HCA Financial Report Shows Harmful Impact of Past Medicaid Cuts

Report is well timed with release of Governor’s budget proposal next week and HCA’s must-attend Advocacy Day on January 28

Governor Cuomo will formally present his 2013-14 Executive State Budget proposal next week, initiating the process of fiscal negotiations that will likely consume much of the legislative session over the next few months. Thanks in big part to our members who participated in HCA’s 2012-13 financial condition survey, HCA is primed for next week’s budget release with the latest financial data available on the state of New York’s home care industry.

On Monday, HCA will be formally releasing our 2013 Report on the Fiscal Health of Home Care in New York State, which we wanted to share with the membership today. (The entire document is attached at the end of this week’s ASAP.)

This report will be a major feature of our advocacy efforts in the coming weeks. It incorporates HCA’s analysis of Medicaid cost reports from 2009 and 2010, along with 2011 cost report data and other information submitted by providers in our 2012-13 survey.

Alarmingly, the report shows that while the median operating losses of home care agencies worsened at a steady rate from 2009 to 2010, these losses took a sudden dip in 2011 – coinciding with $1 billion in

See REPORT p. 2
unprecedented state Medicaid cuts to home care over two years coupled with the state’s initiation of new long term care policy changes that risk further compromise to home care providers financially if appropriate transition measures are not instituted during this year’s state legislative session.

Some of the report’s key findings are summarized below:

• The percentage of home care providers with negative operating margins increased by 22 percent between 2010 and 2011, the most recent year of data available. Seventy-nine percent of surveyed home care providers had negative operating margins in 2011.

• The median operating margin of surveyed Certified Home Health Agencies (CHHAs) was -13.94 percent in 2011, a precipitous drop from 2010 when the median operating margin was -0.31 percent for survey respondents. (Statewide, the CHHA median operating margins were -1.71 percent in 2009 and -1.81 percent in 2010.)

• The median operating margin of surveyed Long Term Home Health Care Programs (LTHHCPs) was -11.47 percent in 2011. Between 2009 and 2010, total operating losses for all LTHHCPs increased from -$21.2 million to -$38 million, a 79 percent increase in operating losses.

• Wide variances in contract rates and a lack of transition support are jeopardizing provider sustainability even as home care agencies work to meet the state’s mandatory managed care enrollment policy. HCA’s survey finds that the vast majority of home care providers are working in good-faith to establish contract partnerships with Managed Long Term Care (MLTC) plans and Managed Care Organizations (MCOs). Yet, at
a time when the Medicaid fee-for-service (FFS) rate has historically proven inadequate, two-thirds of survey respondents indicated they are receiving MLTC and MCO rates well below the already insufficient FFS rates.

For home care providers who receive rates below FFS, their MLTC rates are on average 8 percent below FFS and their MCO rates are on average 20 percent below FFS, further compromising the fiscal stability of home care providers, 79 percent of whom are already operating in the red under FFS. These results speak to the need for adequate FFS and managed care payments to providers as well as premium payments to plans for the provision of home care services.

Meanwhile, when asked which supports are needed to contract with MLTCs/MCOs, “stronger continuity-of-service/transition policies” ranked second only to concerns about adequate payment, again reinforcing the fact that state policymakers have not done enough to provide guidance, regulatory relief, or transition assistance to assure the success of this policy.

HCA urges members to read this report in full and become familiar with the data points which we will use in our advocacy message immediately after the release of the Governor’s budget next week and throughout the legislative session.

**HCA’s State Advocacy Day Call**

On Friday, January 25 at 10 a.m., HCA is holding a special conference call for members to discuss the Governor’s budget proposal and to prepare the membership for HCA’s must-attend State Advocacy Day, which is fast approaching on January 28.

*Continued on next page*
Continued from p. 3

If you have not done so already, please register for HCA’s conference call and our Advocacy Day using the links provided in the sidebar on this page.

The conference call will specifically discuss: the Advocacy Day itinerary and logistical information, HCA’s advocacy message points for 2013, and tips on how to conduct legislative meetings. We will also host a question-and-answer session.

Please note that this year’s Advocacy Day program will not include a formal presentation as we have done in the past. Instead, we ask that members focus on individual legislative appointments throughout the day. We will also be scheduling special legislative leadership appointments for HCA board members and executive staff. Important: if you are planning to bring a member of your board, an executive from your health system or similar executive-level staff, please let HCA know by contacting Billi Hoen at bhoen@hcanys.org so that we can plan for their participation in these legislative leadership meetings.

Please be sure to join us for this critical event. Your participation is vital.

For more information, please contact a member of HCA’s Policy staff.

Upcoming Advocacy Events at-a-glance

January 22

Governor Cuomo releases his 2013-14 Executive State Budget proposal

January 25

HCA to hold must-attend member briefing on the state budget and expectations for advocacy day. To participate, please complete the online form at http://www.surveymonkey.com/s/T3L96MC and dial-in information will be sent to you in advance of the call.

