget and legislative action in six areas.

The second, lengthier document is HCA's 2018 report on the finance and program trends within the home care, hospice and MLTC programs. All of these program types are represented by HCA, whose members comprise the entire continuum of community based long term care services.

This latter report is based on a statistical analysis of state-required financial documents, a survey of HCA's membership, and other data sets. It provides aggregate data on financial margins, accounts-receivable balances, direct-care staffing vacancies and turnover rates, and other important findings within New York's home care, hospice and MLTC sectors that substantiate and inform our budget and legislative platform. I encourage you and your staff to review our findings in the event that you have questions about the current structure of home care, hospice and MLTC, or about the trends driving our proposals.

Of primary concern in this Executive Budget are the proposed cuts and program changes impacting MLTCs and home care. These proposals, and others outlined in our *2018 Budget and Legislative Asks*, would negatively affect MLTCs and the patients they serve and impose upon the decision-making capacities of plans and providers to coordinate necessary services and supports.

As you know, the financial standing of MLTCs and their network providers are inextricably linked. This is shown in our finance report, which finds that **70%** of Certified Home Health Agencies (i.e., home care providers) and **62%** of MLTCs (the managed care plans who predominately administer Medicaid home care services and make payments to providers for such services on behalf of the state) are **operating in the red or at a negative premium income, respectively, according to the latest reported data**. The proposed cuts in the Executive budget would not only harm access to care and care continuity for patients whose eligibility would change, but they would further exacerbate the already precarious financial condition of these entities to serve and manage all of the patients enrolled in these programs.

Reject Cuts to MLTCs and Home Care

The Executive Budget proposes: to cut funding for MLTC and provider operations; a carve-out of transportation and long term nursing home services from MLTC; a ban on provider marketing related to MLTCs; the imposition of new penalties and reporting mandates; and limits on patient eligibility for MLTC coverage. This latter piece, in particular, offers no clear indication as to where those currently-eligible patients would be serviced and have their needs met to prevent their conditions from becoming worse. These proposals threaten to destabilize the system, especially at a time of increasing operational and administrative mandates.

Ironically, the state's mantra for many years was "care management for all." In the case of home care, this has meant the almost wholesale migration away from fee-for-service home care and the movement of patients into MLTCs. Now, this year, the Executive proposes to exclude certain patients from MLTC enrollment, limiting MLTC coverage only to those who are among the sickest (based on a much higher clinical score) upon enrollment, which runs counter to actuarial principles and to the orientation of state policies over the past several years. Meanwhile, a proposal to limit nursing home services under MLTC will have further unpredictable risk

outcomes for MLTCs and network home care providers. Certain populations requiring the highest level of long term care, in nursing homes, would need to disenroll, leaving within MLTC other higher-cost, clinically complex patients who meet a nursing-home-level of care yet are still eligible to receive care in the community (based on a high assessment score), while still-other lower-risk patients may be transitioned to some indeterminate home care setting. All of these factors would converge without any operational or fiscal adjustments to account for the change in risk balance or the overall impact on the continuum of long term care services.

Alarmingly, the Executive's proposed eligibility changes appear guided by a goal of reaching a state-savings target with no clear service placement plan for those patients who do not meet these new proposed requirements and who would ostensibly face disenrollment from MLTC-directed home care. Without services, these patients would fall through the gap and/or place further strain on the system.

The Executive also proposes an arbitrary limit of ten on the number of Licensed Home Care Services (LHCSA) providers that an MLTC may contract with to provide services. There is no clinical or financial rationale for this proposal whatsoever. Yet, in similar fashion to the other MLTC proposals, the Executive "scores" this eligibility change as meeting a savings target, all the while limiting a patient's choice of provider and the MLTC's ability to make a care delivery determination in the best interest of the individual patient. This proposal may cause certain LHCSA to close their doors if they cannot compete for a limited number of contracts, dislocating staff and patients from the trusted caregivers.

Not only does this proposal have questionable savings rationale, but it greatly underappreciates the important differentiation and individuation that exists in home care. Currently, a LHCSA may specialize in care to specific patient populations, such as aides and nurse managers who speak fluently in a patient's native, non-English language. In other circumstances, patients come to trust the individual employed by a particular provider for cultural or other social reasons that are determining factors in the experience and outcomes of care.

