

HOMECARE EFFICIENCY

Home Care Provides Solutions



- Home Care: What it is, Why it Matters
- How Home Care Saves Dollars and Lives

- Report Shows Fiscal Peril of NY Home Care
- Provider Stories about Home Care's Value

\$Billions

In Medicare Savings Through Avoided
Health Care Expenditures



**CONSIDER THE EFFICIENCY OF HOME CARE
MODELS – RETRACT THE HEALTH REFORM CUTS
TO HOME CARE**



A Publication of

Spring 2010

Home Care – an Efficient but Fragile System

Dear Friend of Home Care:



With the advent of national health reform, now is a prime opportunity to focus on and support all of the ways in which New York home care is already at the forefront of efforts to make our health care system work better.

To continue providing quality, cost-effective care, we urgently need your support and your continued partnership with HCA on policies that protect access to services and respond to the needs of providers in fulfilling their mission to New York's Medicare patients.

The federal health reform package contains \$39 billion in Medicare payment cuts over the next 10 years – a figure that will reduce home health reimbursement in New York State by an estimated \$1.9 billion over this same period. On top of Medicare cuts, New York providers have also been afflicted with \$300 million in Medicaid state budget cuts to home care, just since 2008.

Under the specter of future cuts at the state and federal levels, New York's home care agencies find that their only choices amid dwindling funds are to cut services, shoulder increasing debt, or, in some cases, close their doors.

Chronic underreimbursement, a wave of new unfunded mandates, and millions of dollars in funding cuts in recent years have left providers clinging to the edge. Just look at the data. According to a recent analysis by HCA and the New York Association of Homes & Services for the Aging, **67 percent of home care agencies are operating in the red, and 44 percent are borrowing money just to stay afloat.** This latter statistic is particularly alarming; while a number of home care agencies have had no alternative but to shut their doors in recent years, several others have made the difficult choice to plunge further into debt for the sake of providing care to New York's most vulnerable.

For Medicare specifically, data obtained by HCA shows that New York's home health agencies lost money on Medicare for the eighth year in a row, with statewide Medicare operating margins of **-18.73 percent**. For a sector of health care that is saving Medicare dollars – through in-home services that reduce the incidence of higher-cost hospital and nursing-home admissions – the health reform cuts to home care will only further jeopardize the fiscal instability of New York's home care community and endanger efforts to achieve real, lasting reform.

In this publication, you will learn more about: the importance of home care in the lives of our elderly, chronically ill, and medically-fragile citizens; data on the fiscal condition of home care in New York State; and HCA's recommendations for ensuring fair and responsible Medicare reimbursement to providers so that the home care community can continue to meet the needs of an aging population and support the broader goals of health care reform.

I hope you find this publication informative, and I thank you for your continued interest in home care. If I can be of any further assistance, please feel free to contact me or my staff. A staff directory is printed on page 16.

Regards,

Joanne Cunningham
President
Home Care Association of New York State (HCA)

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Home Care: What it is, Why it Matters

Home care is provided at home to patients who need post-acute care following a hospital visit or who require long term care. Comprehensive services are provided by nurses, therapists, home health aides and other direct-care staff.

The complexity of care provided in the home has grown in recent years; so have the number of patients needing care and the health severity level of those patients (especially as our population ages and as people continue to live longer). Home care agencies today use leading-edge disease-management tools, like home telehealth, that further enhance patient monitoring and care delivery and save health care dollars.

On the human level home care allows patients to live independently, providing vital support for families while improving a patient’s quality of life. Patients receiving home care include the elderly, persons with disabilities, technology-dependent patients, as well as chronically ill and post-acute care patients of all ages.

On the health outcomes level home care helps patients better manage a chronic health condition (i.e. congestive heart failure, diabetes, HIV/AIDS) at home, and recuperate after surgery. It allows elderly patients and patients with cognitive impairment to remain safely in their homes, as is their wish.

On the health systems level home care services result in better care management, preventing needless and costly hospitalizations and/or premature nursing-home admission. To illustrate, a study by Avalere (2009) found that early intervention post-acute home care services for patients with diabetes, chronic obstructive pulmonary disease (COPD), or coronary heart failure (CHF) saved \$1.71 billion for Medicare and would have saved \$1.77 billion more with wider use. (See p. 9 for more studies.)

For these reasons, home care is not only patient-centered but it is also the solution to making health care more efficient by reducing costlier service use – one reason why home care is referred to as the “safety net” of health care.

How Home Care Works

1 *Filling the gap, and breaking a cycle of repeat hospitalizations*

Without preventive care management, a patient suffering from a chronic condition is at great risk of being hospitalized, having to visit the ER in an emergency, or requiring care from a physician specialist once a condition worsens.

While vital to our health care system and to the patients who need them, these more intensive-level services can often be avoided through effective home care management, especially for patients at greatest risk, including those who may be suffering from multiple conditions at once such as heart disease, respiratory illness, diabetes, immune system disorders, etc.

Without home care, many of these patients would have two options: 1. go without care (or receive an inadequate level of care) and risk repeat hospitalizations, or 2. enter an institutional

setting, which may not be necessary or, indeed, wanted, especially as the level of home care service delivery becomes more advanced in meeting people’s needs. For these patients, a doctor has the option of ordering home care services which can be developed by the home care provider into a plan of care that is custom tailored to the patient.