January 28

HCA’s State Advocacy Day is on January 28. Please join us by downloading the registration form at http://www.hca-nys.org/documents/HCAAdvocacyDayFlyerRegistrationForm.pdf. Be sure to schedule your legislative appointments as soon as possible to meet with Senate and Assembly representatives on January 28. To do so, simply call your Senate and Assembly members’ Albany offices and ask to schedule a legislative appointment for HCA’s Advocacy Day on January 28 to discuss home care issues and concerns.

HCA and Associations Submit Comments on OMIG Draft CHHA Protocols

This week, HCA, the Healthcare Association of New York State, LeadingAge New York, and the New York State Association of Health Care Providers sent a joint memorandum to the state Office of the Medicaid Inspector General (OMIG) that provides initial comments on OMIG’s draft protocols for auditing Certified Home Health Agencies (CHHAs).

The opportunity for comments followed a January 7 meeting between HCA and other provider associations where OMIG provided background information on the protocols and we provided general comments and concerns about the protocols while also asking for additional time to provide more specific comments.

Some of our comments at the January 7 meeting included: the fact that some of the protocols appeared to be contrary to the discussions of the OMIG reform workgroup on which HCA participated; the lack of flexibility in required timeframes; a perceived rigidity whereby if the standards are not completely met, then claims are completely
denied; vagueness and the need for removal of some prior clarifying language that makes it hard to understand application of the protocols; the linkage of payment denials to deficiencies that are part of the Health Department survey process; and others.

Based on these concerns, OMIG agreed to make some clarifications and resend the draft to the associations. The associations received a new draft on Friday of last week and were asked to respond by this Wednesday. Due to the short turnaround time, the Associations’ letter provides broad-based comments and requests additional time to vet the protocols with our members.

Some of the broad comments expressed in the joint association letter called for:

- Inclusion of language allowing for consideration of specific situations and other mitigating factors that led to a protocol not being met or met untimely.
- Additional timeframes for meeting certain protocols, including those provided in the 2008 CHHA protocols.
- Proportionality of fiscal sanctions/recoveries to compliance findings, especially when medically necessary services were provided, so that claims may be denied partially and not completely.
- Not taking a total disallowance for actions determined to be non-compliant with personnel documentation requirements.
- More circumscribed parameters on the role of OMIG nurse reviewers who seem to be able to overrule the judgment of the home care agency’s nurse and other clinical staff and, even, the ordering physician.
- Benchmarks/guidelines on which types of documentation OMIG expects so that providers are not open to a subjective review by OMIG staff on what is considered acceptable documentation.


HCA urges members to review the draft protocols and provide comments to us by January 25. Comments can be sent to info@hcanys.org (write “OMIG CHHA Protocols” in the subject line). HCA will consider your feedback in developing further comments that we will submit to OMIG.

For more information, contact HCA Policy staff.

**FIDA Finance Workgroup Discusses Payment Recommendations**

HCA this week participated in the third and final meeting of the Fully Integrated Dual Advantage (FIDA) program Workgroup on Finance.

John Ulberg, Director of the Division of Finance and Rate Setting, heads the Finance Workgroup. Tamika Black, Health Care Systems Analyst from the Bureau of Long Term Care Reimbursement, is Co-leader.

Under FIDA, the state Department of Health (DOH) is seeking federal approval to enroll dually eligible beneficiaries into plans for their Medicare and Medicaid physical health care, behavioral health care, and long term supports and services. FIDA would affect 124,000 of the state’s dual eligible population in New York City, Long Island and
Westchester who are now in the process of being enrolled in Managed Long Term Care (MLTC) plans for Medicaid services under the state’s mandatory MLTC enrollment policy. To transition to an integrated system for Medicaid and Medicare services under FIDA, New York intends to contract with those MLTC plans that: are in operation in 2013, have obtained federal approval to be a Medicare Advantage plan for 2013, and are able to meet the FIDA program requirements.

During the finance workgroup meetings, HCA has repeatedly urged DOH to establish a FIDA rate methodology that adequately reimburses for home health, personal care and hospices services in the per member per month (PMPM) capitation break-down by service category. DOH, in response, has stressed that the baseline capitated rates would pay plans an amount comparable to Medicare and Medicaid fee-for-service (FFS) for each service component. The inadequacy of a Medicaid FFS threshold, however, is newly substantiated in HCA’s recently released financial condition report (see p. 1 story) which shows that 79 percent of providers were operating in the red under FFS in 2011 due to payment cuts and rising costs – data which HCA will be sharing with the Department in the context of our FIDA advocacy and elsewhere.

Workgroup members raised several other recommendations which were discussed at the meeting, including:

- Contracted providers should share in any saving targets to the plans since providers will need to reconfigure to adjust capacity and cost structures for the reduced volume of health care services delivered as a result of care coordination.