HCA urges the Legislature to reject these arbitrary limits on MLTC contracting, enrollment, and cuts to MLTC operations (including the transportation carve-out, marketing ban, administration cuts, new fines and reporting requirements), which offer no clear alternative to patients who would be denied or disenrolled from MLTC coverage, and which run counter to actuarial principles, long-established state care-management goals, provider and plan fiscal stability, and patient choice.

Appropriate, Timely and Sound Payment to Providers and Plans

HCA appreciates the Executive's inclusion of direct-care funds for the state's minimum wage mandate, given that the rising wage floor is a statutory requirement and, therefore, must be funded in the state's obligation to meet human service providers' costs under the auspices of the Medicaid program.

As shown in our reports, labor mandates are among the biggest source of financial pressure on MLTCs and home care and hospice providers. But the problem is not merely about dollar amounts; it's also about the distribution of funds.

For many recent labor mandates, providers and plans have had to contend with an uneven, untimely, inconsistent and opaque set of state policy dictates for the distribution of funds necessary to comply with compensation laws across the home and community-based system.

Virtually all of these state payment add-ons have occurred retroactively with oblique instructions as to how – or whether – plans are expected to distribute the funds to providers.

Meanwhile, not all costs are covered by these piecemeal funding add-ons. MLTCs and providers alike need a more sensible and predictable system.

HCA advocates for a transparent, streamlined and timely process initiated by the Department of Health that will meet the premium and rate adequacy needs for providers and plans. We look forward to this process to include meaningful input from plans, providers and labor representatives, as well as legislative review.

Workforce Support, Recruitment and Retention

HCA understands that the workforce issues in home care, hospice and MLTC extend well beyond wage and labor mandates.

HCA urges a multi-part strategy for addressing workforce shortages and recruitment and retention issues in home care, hospice and MLTC by leveraging existing sources of funds and existing laws for staff and operational efficiencies and waivers, as well as establishing pilot projects to address transportation, child care and other pressing needs of the paraprofessional and professional workforce.

The Executive's rural home health care proposal is a step in the right direction, but it should be enabled to operate more flexibly as an essential access fund in both rural and other high-need areas, with an increase in the proposed allocation from \$3 million to \$30 million to support statewide need.

We also request the state to conduct a competitive market study that would provide a rigorous, statistical basis for understanding the financing, regulatory and programmatic actions necessary to support the MLTC, home care and hospice workforce.

Infrastructure

On home care and hospice infrastructure, the Executive Budget proposal moves in the right direction by reauthorizing the Statewide Health Care Facility Transformation Program (SHCFTP) for another round of grants, including dedicated monies for community care infrastructure support.

The state has provided billions of dollars to (mainly) hospital-led Performing Provider Systems (PPSs) under the Delivery System Reform Incentive Payment (DSRIP) program. On a much smaller level, the SHCFTP similarly provides funds for transformation activities across all sectors, yet it is virtually the only pool offering any degree of dedicated access for home care, hospice and community-based providers.

Given the longstanding disparities in home care's access to transformation funds, and the reliance on home care to achieve goals like a 25% reduction in unnecessary hospital use under DSRIP, it is only reasonable that the state's investment for home care match the share of home care's expected contribution toward such cost-savings.

HCA supports the proposed \$425 million in Phase III funding of SHCFTP but we ask that the Legislature ensure that at least one-quarter of funds (\$106.25 million) are for home care, hospice and other community health care providers, while providing additional flexibility to ensure that funds can address the most urgent system priorities.

Maintain New York Licensure Standards for Home Care – and Act Against Scofflaws

In my opening remarks, I referred to a few of the many licensure, oversight, and quality standards applicable to home care. These important standards of care in the home are in danger of being cast aside, as providers that don't meet these standards are seeking to provide care in the home, citing the need to expand their own footprint.

Article 36 licensure of home care was developed to ensure the highest standards and quality for care provided in the home setting. Home care clinicians under Article 36 are specially trained to evaluate, identify and respond to all environmental and social determinants of health in the home that do not otherwise exist in brick-and-mortar settings. Nurses, as an example, even when coming from another care modality such as a hospital, require a usual six-to-nine month training program by a home care agency in order to be successfully deployed in the home care field.