A patient whose health condition is closely monitored, who is assisted in following his or her medication regimen, and whose care needs are assessed and met within the context of his or her home surroundings will be less likely to face hospital or ER admission.

Services provided by home care agencies can break a past cycle of repeat hospitalizations for many patients while allowing patients to remain in the comfort and sanctuary of their own homes.

See HOME, p. 3

2 Coming back home from the hospital sooner and safer

Your elderly father has just undergone major reconstructive knee surgery in the hospital.

Like many patients his age today, he is otherwise healthy, independent, and wants nothing more than to return home. However, his healing and extensive recovery have just barely begun; his knee is tender and swollen from the procedure, he is unable to drive a car, and he now requires weeks of physical therapy and assistive care to get back on his feet again.

In addition to the physical therapy he needs, without proper monitoring, you worry that he may have a fall at home, putting him at greater risk of injury and possibly requiring him to return to the hospital. While he doesn't need to be in the hospital any longer after surgery, he still requires a certain level of skilled and

assistive care to enable him to be properly discharged and cared for at home.

In-home physical therapy and home health aide care make it possible for patients like him to receive post-acute services at home, getting him out of the hospital sooner while providing him with the appropriate blend of therapeutic and support services to help him recuperate.

The same goes for patients who have experienced more intensive hospital intervention, such as for heart failure. Once they are stabilized, these patients can be effectively managed and monitored at home, allowing them to leave the hospital sooner and avoid hospital readmission. The result is good for the patient and for the health system, as inpatient resources are most appropriately utilized.

3 Averting premature or unnecessary nursing-home care

Years ago, the only option was nursing-home institutionalization if you were an elderly patient without able family who needed assistance with self-care (i.e. feeding, bathing), or if you depended on life-sustaining technology to survive, or if you had suffered a severe disabling condition, such as traumatic brain injury, and required assistance with daily living activities.

Today, through care models like New York's Long Term Home Health Care Program (LTHHCP), Managed Long Term Care (MLTC), and the Traumatic Brain Injury (TBI) program, patients now have the option to receive a sophisticated level of care at home, avoiding the unnecessary cost of institutionalization, and remain connected within their communities. These programs are vital to reducing Medicare costs because they keep patients out of the hospital.

Such long term care services are particularly vulnerable to funding cuts from all levels. In fact, as revealed in the HCA/NYAHS *Lethal Doses* report (see p. 11), **76 percent of LTHHCPs are suffering from operating losses.**



Mary Pawan, RN, of Brooklyn-based **New York Congregational's** Long Term Home Health Care Program with her patient, **Boris Goldvarg**.

Ms. Pawan and Mr. Goldvarg are featured in HCA's 2010 *Faces of Home Care* calendar.

The Impact of Home Health Funding Cuts on New York State under the New Federal Health Reform Law

To reverse a growing threat to service access, Congress must take action to fix damaging and arbitrary home health funding cuts under the federal health reform law and other federal actions by 1) Reinstating a Full Medicare Market Basket Update for Home Care; 2) Rejecting Arbitrary Reductions in Reimbursement resulting from a faulty CMS Case Mix interpretation; 3) Eliminating the Home Health “Productivity” Cut and Rebasing Reduction; and 4) Restoring the Rural Add-on.

Background

The Financial Condition of New York State’s Home Health Agencies is Extremely Fragile

Between 1997 and 2008, home health agencies (HHAs) in New York State experienced cuts in their Medicare payments of \$220 million. This has had a debilitating effect on New York’s already fragile home care infrastructure.

While a March 2010 report by the Medicare Payment Advisory Commission (MedPAC) contends that the 2008 Medicare operating margin for HHAs nationally was 17.4 percent, MedPAC’s analysis does **not** include institution-based providers and is not an accurate representation of the financial health of HHAs in New York State.

In fact, **home health Medicare margins in New York vary significantly from the MedPAC analysis and remained negative for the eighth year in a row, at -18.73 percent** (unweighted 2008 data that includes hospital-based agencies).

The 2008 negative home health Medicare margin **more than doubles** last year’s negative margin of -9.07 percent.

Further revealing the extremely fragile status of New York’s HHAs, a joint HCA/NYAHS (New York Association of Homes & Services for the Aging) survey found that 67 percent of HHAs in New York are reporting operating losses across all revenue streams and 44 percent must borrow money to meet their current operating expenses. In addition, almost 60 percent of agencies are facing worse cash-flow issues in 2009 compared to 2008, and 75 percent labeled these cash-flow issues as “serious” or “very serious.” Continued Medicare payment reductions for home care services will further deny HHAs the necessary payments to cover the costs of providing care to Medicare patients and would unravel New York State’s home care infrastructure.

Continued on next page

Federal Health Reform FAST FACTS

\$1.9 billion

Ten-year impact of Medicare cuts to NY providers under recently passed federal health reform

-18.73%

2008 Medicare operating margin of NY home health agencies

67%

Percentage of NY home health agencies operating in the red

44%

Percentage of NY home health agencies borrowing money to meet expenses

HCA RECOMMENDATIONS TO CONGRESS

- ▶ Support a full home health market basket update
- ▶ Reject flawed CMS case-mix interpretations
- ▶ Eliminate home health “productivity” cut
- ▶ Fully restore the 3-percent add-on

Health Care Reform Law Contains Major New Cuts to Home Care

The Health Care Reform law requires a combination of tax increases, spending reductions, employer and individual coverage mandates and other mechanisms to provide for the expansion of health insurance coverage to over 30 million additional Americans. Approximately half of the financing comes from reductions to the Medicare program, including Medicare home health spending.