- The need for adequacy in the baseline rates and services paid to FIDA plans which include establishing county baseline rates and an outlier rate cell for high need individuals or to establish stop-loss payments for community-based care for high need beneficiaries.

- The FIDA program should include independent external appeal rights for providers to allow for independent unbiased reviews of plan payment denials.

- The rate methodology should include other validated measures in risk adjustments so payments to plans include measures of functional status, diagnosis and other relevant socioeconomic factors.

Mr. Ulberg stated that DOH, CMS and their contractors will be developing an integrated federal and state timeline for the implementation of the FIDA program and rate development which will be shared with the workgroup and that DOH will also be sharing the release of a FIDA data book (to be used in rate development) which workgroup members can comment on as well.

HCA will keep members informed of any new developments and will continue to advocate for the important role of home and community based providers in any approved FIDA program.

HCA was also part of three other FIDA Workgroups that have met a few times – Outreach/Enrollment & Consumer Engagement, Plan Qualifications/Quality Metrics and Navigation, and Appeals and Grievances.

For additional information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.
Tools for Thriving in Today’s Home Care World

Look no further than HCA for all of the information and learning opportunities you need to thrive in this dynamic health care environment. Our education programs are designed to support you in these efforts and are brought to you at the most affordable cost possible, with special savings for HCA members. Take advantage of these upcoming education opportunities and view our website weekly for newly added programs.

Several webinar series are being offered this month. You can participate in one session or the entire series of each. Check out the brochures and registration details at www.hcanys.org/events.cfm for each of these programs:


- **The 2013 HR Legal Summit** – Are you ready for the new mandates? This session will review vital human resources compliance topics. February 21, March 7, April 4, April 18, May 16 and June 20

- **Strategies for Growth** – Improve operations and position your agency for growth. January 30, February 19, and March 14

- **Prescriptions for Reducing Re-Hospitalizations: Effective Pain Management for Your Local Hospital** – This series will give home health providers the keys for pursuing valuable partnerships with hospitals in reducing readmissions. February 12 and March 12

- **OASIS Focus Spots** – A series designed to break down OASIS data elements to enhance quality and reimbursement. February 21, March 21 and April 18.

The IPRO Care Transitions Project Team has also shared with HCA the opportunity for our members to take advantage of the free education programs they offer via webinar in the coming weeks.

IPRO’s care transition initiative has brought health care providers from various settings together to evaluate existing transitional care systems and processes. The complimentary webinars offer best practices for transitioning patients across the care continuum. Learn more about the offerings and how to register at www.hcanys.org/events.cfm

HCA is also happy to announce the dates of popularly requested programs. Save the dates and watch for brochures to be posted soon on these full-day workshops:

- **The Art of ICD-9 Coding** – Beginner Coding and Intermediate Coding – March 19 and 20. Register for one or both workshops that will be held in Mount Kisco.

- **Blueprint for OASIS Accuracy** and COS-C exam to be held June 4 and 5 with the exam offered on June 6 in Nanuet.

The HCA education website has a listing of signature event dates that should be highlighted on your calendar as well, including the **HCA Annual Conference, Senior and Financial Managers Retreat** and the **Corporate Compliance Symposium**.

Visit www.hcanys.org/events.cfm for details.
OMIG to Send TPL Repayment Letters to Some Providers

The University of Massachusetts Medical School (UMMS) said it will soon begin sending letters to some providers that have received Medicare payments as a result of demand bills submitted under the traditional third-party appeals process in federal fiscal years 2008 and 2011 for claims previously paid by Medicaid.

UMMS is under contract with the state Office of the Medicaid Inspector General (OMIG) to perform the traditional Medicare appeals process to ensure that providers seek reimbursement from Medicare and all other third parties before submitting a claim to Medicaid.

HCA has requested and received from UMMS a list of our members who will be receiving this letter. To learn if your organization will be receiving a letter, please e-mail HCA at info@hcany.org with the subject line “TPL Repayment Letter.”

Providers that receive a letter from UMMS will find an attached report listing each beneficiary and the associated episodes of care that have been identified as paid by Medicare. The letter informs agencies to submit:

- A copy of the Medicare final remittance advice for each episode listed on the report; and

- A copy of the enclosed report with the Medicare payment amount your agency is returning, listed under “Medicare Payment Amount.” (As an alternative, agencies may also submit an internal spreadsheet used by the agency to track Medicare payments returned to OMIG.)

Providers that disagree with the findings of the letter can contact the UMMS Medicare Appeals Team at 1-866-626-7594 within thirty days.

For further information, contact Patrick Conole at (518) 810-0661 or pconole@hcany.org.

Governor Declares State Public Health Emergency due to Influenza

On January 11, Governor Cuomo declared a Public Health Emergency in response to this year’s influenza outbreak.