Home care clinicians are trained and oriented to provide specialized wound care, therapies and other clinical modalities that are fundamentally different in the home care setting. Home care clinicians require different training in infection control, patient safety, and other areas that are entirely different from similar training in other settings. Patients cared for at home require unique protocols, practices and care-planning to monitor the prognosis and potential exacerbation of symptoms in between home visits (as opposed to a hospital setting where nursing and medical resources operate on an entirely different shift schedule) and to educate the patient and family members on a more long-term treatment plan.

Our financial and program report on the home care industry and other sources find that many home care providers have witnessed first-hand occasions where non-home care entities are seeking to provide services in the home without Article 36 licensure. These scofflaws need to be stopped.

HCA has identified a few areas in the proposed budget that require modification to protect the standards of care for services delivered in the home, including Executive Budget proposals concerning the delivery of home telehealth services and community paramedicine. Still other proposals are likely to emerge in the budget and legislative process, as they have been introduced repeatedly, and with increasing frequency, over the past several legislative sessions.

HCA urges the Legislature to duly reject any proposed change to the home care licensure/certification system that diminishes the standards of quality and training for providers seeking to deliver care in the home.

HCA would like to specifically recognize Senate Health Committee Chairman Kemp Hannon and Assembly Health Committee Chairman Richard Gottfried for working with HCA on a multi-sector collaborative proposal, signed into public health law section 2805-x and implemented in December, which ensures the involvement of Article 36 entities in a streamlined fashion for the coordination of home care services when such needs are identified and requested by other, non-home care sectors.

The state Department of Health's letter implementing this statute definitively asserts: "If the project involves services in the home, [it] must include a home care services agency" [emphasis in original document].

HCA urges the Legislature to use this statute as a vehicle for any proposals that might involve non-Article 36 facilitation of home care.

Home Care's Expertise to Yield Further Savings

HCA understands the fiscal pressures facing the state. Rather than constrain the existing structure of home care and managed long term care, or make eligibility cuts, there are many opportunity areas for home care providers and plans to generate cost savings.

HCA was recently awarded a New York State Health Foundation grant to train home care clinicians on the use of our first-in-the-nation sepsis screening tool and algorithm for the home care setting. Sepsis is the number one driver of hospital readmissions in New York State, and it is among the required interventions for Level 1 Value Based Payment contracts in New York State. So far, HCA has reached hundreds of provider representatives in the training and use of this life-saving and cost-saving tool.

This is just one clinical category among many where home care is uniquely equipped to intervene.

Similar home-care-directed efforts hold promise in addressing top public health issues promoted elsewhere in the Executive Budget, such as opioid management and abuse/addiction prevention, as well as asthma mitigation and mental health.

HCA is eager to work with the Legislature on discrete programmatic initiatives to achieve cost savings, public-health goals, and life-saving interventions in each of these vital areas uniquely compatible with home care.

Thank you for your attention to these critical issues and recommendations. I am happy to answer any questions or meet with you or your staff individually with further information on our proposals and requests.



HOME CARE ASSOCIATION OF NEW YORK STATE 2018 BUDGET AND LEGISLATIVE ASKS

New Yorkers are increasingly dependent upon the home and community-based care system for their health and care – whether they are new mothers and infants postpartum; individuals recovering or rehabilitating after major surgeries or traumas; elderly, chronically ill and disabled individuals striving to stay in their homes and out of institutions; or individuals referred to home care by their physician to receive preventive and primary care at home.

Managed Long Term Care Plans, Home Care Providers and Hospices throughout the state are financially stretched beyond capacity, and are in urgent need of stability and support to fulfill their major role in the health care system. To address this, HCA asks:

1 Reject Budget Cuts to MLTCs and Home Care

- Reject limits on MLTC provider networks to 10 licensed home care services agencies, which: denies consumers and patients access to care and the choice of caregiver and provider; ignores the reality that home care services are delivered locally; micromanages MLTCs' ability to make care delivery determinations and undermines their operations; and dislocates staff.
- Reject sweeping cuts to MLTC administration/operations, cuts to MLTC reserve funding, elimination of MLTC patient transportation, a ban on provider marketing, and sweeping new penalties, fines and reporting mandates.
- Reject limiting patient enrollment to only those that are the sickest. This creates gaps for those patients no longer qualifying for MLTC and who are no longer eligible for the services of network home care providers. It also increases the financial pressure on MLTCs.

