



2018

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

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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.

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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.



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