Executive Order No. 90 allows pharmacists to administer vaccinations against influenza to individuals age six months to 18 years. Pharmacists already can provide vaccinations to people 18 and older.

The Executive Order, at http://www.governor.ny.gov/executiveorder/90, suspends for thirty days the state education law provision that limits the authority of pharmacists to administer immunizing agents only to individuals age 18 or older.

According to the Governor's press release, 19,128 cases of influenza have been reported in New York this season, far more than the 4,404 positive laboratory tests reported all of last season. Additionally, as of January 5, the state Department of Health (DOH) received reports of 2,884 patients hospitalized with laboratory-confirmed influenza, compared to 1,169 total hospitalizations in 2011.

Providers are advised to check the Health Commerce System (HCS) daily for additional Health Advisories. An Advisory dated January 12 states that the state Health Commissioner is authorizing use of influenza vaccines containing more than the mercury levels described in public health law for pregnant women and children younger than three years, due to the severe influenza season and insufficient levels of vaccine. This authorization is in effect for the remainder of the influenza season.

An Advisory covered in last week’s ASAP directed providers to the Influenza Vaccine Availability Tracking System at http://www.preventinfluenza.org/ivats/ for resources on obtaining the vaccine.

MedPAC Outlines Home Health, Hospice Recommendations for Report to Congress

The Medicare Payment Advisory Commission (MedPAC) met late last week to review home health and hospice payments and to discuss its planned recommendations regarding payment updates in its soon-to-be released March Report to Congress.

Before making its determinations, commissioners first reviewed findings presented by MedPAC staff on access to care, quality of care, providers’ access to capital, and Medicare costs in both the home health and hospices sectors.

For home care, MedPAC staff reported the following:

- In 2011, the number of home health agencies exceeded 12,000 and home health expenditures totaled $18.4 billion, with 6.9 million episodes for 3.4 million Medicare beneficiaries;
- 99 percent of beneficiaries live in areas served by home health;
- The number of episodes of care increased by 65 percent from 2002 to 2010 (though it remained flat in 2010 to 2011);
- Agencies providing more therapy episodes had higher margins in 2012 and agencies with high shares of Medicare/Medicaid patients (in the top quartile) had lower margins than other agencies; and
- High rates of home health use are concentrated in a few states with an average of 35 to 39 episodes per 100 beneficiaries, versus a national average of 17 to 18; and

Unfortunately, MedPAC continued to base proposed payment cuts and its assertions about the financial health of home care agencies on a faulty analysis of home care operating margins. MedPAC’s analysis – which projects an 11.8 percent average home health operating margin nationally in 2013 – persists in excluding institution-based home care providers (whose margins trend substantially lower than non-hospital-based agencies) while utilizing weighted data which misrepresents the financial health of home health agencies nationally and, especially, in New York State, where the average Medicare operating margin has been negative for ten years in a row.

Based on the MedPAC staff report and discussion, the Commission opted to maintain the recommendations from 2011 and 2012 in MedPAC’s upcoming March Report to Congress, including recommendations to: begin a two-year rebasing of home health rates in 2013 and eliminate the market basket increase in 2012 – an impact of $5 billion to $10 billion over five years.

As part of our ongoing federal advocacy efforts, HCA will alert New York’s Congressional Delegation that such reductions, coupled with the prospect of 2-percent sequestration cuts, cannot be weathered by home care agencies in New York State whose average operating margins are negative, due to past payment cuts and unique circumstances in New York, with its high concentration of hospital-based agencies and volume of intensive service need, as reflected in the 10 to 11 percent of New York Medicare episodes involving outlier payments.

MedPAC also finalized its hospice recommendations which will include a zero market basket update for hospice payments beginning on October 1, 2013 – an estimated impact of $1 billion and $5 billion over five
years. MedPAC's hospice recommendations also will include many items that were first incorporated in its 2009 report. These include:

- Increasing payments per day at the beginning of the episode and reducing payments per day as the length of the episode increases;
- Providing an additional end-of-episode payment to reflect hospices' higher level of effort at the end of life;
- Implementing a budget neutral payment system in the first year; and
- Recommending focused medical review of hospices with many long-stay patients.

The staff presentation slides, which contain additional data about the Medicare hospice program, are at http://www.medpac.gov/transcripts/hospice_january2013_percent20public.pdf.


For additional information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.

**HCA Collaborates with DOH on Continuation of Hurricane Regulatory Relief**

HCA and representatives of the state Department of Health (DOH) collaborated this week on a potential extension of regulatory waivers and Executive Orders issued for provider flexibility and assistance in the wake of Hurricane Sandy.

HCA was contacted by DOH to assist in gathering field-level input on the continuing importance of the waivers and Orders, which expire in the coming week. HCA had originally worked closely with DOH during and after the storm’s impact to identify an array of areas in home care where regulatory flexibility would be necessary and helpful in support of the impacted providers and patients.