2 Support Budget Proposals to Reimburse Minimum Wage & Health Care Infrastructure

- Fund the Direct-Care Worker Minimum Wage Mandate and its cost increase to home care, hospice and MLTC. We support the Executive's proposed \$450 million allocation for minimum wage but separately request a more transparent, even and structurally sound approach to the dissemination of funds (as detailed later).
- Support the proposed \$425 million in Phase III funding of the "Health Facility Transformation Program," but ensure that at least one-quarter of funds (\$106.25 million) are for home care, hospice and other community health care providers, and provide additional flexibility to ensure funds can address the most urgent system priorities.
- Modify the Executive's rural home health care proposal, enabling it to operate more flexibly as an essential access fund in both rural and other high-need areas and increasing the proposed allocation from \$3 million to \$30 million to support statewide need.

3 Develop Appropriate, Actuarially Sound and Timely Payment for MLTCs and Providers

MLTCs, home care and hospice providers are constantly besieged by the lack of timely, transparent, and adequate premium/rate adjustments to meet mandated costs imposed by the law or regulations, such as minimum wage increases, worker overtime and wage parity requirements, new "conditions of participation" which increase the requirements for care, and enrollment of new or special populations, including pediatrics.

- HCA advocates for a transparent, streamlined and timely rate process initiated by the Department of Health and its finance contractor that will meet the premium and rate adequacy needs of plans and providers.

HCA's BUDGET AND LEGISLATIVE ASKS

4 Address Workforce Needs in Home Care and Hospice

- Increase the HCRA rate add-on for recruitment, training and retention of direct-care workers, targeting the adjustment to specific shortage areas and disciplines, including pilot testing of vital needs (e.g., transportation, education, child daycare, career ladder opportunities, peer support, etc.) for home care/hospice aides.
- Advocate for the implementation of Chapter 444 of 2011 which provides for staff and operational flexibility and innovation for home care providers through waivers.
- Amend the HCRA Health Workforce Retraining Program to include retraining and/or cross-training of the institutional workforce for work in home care and hospice.
- Tap Area Health Education Centers for assistance with home care/hospice worker recruitment in shortage areas.
- Conduct a “Competitive Market Study” through the Departments of Labor and Health to study the rates and actions necessary to support MLTC, home care and hospice workforce recruitment and retention.
- Establish a state interagency workforce coordinating effort (Labor, Health, Education, Aging, Mental Health, etc.) on home care and hospice workforce development and marketing to encourage interest in these important health care professions.

5 Maintain NY Licensure Standards for Home Care – and Act Against Scofflaws

New York State has been dedicated to the highest standards, laws and regulations for home care quality in the nation. A health care provider wishing to provide in-home health care for New Yorkers must be licensed to do so – and adhere to comprehensive standards, quality protections and more. System changes have created a major incentive for entities of all types to attempt to provide in-home care outside of this licensure, regulatory and standards process.

- Reject any proposed compromise to the home care licensure/certification system.
- Modify the telehealth proposal to ensure that services currently limited to home care providers by law are not circumvented by non-home care providers using telehealth. Also, any telehealth extension in the home must be coordinated with the patient’s primary care physician and home care or hospice provider.
- Modify the community paramedicine proposal to anchor it to the existing collaborative statute as accomplished in S.5588 (passed in 2017) and A.2733-A.
- Direct the Office of the Medicaid Inspector General (OMIG) to investigate scofflaw practices by non-home care/non-article 36 entities, with Medicaid fund recoupments returned to the state for investment in home care.

6 Utilize Home Care's Expertise to Yield Savings in Community and Public Health

Tap home care’s unique capacity and expertise to help address major and costly public health priorities, including: sepsis prevention and treatment, medical support for community mental health, asthma management, opioid management and abuse/addiction prevention, elimination of health disparities, pressure injuries prevention and management, and others.



388 Broadway
Fourth Floor
Albany, New York 12207

QUESTIONS

Contact HCA at info@hcany.org
and (518) 426-8764.