The Health Care Reform Law reduced Medicare home health reimbursement nationally by \$39 billion over the next 10 years and will reduce anticipated home health reimbursement in **New York by an estimated \$1.9 billion over this same period.**

Information on the following pages further outlines HCA's major issues and concerns with the home care cuts of the Health Care Reform Law, along with other federal actions, and shows how some of these provisions will significantly affect HHAs in New York as well as the patients that they serve.

◆ ISSUE 1: Reinstate a Full Medicare Market Basket Update for Home Care

OVER THE YEARS, CONGRESS has been presented with flawed MedPAC proposals to eliminate or reduce the Medicare home health care market basket update. MedPAC's recommendations are rooted on misleading assertions that home health operating margins on Medicare services have consistently been between 12 and 17 percent.

HCA and the National Association for Home Care & Hospice (NAHC) challenge MedPAC's assertions related to HHAs' operating margins based on the facts that:

- ① **MedPAC's analysis of the data does not include any consideration of the 1,626 agencies (21 percent) nationally that are part of a hospital or skilled nursing facility.** In some states, hospital-based HHAs comprise a significant percentage of home health providers.

In New York, facility-based HHAs represent more than 25 percent of Medicare certified agencies. Nationally, facility-based agencies have an average Medicare operating margin of -6.19 percent, while in New York that number is -13.88 percent (based on 2008 Medicare cost reports).



- ② **MedPAC's analysis uses a weighted average which overstates the positive margins of large individual agencies rather than accurately representing the margins of all individual agencies.** It further misrepresents a single national operating margin for freestanding agencies as representative of over 9,700 very diverse home health agencies.

When all agencies' margins are included and simply averaged together ("unweighted"), the true average Medicare margin nationally of individual agencies would be approximately 3 percent, while **in New York, unweighted Medicare operating margins remain negative for the eighth year in a row at -18.73 percent (2008 Medicare cost report data that includes hospital-based agencies).**

The recently passed Health Care Reform Law accepted MedPAC's recommendations by applying a 1 percentage point reduction off the market basket in 2011, 2012, and 2013. The estimated one-year impact of the 1 percentage

ISSUE 1, continued on next page

ISSUE 1, continued from p. 5

point reduction off the market basket for New York HHAs is \$7.6 million and \$23 million over the three year period from 2011-13.

Further reductions of the market basket update will only escalate the growing gap between payment and reimbursement for agencies serving Medicare patients.

This payment gap, which is exacerbated every year that the home health market basket adjustment is reduced, compromises agency operations and the ability of agencies to deliver necessary care. Given the rising costs of basic operating expenses — personnel, clinical technology and medical records, fuel, medical supplies, insurance, corporate compliance and other general operating costs — the full market basket update is vital to ensure that agencies have the resources to meet patients' needs.

ISSUE 1: Recommendation

HCA and home health providers urge Congress to restore the 1 percentage point reduction to the home health market basket in 2011-2013 and **support a full market basket update for Medicare home health services in 2011-13.**

◆ISSUE 2: Reject Arbitrary Reductions in Home Health Reimbursement Resulting From Faulty CMS Case Mix Interpretation

Establish a More Transparent Process for Evaluating Case Mix Changes

IN JANUARY 2008, the U.S. Centers for Medicare and Medicaid Services (CMS) implemented a regulatory provision that will reduce Medicare episodic payments by 11.75 percent from 2008 to 2011 (an arbitrary cut attributed to “case-mix creep”).

CMS' provision was based on the unfounded assertion that HHAs have intentionally gamed the system by coding their patients at a higher clinical severity in order to receive higher Medicare payments under the Prospective Payment System (PPS) implemented in 2000. CMS and MedPAC based this flawed determination on a review of providers' OASIS case-mix data from 1999 to 2003.

The data CMS used, and its assumptions based on this data related to inflated coding, are flawed because CMS' analysis does not fully recognize **real** increases in case mix due to **real** increases in the severity of need that have occurred since the inception of PPS and that are caused by:

- Earlier and sicker hospital discharges;
- Technology improvements which enable more complex patients to be cared for at home;
- Improvements in the accuracy of OASIS coding that more precisely measure patient severity; and
- Increased patient therapy needs which also indicate a higher level of patient acuity.

In fact, a closer analysis of OASIS data, conducted by the Lewin Group, discovered significant changes in patient characteristics from 1999 to 2003 (the same period encompassed by the data review used by MedPAC to back its



ISSUE 2, continued on next page

“case-mix creep” adjustment). This analysis points to a growing incidence of more medically complex patient cases entering the home care system, including such factors as:

- An increase in patients with wounds;
- An Increase in patients with urinary incontinence;
- Patients with gait abnormality (disorders or conditions creating problems walking) increasing by 50 percent;
- The number of beneficiaries with a primary diagnosis of diabetes increasing by 17 percent;
- Home health patients age 85 and over increasing to 27 percent (a 4 percent increase)

CMS’ reduction of Medicare episodic payments by 11.75 percent from 2008 to 2011 reduces payments to New York HHAs by \$83 million for this period and further contributes to the financial instability of New York State’s home care infrastructure.