Canvassing a cross-section of members in the storm-impacted areas, HCA asked their perspectives and needs in relation to all of the specific waivers and requirements covered by the state and federal governments in Sandy’s aftermath. We asked for particular feedback on any or all of the specific waivers which providers felt should be highlighted to DOH for extension.

HCA was extremely encouraged to learn from our canvass that agencies’ functions have substantially returned to normal and that the heretofore waived regulatory and procedural provisions were being substantially met, though some areas were stressed in their need for extension, including: flexibility in the time requirements for receipt of written medical orders, flexibility in training, and hospice contracting flexibility.

In communicating this feedback to DOH, and urging extension of these and the other waiver areas, HCA also urged the addition of flexibility (via exemption code) in the 90-day time limit for Medicaid billing, flexibility in the 12-month Medicare billing limitation (although to date, the federal government has not been open to such extension) and clarification/extension of the training requirement flexibility to cover in-service as well as primary training.

Given the devastation of Sandy, including the displacement/disruption of patients, utilities, services, agency personnel, community services and agency physical plants and information systems, it is a testament to the home
care community that providers have regained their footing and their ability to be operationally compliant to this extent.

Ultimately, along with recommending these areas of emphasis, HCA recommended as a safety-net strategy the straight continuation of the entire packages of state and federal waivers and the Executive Orders. In this way, individual providers or cases that need and should rightfully have the continued consideration of the waiver flexibility for yet an additional period will be duly protected. HCA will immediately report to the membership on the outcome of this effort in terms of what DOH will ultimately request in terms of extension and what in the end is granted.

HCA greatly appreciates the outreach of the Department in this effort, the responses of HCA members, as well as the Department’s continuing engagement with HCA in assessing the needs and relief responses to home care providers in the aftermath of Hurricane Sandy. HCA is particularly grateful for the accessibility and assistance of DOH Home Care Division Director Rebecca Fuller Gray.

The complete listing of the original waivers can be found in the member alerts on HCA’s Emergency Preparedness Website at www.homecareprepare.org.

For further information, please contact Al Cardillo at acardillo@hcanys.org.

NGS Awarded J6 MAC Contract
Jurisdiction 6 protest dismissed

This week, National Government Services (NGS) announced that the Jurisdiction 6 (J6) Medicare Administrative Contract (MAC) award protests filed by Wisconsin Physician Services and Noridian Administrative Services have been dismissed by the Government Accountability Office (GAO).

The GAO decision means that NGS will maintain its Jurisdiction 6 MAC and continue to process Medicare claims and provide benefit administration.

CMS to Hold Special Forum on Future of the QIO Program

On Thursday, January 24, from 12:30 to 2 p.m., the U.S. Centers for Medicare and Medicaid Services (CMS) and Center for Clinical Standards and Quality (CCSQ) will host a special Open Door Forum on plans for redesigning the Quality Improvement Organization (QIO) Program in future years.

QIOs organize providers, practitioners, and patients to build and share knowledge, spread best practices, and achieve wide-scale improvements in patient care, increases in population health, and decreases in health care costs for all Americans.

In advance of the Forum, CMS will post discussion material to download at:


To participate, dial 1-800-837-1935 and enter conference ID: 90637068.


For additional information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.
related services for all Part A and Part B providers in three states and its home health and hospice workload in New York and 17 other precincts.

The contract includes a base year and four one-year option periods. If all options are exercised, CMS estimates that the contract will process and pay more than 477 million Medicare claims over the five-year period.

HCA looks forward to continuing our engagement and strong working relationship with NGS on reimbursement and other issues to assist our membership.

Other NGS news

NGS has posted the following news this week to its website.

- **Some Health Remittance Advices Incorrectly Showing Positive Reimbursements** – Since the January 2013 release, home health agencies may see cancelled claims (TOB 328 or 338) on the remittance advice for certain home health claims with a positive reimbursement amount instead of a negative amount. There will also be an adjustment to balance amount present to offset the overall payment. This may affect provider posting and account balancing. The issue has been sent to the Fiscal Intermediary Standard System (FISS) maintainer for review/resolution.

  HCA has heard from some Medicare certified members that have been affected. HCA will notify the membership as soon as NGS provides additional information regarding the resolution of this issue.

- **Hospice Clinical and Billing Scenarios Education Session** – On Thursday, January 24, from 1 to 2:30 p.m., NGS will host the first of a three-part series that will show clinicians and billers alike how their jobs go hand-in-hand. NGS staff will focus on the Medicare hospice coverage and billing rules by reviewing several real-life scenarios. For each scenario, NGS will discuss documentation and billing, starting with the patient admission and ending with the claim submission.

  HCA members can register via NGS’s website at [www.NGSMedicare.com](http://www.NGSMedicare.com) and clicking on “HHA.” At the Home Health Agency page, select the “Training Events Calendar” option under the Education and Training category (on the left hand side).