2018

HOME CARE, HOSPICE AND MANAGED LONG TERM CARE FINANCIAL AND PROGRAM TRENDS

Learn more about Home Care by visiting
www.hca-nys.org

Updated Statistics: February 12, 2018

Background

Hundreds of thousands of individuals and their families rely on the home care system for patients to stay safe, medically stable, and healthy at home in the absence – or in the necessary avoidance – of other, higher-cost care. New York State’s home care system is a critically important and vital part of the health care continuum that offers patients and consumers the ability to receive needed care in their homes, rather than in a facility-based setting.

Hospitals, nursing homes, physicians and health plans all rely on New York’s high-quality home care system to deliver post-acute care, long term care, personal care, primary care and rehabilitation care. The home care provider is very much a mobile unit, operating in a home setting which stays with the patient from start of care to discharge, allowing the home care team to be nimble, to coalesce uniquely around the needs of each patient, and to do so cost-effectively. As such, home care has long been vital to the functioning of the entire health care system, and it is peerless in its compatibility to achieving every state policy and fiscal goal.

Over the years, the growing reliance and increased access to home care services have enabled patients to leave the hospital earlier, avoid nursing home placement entirely, and receive rehabilitation and primary care in the lowest cost and most preferable setting possible – the home of the patient.

While New York’s robust home care system offers high-quality, cost-effective, expert care in the home, chronic underpayment and unfunded mandates have resulted in a fragile financial position for the home and community provider sector.

Given home care’s vital role, HCA has undertaken a rigorous examination of the home and community-based system’s current financial profile, its experiences with new models of care, and other trends that demand attention and support in the state budget and legislative arenas.



Executive Summary

New York home care, hospice and Managed Long Term Care plans are inadequately reimbursed for their significant role in the health care system. This inadequacy takes its toll on the financial margins of these entities. Nearly 80% of Certified Home Health Agencies (CHHAs) are expected to report negative operating margins in 2016, or costs that exceed revenues.

Similar trends exist across the entire continuum of community based-services in New York State – a system that is funded substantially by government payors, including the state's Medicaid program, which covers 87% of home care and personal care services in New York.

According to HCA's members, the major reasons for home care agency cost pressures are: 1) wages and overtime; 2) benefits; and 3) the costs associated with recruitment and turnover. For virtually all of these areas, the state's reimbursement methods to fund Medicaid home care have not kept pace with: an increasing minimum wage and state wage parity laws; federal Fair Labor Standards Act (FLSA) overtime cost changes; increasing health care and benefits costs; regulatory compliance costs; and administrative costs directed toward managing double-digit turnover rates and vacancies across most direct-care staffing roles.

Meanwhile, support for home care infrastructure has been scant, or confined merely to purposes of facilitating consolidation within the industry, and not to supporting the safety-net or investing in vital technologies where such investments hold promise to help agencies better meet patient needs – and where the contraction of home care service capacity would run counter to delivery system goals.

The Statewide Health Care Facility Transformation Program ("SHCFTP") is virtually the only pool of state infrastructure funds available directly to home care providers at the same time that the state has more broadly invested billions of dollars into remaking the health care system, largely through funds flowing into the institutional sector. As a result, it is vital that the state ensures distribution of the next phase (Phase 2) of SHCFTP funding to home care providers, significantly increasing the amount of funding that will be dedicated to the home care industry in future phases of SHCFTP (e.g., Phase 3), and ensuring home care is included as a key partner in other grant opportunities.

Summary continued on page 3

Financial/Program Analysis and Methodology

In late 2017 to early 2018, HCA conducted a comprehensive review of the financial status of home care, hospice and Managed Long Term Care (MLTC) plans in New York State. HCA also gathered survey responses to gauge other trends affecting these providers and plans – from their experiences with staff recruitment and retention issues to their participation in new models of care.

HCA specifically reviewed the latest available collection of state-mandated Medicaid Cost reports, Statistical Reports and Medicaid Managed Care Operating Reports (MMCORs) for all home care, hospice and MLTC plans functioning in New York State.

To supplement this data set, much of which is derived from 2015 (the most recent year of reports that DOH authorized for release), HCA also surveyed our home care membership to learn about their more recent financial experiences and to gather other statistical data not otherwise available in the state-mandated reports. These responses include data from 2016 Cost Reports and Statistical Reports, which providers just recently filed with the state Department of Health.