ISSUE 2: Recommendation

Reject arbitrary reductions in reimbursement stemming from CMS case mix interpretations; enact legislation to replace the reductions with a reliable and transparent process for determining whether payment rate cuts are needed to account for improper changes in “case-mix scoring” that are not related to changes in the nature of the patients served in home health care or the nature of the care they received; and ensure that providers are not subject to cuts for having legitimately served higher need cases.

◆ ISSUE 3: Eliminate Home Health “Productivity” Cut and Rebasing Reduction

THE HEALTH REFORM law also makes two other payment reductions to home health agency rates by:

- Imposing a home health productivity reimbursement cut beginning in 2015 which is estimated as a 1 percentage point reduction. The estimated impact of this reduction for New York HHAs is \$7.6 million.
- Rebasing home health payments, beginning in 2014 and phased in over four years through 2017. The rebasing adjustment will yield up to a 3.5 percent reduction each year. If CMS implements an annual 3.5 percent reduction beginning in 2014 and continuing through 2017, the reductions in payments to New York HHAs are estimated at \$107.2 million.

ISSUE 3: Recommendation

Eliminate these two provisions, which will reduce payments to New York’s HHAs in the out years by almost \$115 million. Their **elimination** is particularly critical in view of the \$1.8 billion in payment reductions already imposed on New York’s HHAs.

◆ISSUE 4: Make Permanent and Fully Restore the Rural Health Add-On

THE HEALTH REFORM LAW reinstates the rural payment differential (add-on) at 3 percent from April 1, 2010 until December 31, 2015. HCA is pleased that the Health Care Reform Law reinstates an add-on to the payment rates of HHAs serving patients in rural designations.

New York State is a very geographically diverse state with nearly 50 percent (25) of the state's counties being designated rural by CMS. In 17 of New York's 25 rural counties, the county-sponsored Certified Home Health Agency (CHHA) and/or Long Term Home Health Care Program (LTHHCP) is the sole community provider of skilled home care services for Medicare and Medicaid.

A recent HCA study, meanwhile, revealed a very troubling statistic that **75 percent of county-operated HHAs were reporting operating losses.**

Home care delivery in rural communities is challenged by chronic staffing shortages, the severe absence of other community services needed to sustain the health and support needs of New Yorkers living in these areas, as well as the challenge of serving patients dispersed across vast geographic stretches.

Increasing the rural add-on to 5 percent is necessary to prevent the continued demise and closure of rural HHAs in New York State.

Issue 4: Recommendation

The 3-percent rural add-on should be increased to its prior level of 5 percent (in calendar year 2006). In recent years, eleven public HHAs in New York rural counties have closed and others are on the brink of closing. HCA is greatly concerned about continued access to home care services given the financial fragility of home care agencies that serve rural communities.



HOME CARE: Saving Dollars, Saving Lives

What research tells us about home care's cost-effectiveness

Home care is a vital component of health care, especially as our nation's population ages and demand rises for services to meet a variety of health, therapeutic and assistive needs.

An effective model of prevention, rehabilitation and chronic-care management, home care helps to prevent unnecessary hospital visits or nursing-home admission. In so doing, it saves millions of health care dollars while allowing patients to receive life-saving and life-sustaining care in the most preferred setting – their homes.

What follows is a glimpse at leading research that sheds light on the cost-effectiveness of home care, providing insights which further inform the debate about health care policy in New York State and nationally. It is hoped that this collection of research will prompt further analysis, study, and appreciation of home care's success as a powerful solution for achieving cost-efficiency while supporting the individual and public-health needs and preferences of our citizens.

1 Home Care: Averting Higher-cost Service Use

Studies show how home care saves dollars by preventing the need for patients to be admitted or readmitted to the hospital or nursing home (where the cost of care is often higher). Home care succeeds at preventing health conditions from becoming worse – and rising to the level of a costlier hospital intervention – and/or provides a range of health, therapeutic and assistive services that keep patients out of the nursing home where bed capacity is at a premium.

Economic models show massive savings in home care by averting/reducing other health care utilization. For example, a 2001 study showed home care's potential to **save as much as \$472 per day per patient** in averted hospital days – a **total of 17 averted hospital days and a savings of \$5,024 per patient per year** (Eastaugh, 2001).

A national study shows that services to home and community based (HCBS) waiver patients cost the public **\$43,947 less per person per year than Medicaid institutional care**, even if housing and other spending are included for HCBS waiver participants (Kitchener, Ng, Miller, & Harrington, 2007).

THE RESEARCH

2 Greater Investment in Home Care Reduces Cost of Long Term Care

States that invest in home and community based services are not only able to control costs but they can also expand long term care (LTC) service access beyond what is possible through exclusive or predominant use of institutional care models.

Repeated statistical analyses by the New York State Department of Health, the State Senate Health Committee, the State Department of Social Services, HCA, and others, as well as New York Medicaid claims data, have shown that nursing-home-eligible patients in New York State's Long Term Home Health Care Program (also known as the "Nursing Home Without Walls") are cared for at home at **about 50% of the average Medicaid rate** for nursing home care.