- **Reminder: NGS Closed on Martin Luther King, Jr. Day** – The NGS office will be closed on Monday, January 21, 2013, including: the Electronic Data Interchange (EDI) Help Desk, Provider Contact Center, Provider Enrollment Line, and Telephone Reopening Unit. The Interactive Voice Response (IVR) system will be available. Electronic claim files transmitted after 5 p.m. on Friday, January 18 through 4:59 p.m. on Tuesday, January 22, 2013 will have a receipt date of Tuesday, January 22, 2013 and produce electronic front-end edit reports.

*For additional information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.*
CMS Issues Rule on Health Coverage Under ACA

HCA members reminded to complete survey

This week, the U.S. Centers for Medicare and Medicaid Services (CMS) issued a proposed rule to implement many parts of the Affordable Care Act (ACA).

The provisions include:

- A coordinated Health Insurance Exchange and Medicaid appeals process;
- Procedures for the Exchange to verify access to employer-sponsored coverage and determine if the coverage meets certain affordability and minimum value standards;
- Notices that will include clear and accurate information about eligibility for all programs, including Medicaid, advance payments of the premium tax credit and cost-sharing reductions, and eligibility to enroll in a qualified health plan through the Exchange; and
- Streamlined eligibility categories for Medicaid and updated and simplified Medicaid premium and cost-sharing requirements.


NAHHC Survey

HCA members are also reminded to complete a survey, developed by our partners at the National Association for Home Care and Hospice (NAHC), to measure the effects of the “employer mandate” under ACA. The survey is open to all providers and will support NAHC and HCA’s advocacy efforts to eliminate or change the “employer mandate” penalty as it affects home care companies, starting in 2014, by quantifying its impact.

Under this “employer mandate” requirement, starting in 2014, “large” employers (more than 50 full-time equivalent employees) will face a penalty if they do not offer health insurance coverage to full-time employees (and their dependents) and one or more of their full-time employees obtains a premium tax credit or cost-sharing reduction through a state’s health insurance exchange. In 2014, the annual penalty will be equal to the number of full-time (not part-time) employees (minus the first 30) multiplied by $2,000.

In addition, large employers that offer health insurance can also face a penalty if the insurance is considered not “affordable” or does not provide “minimal value” and at least one full-time employee obtains a premium credit in an exchange plan. In 2014, the annual penalty assessed to these employers is the lesser of $3,000 for each full-time employee who obtains a premium credit in an exchange plan, or the total number of the firm’s full-time employees (minus 30) multiplied by $2,000.

Please complete the survey as soon as possible at [https://www.surveymonkey.com/s/ACAEmployerImpact](https://www.surveymonkey.com/s/ACAEmployerImpact), but no later than January 31.

For more information, contact Andrew Koski at akoski@hcany.org or (518) 810-0662.
CMS Announces New Sites for Care Transitions Program

HCA members participating

This week, the U.S. Centers for Medicare and Medicaid Services (CMS) announced 35 additional participants in the Community-based Care Transitions Program (CCTP), including HCA member Isabella Geriatric Center.

Two other HCA members, Visiting Nurse Service of Schenectady and Saratoga Counties and Eddy Visiting Nurse Association, were previously announced as participants in CCTP.

The 35 new sites will join the 47 organizations already participating in the CCTP, bringing the total number of sites to 82. These participants will work with local hospitals and other health care and social service providers to support Medicare patients who are at increased risk of being readmitted to the hospital while transitioning from hospital stays to their homes, a nursing home, or other care settings.

Three programs in New York were accepted in the current round, including HCA Member Isabella Geriatric Center, which will partner its Bridge to Home program with two health systems to coordinate a range of community resources with direct, evidence-based transition services for high-risk Medicare beneficiaries.

Two additional HCA members were announced earlier as partners in this initiative. They include:

- Visiting Nurse Service of Schenectady and Saratoga Counties (VNS). VNS will partner with six community-based organizations and eight acute-care hospitals to deliver care transition services in upstate New York. VNS will provide care transition services across a largely rural area to serve 5,500 Medicare beneficiaries annually. Participating hospitals include: Adirondack Medical Center, Alice

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**At Home Care, Inc.**

**Manager of Human Resources**

At Home Care, Inc. is a nationally recognized progressive home health care leader. To support significant growth in operations, AHC is recruiting for a (new) FT position Manager of Human Resources.

The successful candidate must have as minimum a bachelor’s degree in Human Resources, or related field, and a minimum of two years HR “generalist” experience within a progressive environment, preferably within a health care setting.

Interested applicants may apply in confidence:

Laurene Vosburgh, HR Coordinator

800-783-0613, 607-432-7634 or Email: lvosburgh@ahcnys.org

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**Bassett Healthcare Network**

**At Home Care**

[www.bassett.org/at-home-care](http://www.bassett.org/at-home-care)
Hyde Medical Center, Champlain Valley Physicians Hospital Medical Center, Ellis Hospital, Nathan Littauer Hospital, St. Mary’s Hospital at Amsterdam, Saratoga Hospital, and Glens Falls Hospital.