HCA has conducted similar surveys in the past, yet this year's effort drew our biggest response to date, comprising providers, large and small, from every geographic region of the state.

To give a broad idea of the typical agency, our survey respondents had an average full-time equivalent (FTE) of approximately 160 (for CHHAs) and an average unduplicated patient count of 2,897 (for Licensed Home Care Services Agencies, LHCSAs). These agencies comprised hundreds of millions of dollars in Medicaid transactions and tens of thousands of cases out of the approximately 400,000 home care cases known to be annually served in New York State.

Summary – *continued*

Meanwhile, home care providers are contributing to the goals of value-based payments, the Delivery System Reform Incentive Payment (DSRIP) program and other state-sponsored care models. Providers are launching innovative programs aimed at achieving state and federal outcomes goals to drive “value over volume,” reduce rates of hospitalization, and improve the care experiences of at-risk populations in practical, cost-saving ways. In order for home care providers to continue to support these statewide efforts, it is imperative to provide adequate access to statewide funding to preserve the long-term sustainability of this critical component of New York’s health care continuum.

MLTC, Home Care, Hospice Financial Profiles

MLTC Financial Profile

MLTC plans play a dominant role in the management of home care services and in the payment to home care providers for their services. MLTCs receive what is called a per-member-per-month (PMPM) premium from the state to manage and arrange for the long-term care services of many citizens enrolled in Medicaid. The MLTC plans contract with home care providers, including CHHAs and LHCSAs, who deliver the services.

For the vast majority of home care services, state Medicaid funds flow through MLTCs and other managed care plans, and this structure applies whenever the state must change rates to meet new minimum wage requirements or other payment add-ons: nearly all funds flow through the managed care plans first, who then apply negotiated rates or rate amendments to reimburse providers that directly employ, oversee and pay the worker. Thus, the financial experiences of plans and providers are inextricably linked.

- Approximately 62% of all MLTC plans had negative premium incomes in 2016, up from 42% in 2012 (a 39% increase since 2012). A negative premium income means that the state’s payment to the plan is less than the plan’s costs and adversely affects its capacity to reimburse services delivered by downstream home care and other providers.
- Approximately 52% of all MLTCs had medical expense ratios over 90% in 2016 compared to 42% of MLTCs in 2015. This indicates that PMPM revenues from the state are not sufficient to meet overall plan medical expenses to pay CHHAs, LHCSAs and other network providers adequately.

CHHA Financial Profile

CHHAs are Medicare-certified providers authorized to provide Medicaid and Medicare coverage for services. Approximately 60% of all CHHA Medicaid revenue is derived from MLTC and other Medicaid Managed Care plans. These plans manage and contract for home care and other services on behalf of – and as an intermediary to – the state Medicaid program.

- HCA's survey found that 78% of CHHAs reported negative margins for 2016, up from 70% of all CHHAs that had negative operating margins in 2015.
- In 2016, according to our survey, the average CHHA operating margin was minus-13.46%. In 2015, the average CHHA operating margin was minus-7.30% statewide.
- The total statewide operating loss for all CHHAs in 2015 was minus-\$110 million.

Financial Findings for All CHHAs and LHCSAs: Debt and Accounts Receivable

HCA's survey asked specific financial questions applicable to all home care providers. As in past years, we find that the squeeze on MLTC margins and other state Medicaid payor sources has resulted in underpayments across the system and in hefty accounts receivable balances.

- 40% of all home health agencies in 2016-2017 had to use a line of credit or borrow money to pay for operating expenses.
- Home care revenues (from all payors) remain in Accounts Receivable for an average number of 69 days. Accounts Receivable represent the money owed to an entity from outside sources.

Hospice Financial Profile

HCA represents approximately one-third of the state's hospice organizations, who deliver skilled, compassionate care to patients and their families so that they receive the support, help and guidance they need to meet the challenges of serious illness.

Hospice embraces all patients coping with advanced illnesses and the care is most often provided in the patient's home, but, when necessary, it can also be provided in a nursing home and inpatient setting.

Unfortunately, New York's Medicaid hospice benefit is significantly underutilized.