THE RESEARCH

See COST-EFFECTIVE, p.10

3 Home Care: Reducing Costs for Certain High-Priority Health Conditions

Home care is particularly cost-effective for treating patients with certain high-intensity chronic conditions.

Such findings further bolster support for the strategic deployment of home care in addressing top-tier public health goals such as chronic heart disease and diabetes management.

The research highlights innovative and cost-effective home-based approaches to patients needing this level of care.

The cost of post-acute home care for individuals with a primary or secondary diagnosis of diabetes, chronic obstructive pulmonary disease (COPD), or coronary heart failure (CHF) was much lower than the cost of post-acute care in other settings, resulting in a **total Medicare savings of \$1.77 billion during 2005-2006**. (Avalere Health LLC, 2009).

Long-term home oxygen therapy – “The only non-surgical therapy to extend life of COPD patients” – is very effective in reducing Medicare costs: **spending for one hospital day is equal to the cost of covering home oxygen therapy for one full year** (AAHomecare White Paper, 2004).

When hip and knee replacement patients received in-home rehabilitation, the total cost was **\$3,500 less than in a skilled nursing facility and \$8,000 less than in an inpatient rehabilitation facility** (Buntin & Kaplan, 2005).

In 2006, New York’s Traumatic Brain Injury (TBI) Medicaid HCBS waiver had 1,953 participants. For each patient, **the program saved \$30,832 in Medicaid costs** compared with services provided in nursing homes, hospitals, and other institutions, resulting in a **total annual savings of \$60 million**. In 17 states, the waiver saved almost \$273 million annually compared with institutional care (Hendrickson & Blume, 2008).

Experts studied the positive impact of an in-home palliative care (IHPC) intervention on 298 terminally-ill patients. The study found that **IHPC intervention greatly reduced the rate of emergency-room visits** (20% versus 33% for patients who didn’t receive the IHPC intervention) and the rate of hospital admission (36% versus 59% for patients who didn’t receive the IHPC intervention). The average adjusted cost of caring for each IHPC patient per diem was \$95.30 versus a cost of \$212.80 for usual-care patients (Brumley, Enguidanos, Jamison, Seitz, Morgenstern, Saito, et al, 2007).

THE RESEARCH

4 Pediatric Home Care Reduces Costs and Supports Emotional Well-being

A sense of normalcy is critical to a child’s social and emotional development. For children who are chronically ill, this sense of normalcy is best supported in a setting that is least disruptive to their lives. The option of receiving care at home is particularly important for pediatric patients. At home, the process of healing and chronic-care management succeeds in a nurturing environment close to family.

In-home care for ventilator-dependent children and children with high-tech needs cost an average of **87% less and 70% less, respectively, per child than hospital care** (Balinsky, 1999).

Home chemotherapy for children with cancer costs **20% less than hospital costs** – \$55,950 for home care versus \$69,870 for hospital care (Balinsky, 1999).

Home care services cost **56% less than hospital costs** for oxygen-dependent children (\$5,250 for home care versus \$12,090 for hospital care). The cost of caring for low-birth-weight babies at home is only **1% of hospital expenditures** (\$330 for home care versus \$26,190 for hospital care, a savings of \$25,860) (Balinsky, 1999).

THE RESEARCH

TIPPING POINT

HCA/NYAHSAs Report: Crush of Payment Reductions, Unfunded Mandates Imperil NY's Home Care System

New York's home care system is teetering on the edge. Providers have been subject to over **\$300 million** in Medicaid cuts since 2008, and **\$220 million in Medicare cuts** from 1997 to 2008.

And now, with the newly passed federal health reform act, New York's home care community faces an astonishing **\$1.9 billion in payment cuts over the next ten years**, worsening the pain for New York home care agencies, 67 percent of which were already operating in the red as of 2007.

Further cuts would undermine a cost-effective component of our health care system that allows individuals to obtain life-saving and life-sustaining services in a preferred home setting while helping patients to avoid unnecessary higher-cost service use through interventions appropriately tailored to individual need.

Health policy experts know that home care is not only preferred by patients and their families; these services help keep patients out of the hospital and avert premature nursing-home placement, thus saving Medicare dollars while supporting the desire of patients to remain in a setting that supports their independence and well-being.

HCA/NYAHSAs fiscal-conditions report

In late 2009, HCA and the New York Association of Homes & Services for the Aging (NYAHSAs) conducted a multi-tier analysis of the financial stability of home care providers in New York State. The analysis is presented in a report entitled **Lethal Doses: Chronic Cuts and New Mandates Threaten Home Care in New York State**, available in full from HCA's website at www.hcanys.org.

Key survey results

As part of this study, HCA and NYAHSAs surveyed our Certified Home Health Agency (CHHA) and Long Term Home Health Care Program (LTHHCP) provider members to assess the impact of recently enacted funding cuts and to gauge the fiscal, operational and regulatory challenges plaguing agencies that directly provide care to New York's most vulnerable patients.

NEW YORK HOME CARE IN JEOPARDY*

- 67%** of home care agencies reported **total operating losses**, according to most recent data.
- 75%** of **county-operated** home care agencies had **operating losses**, according to most recent data.
- 44%** of agencies are either **"likely" or "very likely" to close** their program if hit with an additional **5-percent cut**.
- 54%** of home care agencies would be **"likely" or "very likely" to close** under a **10-percent cut**.
- 65%** – **increase in total operating losses**, from 2004 to 2007, for home care agencies serving patients with chronic health conditions and long term care needs.
- \$65M** – estimated **cost of new unfunded mandates and taxes** on home care providers.
- 44%** of agencies **must borrow money** to meet their operating expenses.