- **The Eddy Visiting Nurse Association** (under the Home Aide Service of Eastern New York, Inc.) will coordinate with four local Offices for the Aging, the Columbia Rural Health Consortium, and Greene County Long Term Care Council to expand care transition services in northeastern New York State. Partnering hospitals include: Albany Memorial Hospital, Samaritan Hospital, Columbia Memorial Hospital, St. Peter’s Hospital, and Seton Health.

New York home care providers have well-established expertise in care transitions. A study prepared and released this past fall by Simione Healthcare Consultants in partnership with HCA found that innovative care-transitions programs for a defined group of high-risk patients at just five of New York State’s Medicare-certified home health agencies saved **$1.2 million** in averted hospital expenses annually by reducing each agency’s 30-day readmission rate. More information about the study can be found in a press release on the press release page of HCA’s website at [http://www.hca-nys.org/pr.cfm](http://www.hca-nys.org/pr.cfm).

More information on the CCTP, including the participants announced this week, is available at: [http://go.cms.gov/caretransitions](http://go.cms.gov/caretransitions).

**CMS Releases January 2013 Quarterly OASIS Q&As**


CMS’s quarterly update contains 16 new Q&As on OASIS-C, including instructions related to:

- Compliance issues with medical record software products that select OASIS responses;
- Compliance with resumption of care timing when outpatient observation stays occur directly after inpatient admissions;
- Selecting a response to M1040 when a patient’s outcome episode overlaps more than one flu season;
- Selecting a response for availability of assistance for patients attending adult day care;
- Revised guidance related to M1300 when both clinical factors and standardized pressure ulcer assessment tools are used;
- Selecting a response when findings resulting from a multi-factor fall risk assessment and single factor standardized assessment don’t match; and
- Guidance on when/how to report best practice actions provided before the start-of-care date, and/or before the Comprehensive Assessment is completed.

*For additional information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.*
NY Receives Additional Funding for Health Exchange

The U.S. Department of Health and Human Services has announced that New York and other states have received funding to initially establish or further bolster efforts to establish health insurance marketplaces known as exchanges.

Under the Affordable Care Act (ACA), consumers and small businesses will have access to marketplaces starting in 2014 where they can purchase health insurance from “qualified health plans.”

New York is receiving a Level Two Establishment Grant of $185.8 million that will be used to support outreach and marketing, training and certification, and stakeholder engagement activities.

New York has already received Level One Establishment Grants of over $150 million for the development of its Health Insurance Exchange.


Health Care Resources

Publications

- “Tools for Choosing a Medicaid Managed Long Term Care Plan,” by the Evelyn Frank Legal Resources Program at Selfhelp Community Services
  http://www.wnylc.com/health/entry/169/

- “Compliance Guidelines Program,” Transmittal by the U.S. Centers for Medicare and Medicaid Services

- “A Bridge to Health,” by the Medicare Rights Center

- “Medicaid Third-Party Liability Savings Increased, But Challenges Remain,” by the Government Accountability Office

For more information, contact Andrew Koski at akoski@hcanys.org or (518) 810-0662.
A Report on the Fiscal Health of Home Care in New York State

Provider survey and analysis of the most up-to-date cost-report data show that plunging negative margins, coupled with a lack of transition support, jeopardize provider efforts to participate in new long term care environment.
A Report on the Fiscal Health of Home Care in New York State

Key Findings

- **Home care provider margins plunge further into the red, threatening viability.** The percentage of home care providers with negative operating margins increased by an alarming 22% between 2010 and 2011, the most recent year of data available. In 2011, 79% of surveyed home care providers had negative operating margins.

- **CHHA operating margins drive deeper into the red.** The median operating margin of surveyed Certified Home Health Agencies (CHHAs) was -13.94% in 2011, a precipitous drop from 2010 when the median operating margin was -0.31% for survey respondents.

- **LTHHCPs face a unique threat to their financial and programmatic viability.** The median operating margin of surveyed Long Term Home Health Care Programs (LTHHCPs) was -11.47% in 2011. Between 2009 and 2010, total operating losses for all LTHHCPs increased from -$21.2 million to -$38 million, a 79% increase in operating losses.

- **Wide variances in contract rates and a lack of transition support are further jeopardizing provider sustainability even as home care agencies work to meet the state’s mandatory managed care enrollment policy.** HCA’s survey finds that the vast majority of home care providers are working in good faith to establish contract partnerships with Managed Long Term Care (MLTC) plans and Managed Care Organizations (MCOs). Yet in 2011, when the Medicaid fee-for-service (FFS) rate has historically proven inadequate, two-thirds of survey respondents indicated they are receiving MLTC and MCO rates well below the already insufficient FFS rates. For those providers who receive rates below FFS, their MLTC rates are on average 8% below FFS and their MCO rates are on average 20% below FFS, further compromising the fiscal stability of home care providers, 79% of whom are already operating in the red under FFS. These results speak to the need for adequate payments to providers as well as adequate premium payments to plans for the provision of home care services. Meanwhile, when asked which supports are needed to contract with MLTCs/MCOs, “stronger continuity-of-service/transition policies” ranked second only to concerns about adequate payment.