- 82% of hospices in the state had negative operating margins when compared with their net patient revenue; and 52% of hospices had negative operating margins when total revenue was utilized.
- For 2015 to 2016, the average operating margin for all hospices statewide was negative-16.57% (calculated using net patient revenue).
- In 2015, the total statewide operating losses for all hospices was minus-\$79 million (calculated using net patient revenue).
- Hospices only receive 4.3% of their total revenue from Medicaid, while Medicare revenue represents 86.7% and other insurer revenue represents 9%.



Labor, Staffing, Recruitment and Retention Issues in Home Care

Home care agencies experience high staff turnover and shortages, as revealed in last year's version of this report and examined by the state Assembly and other officials during workforce hearings over the past year. High turnover and shortages are functionally disruptive, and they jeopardize access to services. With the recruitment of new staff, home care agencies also end up bearing extra costs for retraining, orientation and supervisory activities. These activities are especially necessary for home care, given its remote practice settings that require specialized training and competencies.

Staff vacancies often mean that organizations can't accept cases, which is disruptive to patient care needs. More specifically, further complications stem from a series of recent court decisions at the state Appellate level which have called into question the compensation levels for home health aides assigned to 24-hour shifts (aka, "24-hour/live-in" services), and the amount of sleep and meal time that constitute compensable hours. These court decisions have a chilling effect on the assignment of these services because they create exposure for increased 24-hour care costs or they require more than one aide to service the needs of a single patient, complicating and similarly increasing the costs of case assignment.

- A home care agency's average home health aide turnover rate is 24.80%. Twenty-three percent of agencies in HCA's survey reported a home health aide turnover rate of 30% or higher, with the highest turnover rate being 53%.
- The average RN/professional staff turnover rate is 23.09%. Almost thirty-two percent of agencies reported an RN/professional turnover rate of 30% or higher, with the highest turnover rate being 63%.
- For "24-hour/live-in" services, 7% of agencies said they are unable to serve these cases and 20.45% are unable to serve some of these cases due to litigation that has called into question the compensable hours for sleep and meal times, which increases the cost of these services exponentially.
- On average, home care agencies reported the following percentages of unfilled jobs due to staff shortages in the following categories: 11.6% of jobs unfilled for home health aides; 10.2% of jobs unfilled for personal care aides; 9.3% of jobs unfilled for RNs and 7.2% of jobs unfilled for therapists.
- Home health aide and personal care aide vacancy rates were as high as 50-60% at one agency, and at least twelve percent of agencies reported an RN vacancy rate of 30% or higher, with some rates as high as 50% to 60%.

Overall, the top reasons for staff turnover are that "staff find higher pay elsewhere" (62% of agencies cited this as a top reason) and an equal percentage (62%) cited "paperwork and regulatory burden create a disincentive for staying in home care." Several mentioned aides needing more hours than are allotted. But many cite other, specific burdens:

"The feeling of clinicians of "never being done" with their work ... EMR (electronic medical records) too burdensome ... Documentation demands often require staff to work beyond their scheduled day. Many return to the hospital setting to avoid extra work hours."

"Consistently, the reasons cited to leave home care are: work-life imbalance; surveyor requirements for perfection; EMR workflow; regulatory overlay; changes/expectations growing and constant; and on-call requirements. Patients are extremely ill, and are transferred directly from hospital to home without a midlevel step-down. It leads to burnout."

Home Care Participation in New Models of Care

In the past few years, the state has launched major new multibillion-dollar initiatives transforming the delivery of services to nearly every patient in the Medicaid program, with major effects on providers throughout the delivery system.

Among these new models is the Delivery System Reform Incentive Payment (DSRIP) program, which has created multi-provider structures called Performing Provider Systems (PPSs) tasked with reducing hospital use by 25% over five years. As a post-acute setting, home care has a vital role in preventing unnecessary hospital admissions and readmissions, thus reducing hospital use. These providers are essential to DSRIP goals, yet they remain fundamentally excluded by many of the decision-makers and PPS leads.

Worse yet, many non-home-care providers are instead seeking to provide homecare-like services without being appropriately licensed under Article 36 state law that governs the practice and delivery of home care. In so doing, they bypass quality, supervision, assessment and surveillance requirements that licensed home care providers must abide. The requirements set forth in Article 36 were instituted in order to protect the health, safety and welfare of individuals receiving care in the home setting. Allowing for the circumvention of these critical patient protections, uniquely designed to ensure safety in the home setting, is often unlawful, detrimental to quality care, and should be closely scrutinized.