*HCA/NYAHSAs provider survey and cost report analysis

Among the survey's key findings, **44 percent** of agencies reported that they are either **"likely" or "very likely" to close** if hit with an additional 5-percent Medicaid funding cut. **Fifty-four percent** of respondents, meanwhile, said they would be **"likely" or "very likely" to close** under a 10-percent cut.

The HCA/NYAHSAs survey also asked providers to tell us what actions they had already taken, or would be compelled to take, due to enacted and proposed home care cuts. Such actions include: resorting to staff reductions, borrowing money to stay afloat, and/or delaying needed (and cost-saving) technological investment. (See "Actions Taken" chart, next page.)

One of the most alarming trends is the fact that **44 percent of home care providers are borrowing money to remain afloat**, revealing a home care system clinging on the edge and risking financial insolvency for the sake of continuing the mission to provide care. In the case of these providers, the impact of operating losses, compounded by today's funding cuts, is mortgaged into future years.

As demand for home care grows, and as providers are increasingly forced to do more with less, the only options

for many agencies are to close up shop, reduce services, or spiral deeper in the red.

Cost-report analysis

Further reinforcing the survey findings, HCA and NYAHSAs also conducted a statewide analysis of home care provider cost reports which found that **two-thirds of home care agencies reported operating losses** due to inadequate reimbursement and rising costs in 2007, the most recent year of available data. The operating loss applied to **all payor** sources, including Medicaid, Medicare, and private pay.

Our analysis specifically examined providers' 2007 Medicaid cost reports. These are the certified financial statements that agencies must submit every year to the state. The cost report is a valuable source for understanding the relationship between financial status and reimbursement policy, as these reports include a very comprehensive picture of each home care agency's overall cost profile.

HCA and NYAHSAs then compared the 2007 reports to 2004 data to examine how financial conditions had changed over the three-year period.

For Medicare specifically, HCA has also obtained 2008 Medicare cost report data which shows that New York's home health agencies lost money on Medicare for the eighth year in a row, with statewide margins of **-18.73 percent** (unweighted 2008 data that includes hospital-based agencies).

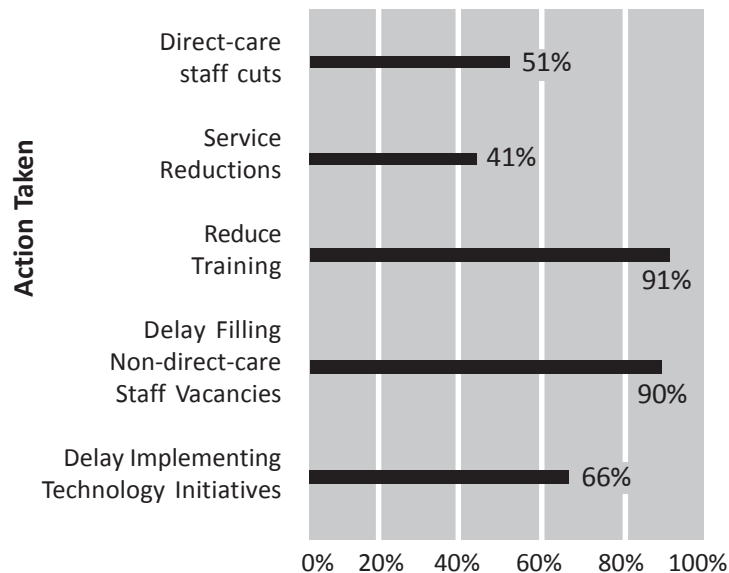
Toll of cuts and unfunded mandates

It became clear from this analysis that further Medicare and Medicaid cuts alone are enough to destabilize New York's already fragile home care safety net; yet the impact of these cuts is significantly more lethal when mixed with already inadequate rates of reimbursement and the unprecedented avalanche of new unfunded mandates imposed on providers over the past several months. These new mandates have occupied precious staff and financial resources at agencies whose model of care delivery is already streamlined.

In fact, new unfunded mandates and taxes alone are costing providers millions of dollars. This impact is approximately \$21.5 million for the HCA/NYAHSAs members who responded to the survey. When extrapolated to all New York

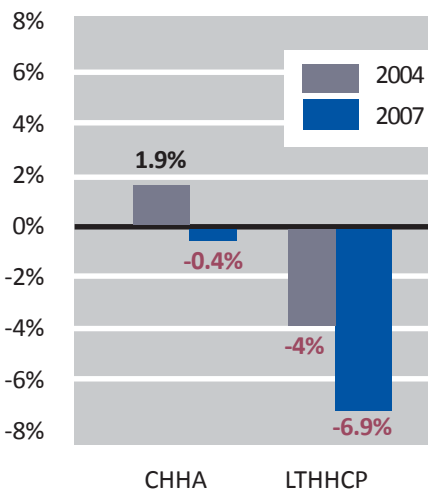
ACTIONS TAKEN

Percentage of agencies that have taken the given actions in response to funding cuts already enacted



IN THE RED

Drop in median operating margins of Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPS) between 2004 and 2007



LTHHCPS and CHHAs, the impact amounts to an estimated **\$65 million** in costs that fall outside of traditional operational expenses devoted to the mission of providing quality patient care. This number increases substantially if other home care provider types (including Licensed Home Care Services Agencies, or LHCSAs) are factored in.