Why These Findings Matter

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

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

Executive Summary

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

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

Continued on next page
Executive Summary - continued

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

In the case of surveyed CHHAs, median operating margins dropped from +0.3% in 2009 to -0.31% in 2010 and then dove to -13.84% in 2011.

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

Meanwhile, variances in negotiated contract rates and a lack of transition support continue to jeopardize the standing of providers in their efforts to meet state-initiated changes in the long term care system – changes that home care providers are striving to meet in good faith. These findings make clear the need for more adequate FFS payments to providers as well as premium payments to plans for the provision of home care services.

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

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

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

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

Background on HCA’s Data and Survey Analysis Methods

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

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

Continued on next page
Background - continued

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

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

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

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

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

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

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

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

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

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

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

For home care providers, this policy means that many agencies (including those with long-established care-management experience and well-established roots in the community) will increasingly expect to operate in a subcontracting role, providing services to this patient population under contract with MLTCs or MCOs rather than directly functioning as the care managers for these patients and the Medicaid program.

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

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

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

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

Starting on the next page is a summary of four key findings from HCA’s cost report and survey analysis overall.
Finding 1: Home Care Provider Margins Plunge Further into the Red, Threatening Viability

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

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

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

These and other findings are detailed below.

Operating Margins

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

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

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

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<td>All CHHAs statewide</td>
<td>-1.71%</td>
<td>-1.81%</td>
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<tr>
<td>All LTHHCPs statewide</td>
<td>-8.1%</td>
<td>-8.77%</td>
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<td>CHHAs that completed HCA survey</td>
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<td>+0.3%</td>
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<td>LTHHCPs that completed HCA Survey</td>
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<td>% of providers with negative</td>
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<td>operating margins</td>
<td>63%</td>
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While 63% of CHHAs and LTHHCPs had negative operating margins in 2009 and 65% had negative operating margins in 2010, 79% of survey respondents had negative operating margins in 2011 – a sharp increase during a year of unprecedented budget cuts and policy changes.

The number of all CHHAs and LTHHCPs experiencing operating losses greater than $500,000 increased 18% from 2009 to 2010.

**Revenue and Cost Impacts**

According to HCA’s survey results, the top three factors having the “largest impact” on an agency’s rising costs were: wages (66% of providers ranked it as “largest impact”); benefits (52%) and unfunded mandates (40%).

Eighty-five percent of providers reported an increase in administrative costs due to state and federal audits alone.

In response to the Wage Parity Law, in particular, 57% of providers have laid-off non-direct-care staff, 50% have stopped accepting cases where the contractor rate is inadequate to meet the costs of the unfunded mandate, 36% have reduced hours and overtime of direct-care staff and 7% of providers have laid off direct-care staff.

Over the past two years, almost half of respondents had to use a line of credit or borrow money to meet expenses.
Finding 2: CHHA Operating Margins Driven Deeper into the Red

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

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

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

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

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

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

HCA’s findings are detailed below.

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

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

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

Continued on next page
Finding 4 - continued

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

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

These and other findings are detailed below.

• Providers are working to pursue contracts with MLTCs/MCOs. When asked “Have you, or are you planning to, contract with an MLTC/MCO to provide home care services?” almost 90% of providers answered “Yes”.

• Yet, a state policy of chronic Medicaid under-payment and unclear transition guidelines nevertheless puts home care providers at risk even in cases where they are able to contract for services. Two-thirds of survey respondents indicated they are receiving MLTC and MCO rates below a FFS rate that is already inadequate; in many cases, the variance in contracted rates is substantial and inconsistent. For those rates below FFS Medicaid – under which nearly 80% of providers are operating in the red in 2011 – the MLTC rate is on average 8% below FFS Medicaid and the MCO rate is on average 20% below FFS Medicaid, with one respondent experiencing a rate difference as high as 50% below FFS.

• Overall, the transition to mandatory enrollment has affected agency finances at a time when the vast majority of providers were already operating at a loss: While most providers ranked “payment cuts/reimbursement changes” as the number 1 reason for a recent decrease in Medicaid revenues, “transition to managed care” ranked as the number 2 reason affecting most providers’ Medicaid revenues.

• When asked which transition supports are needed to make it possible for providers to contract with an MLTC/MCO, the need for payment adequacy was rated highest by respondents, followed by “stronger continuity-of-service/transition policies” and then “staff retraining funds or support.”
Conclusion

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

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

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