Another new system change is the state's move to Value Based Payments (VBP), which requires providers and payors to enter into 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 providers are working arduously in this arena to forge VBP contracts and projects designed to address specific clinical areas where better outcomes, and lower volume of services, could be achieved through home care.

DSRIP

As in last year's HCA report, home care providers continue to experience a sense that DSRIP PPSs do not understand home care's role, and home care providers generally find enormous barriers to their participation in DSRIP.

- Twenty-five percent of home care agencies report that DSRIP PPSs have "not involved them at all" in DSRIP activities (36% percent of agencies feel that PPSs "somewhat involve" them, with 15.9% feeling "actively involved"). This is consistent with last year's findings where 24% did not feel involved at all.
- Half of home care agencies report not receiving any payment directly from a DSRIP PPS.
- Even more concerning, 11.36% of survey respondents reported that they have observed PPSs deploying home care services without license to do so, using entities that lack Article 36 authority.

"We are concerned with a lack of effort on the part of the PPS to ensure sustainability of the programs by connecting programs/providers with managed Medicaid plans," says one agency in HCA's survey. "We are very concerned that when funding ends, the programs will end regardless of successful outcomes."

In cases where home care agencies find they are embraced by PPSs, home care agencies are finding novel approaches to make a difference and provide vital services:

- One home care agency reports that it arranged for staff placement at physician practices known for high proportions of at-risk patients to ensure medication compliance and other outcomes.
- Another agency reports that it is taking the lead on DSRIP projects for care transitions from hospital to home, a home-based asthma management project, and palliative care.

VBP

Home care participation in value-based payments has increased exponentially during the last year, with home care agencies initiating several concrete programs, protocols, best-practices and operational changes to aggressively meet the VBP goals of reducing health care volume and increasing value.

To achieve VBP goals, 90% of agencies report they are implementing specific interventions or programs aimed at improving outcomes for heart failure patients, 71% are addressing sepsis, and 64% are addressing respiratory infection as the top three areas of focus. Some specific VBP actions are summarized below:

- In one agency's case, the field operations department is meeting monthly to review all hospital admissions; the agency is creating educational materials for all aides, clients and family members; and it is closely monitoring its methods and strategies to prevent hospitalizations.
- Another agency says it is "tracking infections very closely. All infections are case-conferenced during our certification period ... and we are conducting education sessions to hospital care-management teams, recommending that all heart failure patients go to home care: Our agency attempts to fast-track these individuals."
- Several agencies are using HCA's sepsis screening tool and engaging in train-the-trainer sessions on sepsis prevention, identification and response. Others are using telehealth monitoring or expanded telehealth for congestive heart failure patients specifically, applying data analytics software with automatic calling features to reach high-risk patients.

Conclusion

The home care workforce is uniquely equipped to provide cost-effective, compassionate care in the home through initiatives such as: infection monitoring; better coordination of home care with physician practices on medication management and self-directed care improvement; and home telehealth analytics overseen by expert care managers to deliver interventions to high-risk patients. However, these kinds of activities require financial and organizational stability, staffing continuity, technological and infrastructure investment – and the commitment of state policy support and resources to meet these baseline needs.

Our report reveals major and growing areas of concern related to the financial stability of home care and hospice, from MLTC plan to provider. Furthermore, paperwork burdens, inadequate state reimbursement for competitive wages, and increasingly complex patient care needs are among many factors conspiring to create a workforce crisis in home care that hampers progress on new, cost-saving and clinically effective innovations.

State funding sources and policy supports exist to help stabilize this structure, but the criteria for funding and support are either too restrictive or the funds are directed elsewhere – in some cases, even incentivizing non-home care providers to unlawfully duplicate services that already exist. During the 2018 State Legislative Session, HCA is committed to advancing a set of concrete policies to better secure the home care safety-net, cost-effectively and mindful of the needs of patients and the staff who support them.



388 Broadway
Fourth Floor
Albany, New York 12207
PH) 518-426-8764 W) www.hca-nys.org