See FISCAL, p. 13

FISCAL, from p. 12

One of these onerous new mandates concerns Third Party Liability (TPL) for home care patients covered both by Medicaid and Medicare. Previously, the state and federal governments utilized a fair and efficient claims-sampling method (called the **TPL Demo Project**) to determine which program — Medicare or Medicaid — pays for home care services provided to tens of thousands of patients covered by both programs. The TPL Demo expired in 2007. As a result, the state mandated that home care providers resubmit to Medicare thousands of prior-year paid claims, along with a mountain of related paperwork, to trigger a case-by-case redetermination of whether Medicare or Medicaid should have paid.

This process has cost providers thousands, in some cases millions, of dollars to achieve what the TPL Demo Project was able to resolve much more efficiently and without this provider burden. New York's home care community is vigorously advocating for reauthorization of the TPL Demo Project at the federal level, which would save dollars both for the government and for providers, removing an unnecessary administrative diversion from the provider's main task of delivering patient care.

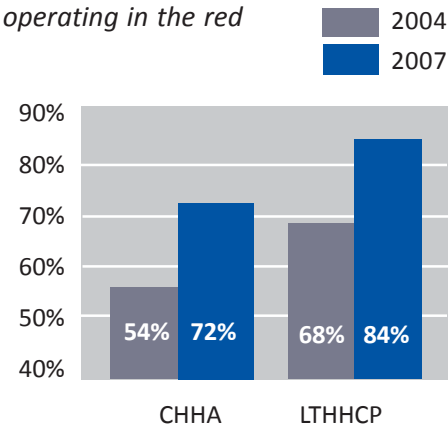
Long term care, rural agencies particularly hit

The situation is even more precarious for agencies serving chronically ill New Yorkers and/or patients who would otherwise require nursing-home admission. The total operating losses for these providers (LTHHCPS) **increased by 65 percent from 2004 to 2007**, according to the HCA/NYAHSAs study, with a total of 76 percent of such programs suffering operating losses. These services are vital in the context of Medicare policy since LTHHCPS providers help manage a patients' long term health and assistive needs, averting needless and preventable hospitalizations that would, in many cases, otherwise be covered by Medicare.

HCA and NYAHSAs analysis also uncovered a particularly stark reality for home care service access in rural areas, where a shocking **75 percent of county-run home health agencies reported operating losses in 2007**. Home care delivery in rural areas is tested enough by chronic staffing shortages, the absence of related community health and support services, as well as the

RURAL HOME CARE ENDANGERED

Percentage of county agencies – which are primarily located in rural areas – operating in the red



challenge of serving patients dispersed across vast geographic stretches, where one agency may be the sole provider of its kind. Further proposed home care cuts, if enacted, are certain to wipe out services in large stretches of rural New York.

In addition to the grave threat of agency closure, the likelihood of diminished access to services, and the enormous cost of unfunded mandates, the HCA/NYAHSAs survey also uncovered other severe operational stresses that stem from the chronic underfunding of the home care industry.

These stresses include: an incapacity to fill staff vacancies needed for providing care in the community; the postponement or cancellation of investments in cost-saving and care-enhancing technologies; and the elimination of workforce training and education initiatives vital for preparing direct-care personnel to meet the growing complexity of patient needs while preparing all staff for the administrative requirements of voluminous new state and federal regulations.

With imminent state and federal funding reductions, chronic staffing difficulties, increasing pressure to serve patients with unmet needs, oppressive regulatory mandates, and overly aggressive governmental audits, New York's home care system is already in grave danger. Add to this millions of dollars in further proposed cuts, and the very survival of this system to keep people at home is clearly in jeopardy. ■

NOTES FROM THE FIELD

Patients and providers share their stories about home care's value in the community

For Children, Home Care Vital to Health and Development

A two-and-a-half-year-old patient has received services from Patchogue-based **Brookhaven Memorial Hospital Home Health Agency** periodically since he was only two-months-old, after being discharged for the first time from the neonatal intensive-care unit (NICU). The child was born with Netherton Syndrome, a genetic disorder characterized by ichthyosis (skin discoloration and shedding), malabsorption syndrome, with pancreatic insufficiency, immune deficiency, and developmental delays. He weighs only 17.7 lbs.

After many months of physical therapy, he can now sit alone. He is fed special formula thickened with rice cereal through his gastrointestinal tube via an electric pump. Since his NICU stay, he suffers from many infections, including recurrent MRSA and C.difficile, and was recently admitted to the hospital because of Respiratory Syncytial Virus. Developmentally, he gestures and verbalizes a few words and sounds. He does not stand, crawl, or eat many oral feedings. He does communicate pain by crying and can be consoled.

Home care has been able to assist the young patient and his family by teaching infant care skills, child safety, developmental goals, pump feeds, temperature control, warning signs and symptoms of an emerging illness or infection and seizures, as well as medication management.

Brookhaven in-home caregivers have taught his mother how to sterilize equipment, keep her environment safe, care for her child's skin condition, and know when to call for emergency help. The patient is closely monitored for weight gain and signs and symptoms of a developing infection. Brookhaven's social work team is also assisting the family.

The home care personnel collaborate with a tertiary pediatrics center to coordinate efforts to care for the young patient. He is seen by a pediatrician, pediatric gastroenterologist, infectious disease specialist, ophthalmologist, dentist and dermatologist. His home care nurse follows up with any orders received from those team members and assists his parents to understand them and carry them out. Early Intervention program services have also been incorporated, through which the patient now has access to therapy services and a special education teacher in the home environment.

His mother and father are very devoted and mom cares for him full-time, administering his medications and his feedings every two to four hours.

Home health services are vital to this young patient's wellbeing, helping his family to manage his health conditions and allowing him to develop and remain safe in the comfort of his own home.

Chronic Care Management: Keeping Patients Safe and Out of the Hospital

Ms. K is a 55-year-old woman with diagnoses of Guillain-Barré syndrome (a disorder in which the immune system attacks part of the peripheral nervous system causing severe muscle weakness, paralysis and sometimes death), chronic obstructive pulmonary disease, type 2 diabetes, hypothyroidism, and sleep apnea. Ms. K also has a tracheotomy and an IV port, is on continuous oxygen and is morbidly obese.

She has been a patient of **Eddy Visiting Nurse Association** for three years and has had just one

See CHRONIC, p. 15



Patricia Ann Smith, RN, Case Manager for **Lourdes at Home** in Vestal, NY provides care for pediatric patients, making a difference for many families in the community.

Ms. Smith is featured in HCA's 2010 *Faces of Home Care* calendar.

CHRONIC, from p. 14

hospitalization in that time, for pneumonia. She receives home telehealth monitoring on a daily basis, combined with nursing visits one to two times per month for skilled care, assessment and patient teaching and monitoring. She is clearly a highly needy and medically unstable patient who would lose her ability to remain at home without the care and support of the home care agency.

Another patient, Ms. M, is a 58-year-old woman with a diagnosis of Pyoderma Gangrenosm (open leg wounds which will never heal), a history of strokes and osteoarthritis. She lives with her elderly father and has been receiving Eddy home care services for over 20 years.

The agency provides Ms. M with nursing visits two to four times per week and a home health aide to assist with her personal care needs. Despite the intensity and complexity of her condition, Ms. M has had just one hospitalization in all this time.

When Ms. M's father became ill, the agency provided him with services as well, delivering care in a single community setting that was both efficient and critical to the support of his role as his daughter's caregiver. The agency similarly supported Ms. M's mother prior to her passing in 2003.

This is a great example of not only what home care can do to keep an extremely ill person at home, but to also incorporate and support the assistance of family caregivers in this effort.



In May of 2007, Nicole Piper Adams, a patient of the **Visiting Nurse Association of Central New York**, was diagnosed with a non-malignant brain tumor. She was four months pregnant with her second child, and although doctors wanted to operate immediately, Nicole chose to postpone surgery until after the baby was born. Unfortunately, several weeks later the tumor had doubled in size and immediate surgery was the only option. After the surgery Nicole fell into a "locked-in coma" while her baby continued to thrive. During her three months in the coma, doctors delivered a healthy baby girl. Soon after, Nicole began to move her fingers, toes and head – miraculous progress considering she had lost a portion of her cerebellum.

After a year at a rehabilitation hospital, Nicole is now living at home in Central New York with her parents. She is still confined to a wheelchair, has limited control of her facial muscles, cannot speak or see, and communicates through a letter board and series of head nods. Home care has played an instrumental role in helping Nicole gain better control of her body and develop more strength. Nicole's care team consists of 24-hour-a-day support from family, friends, shift nurses and therapists. Nicole is able to make improvements each new day with their help.

Ms. Piper Adams' story is featured in HCA's 2010 *Faces of Home Care* calendar.

Technology at the Forefront of Exceptional Outcomes

Telemedicine continues to be woven into the fabric of home care at **Visiting Nurse Service (VNS) of Rochester and Monroe County**, helping to improve outcomes for more patients and to place VNS on the national map in terms of efficiency and expertise in the use of telemedicine.

From the first 20 *Health Buddy* telehealth units secured in 2004 through private and grant funding when VNS' program began, to the 100 fully-funded units now in use in the field today, the appliance serves as a vital monitoring and health status safety check for clinicians. Through the system, a patient answers a series of questions about his or her health. Information is sent via data links for review at the agency's central office. Results are analyzed, allowing the provider to intervene before a patient's condition worsens and rises to a level requiring acute care.

The patient's telehealth experience produces long term benefits as a result of improved disease self management. Excellent patient outcomes continue to be demonstrated

at VNS and other agencies that employ telehealth. The equipment has resulted in a 25 to 49-percent reduction in acute-care hospitalization rates at VNS depending on patient diagnosis, including congestive heart failure, chronic obstructive pulmonary disease, and diabetes.

Clearly, by adopting evolving programs and technology, like the *Health Buddy*, VNS has dramatically affected the lives of patients, reducing costly use of hospital services and giving patients greater control over their health management.

And patient satisfaction couldn't be higher, according to a recent VNS survey which reported: a 100-percent overall rate of satisfaction with *Health Buddy*; 84 percent positive and 16 percent neutral experiences using *Health Buddy*; and a 97 percent rate of patients who said they would be likely or very likely to use *Health Buddy* again if needed.

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