

Public Policy

HCA Public Policy No.4-2011



TO: HCA PROVIDER MEMBERS

FROM: HCA POLICY

RE: PRELIMINARY SUMMARY OF GOVERNOR CUOMO'S 30-DAY AMENDMENTS

DATE: MARCH 8, 2011

On March 3, Governor Cuomo submitted his 30-day amendments to the proposed 2011-12 Executive Budget. The amendments incorporate final recommendations of the Medicaid Redesign Team (MRT) along with several other sweeping changes that are stunning in their reach, amounting, in total, to an unprecedented and disproportionate \$1 billion impact on home care. If enacted, this budget package would effectively shut down entire segments of the existing home care infrastructure, jeopardizing the availability of home care services for New York's frail elderly, chronically ill and disabled residents.

During the past several months, HCA has actively and repeatedly engaged with the Cuomo Administration, the MRT, and the Legislature to press for the incorporation of HCA's reform and efficiency ideas – which offer hundreds of millions of dollars in responsible, policy-based reform savings – as outlined in HCA's *Blueprint for Home Care Reform and Efficiency*. As earlier reported to the membership, neither HCA nor any other statewide representative of long term care was on the MRT and HCA's reform and efficiency ideas were largely bypassed in the Executive's process of vetting Medicaid proposals for consideration by the panel.

With the recent issuance of Governor Cuomo's 30-day amendments, HCA's advocacy now focuses on the Legislature and its constitutionally defined role in the process of shaping, amending and responding to the Governor's plan. HCA will continue to maintain an aggressive campaign of legislative and public outreach against the MRT's \$1 billion impact on home care as we have done most recently with our February 28 State Advocacy Day, through HCA's ongoing outreach efforts to statewide media, in our individual meetings with key lawmakers and legislative leaders, and in HCA's delivery of legislative testimony during a joint hearing of the Senate Finance and Assembly Ways and Means Committees late last week.

The far-reaching threat to home care in this budget package includes three main target areas: 1) direct home care cuts; 2) unprecedented home care wage mandates and state interference in home care contractual agreements; and 3) elimination of New York's existing care-management models through the forcible enrollment of patients into managed care. HCA stresses that **any one of these three proposals alone would decimate New York's home care system**; in combination, these proposals are a lethal blow to a system that is already financially imperiled by past cuts, unfunded mandates and chronic underfunding, as chronicled in the *Vital Signs* fiscal condition report that HCA recently prepared in collaboration with the New York Association of Homes & Services for the Aging (NYAHSAs).

HCA's continuing efforts to scale back the Governor's budget proposals for home care will not succeed without a vocal, relentless voice of opposition from the membership. HCA members must actively engage with their State Assembly and Senate representatives to seek elimination of the budget's harmful and potentially devastating home care provisions, focusing your message on the three main areas of threat: direct cuts, unfunded wage mandates, and forcible enrollment of vulnerable patients into managed care.

Your advocacy is especially critical given the constrained timeline for action, as **the Legislature faces increasing pressure to vote on the Governor's package in a matter of weeks**, providing little time for deliberation, especially in the advent of eleventh-hour changes, funneled through the Governor's 30-day amendments, which have enormous consequences for providers, including unprecedented "pre-claim review" program-integrity measures and provisions dictating home care contractual relationships.

What follows is a preliminary overview and analysis of the proposals in Governor Cuomo's amended budget. In the coming days, HCA will seek further clarification on these provisions and respond accordingly with any related advocacy or notification to the membership. Please stay tuned for additional updates on HCA advocacy activities and action items during this absolutely critical time in the budget process.

Reimbursement Cuts and Actions

The Governor's amended budget includes the following reimbursement cuts and actions and related fiscal impacts for home care:

- Trend factor elimination – Discontinues the trend factor for Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPS), Personal Care programs, hospitals, nursing homes, outpatient services and diagnostic and treatment centers (home care impact: \$26.5 million state share and \$53 million state and federal shares).
- Two percent payment cut – Applies a two percent across-the-board reduction in nearly all Medicaid payments (home care impact: \$57.8 million state share and \$115.6 million state and federal shares).
- CHHA patient expenditure caps – Establishes patient specific annual expenditure caps for each CHHA's payments at the 2009 level, weighted by case mix and a wage index, for the period April 1, 2011 through March 31, 2012 (home care impact: \$100 million in state share and \$200 million in state and federal shares).

The provider specific caps would reduce home care reimbursement and utilization to a provider's average claims per patient during the 2009 base period. (The use of 2009 rates to set the caps would set providers back to 2007 costs since CHHA rates are established using rates which are already two years old.) The provider-specific caps would be calculated using a to-be-determined weighted combination of the provider-specific average total paid Medicaid claims per patient during the 2009 base period and the statewide average for all CHHAs during the same period. DOH would also apply an agency-specific case mix factor as well as a regional wage index factor.

In determining case mix, each patient shall be classified using a system based on measures which may include, but are not limited to, clinical and functional measures, as reported on the Outcome and Assessment Information Set (OASIS).

The state Department of Health (DOH) will then compare each provider's per patient spending cap to actual Medicaid paid claims for the period April 1, 2011 through March 31, 2012. In those instances when an

agency's per patient Medicaid claims are determined to exceed the agency's adjusted cap, such excess will be recouped by DOH in either a lump sum amount or through reductions in the Medicaid payments due to the agency. In instances when an agency's per patient Medicaid claims are determined to be less than the agency's adjusted cap, the amount by which such Medicaid claims are less than the agency adjusted cap will be paid back to the agency in either a lump sum or through an increase in Medicaid payments.

- CHHA Episodic Pricing – Implements a Medicaid episodic pricing methodology for CHHAs (excluding children under 18 years of age and other discrete groups as may be determined by the DOH Commissioner), based upon 60-day episodes of care, effective April 1, 2012 (home care impact: \$70 million state share and \$140 million state and federal shares).

A statewide base price would be established, based on paid 2009 Medicaid claims data, and this price would be adjusted for case mix and differences in regional labor costs. CHHA patients under the age of 18, low utilization claims (under \$500/less than 25 hours of care in a 60-day period) and other discrete groups, as may be determined by DOH, would continue to be paid under fee-for-service.

- Global cap – Imposes a global cap on Medicaid (estimated at four percent for this fiscal year) with unbridled Executive authority for further cuts and changes; caps annual State Medicaid expenditure growth to a ten-year rolling average of the medical component of the consumer price index, published by the United States Department of Labor, Bureau of Labor Statistics. The DOH Commissioner is authorized to reduce Medicaid disbursements through further rate cuts, programmatic changes or Medicaid benefit changes if Medicaid expenditures are expected to exceed the cap level. **Note:** Though the Executive has provided no impact estimate for this global cap, it should be noted that the 30-day amendments leave an estimated \$640 million gap (between the total \$1.67 billion in Medicaid savings that the MRT package enumerates and the Governor's revised reduction target of \$2.3 billion) to be either voluntarily made up by the health care industry ("Voluntary Health Care Industry Cost Containment Initiative") or unilaterally determined by DOH. It is presumed that this \$640 million gap reflects the expected savings across all sectors resulting from the global spending cap.
- Elimination of case-mix adjustment for HIV/AIDS nursing rate – Eliminates the case-mix adjustment in the HIV/AIDS nursing rate for home care services provided by a CHHA or a LTHHCP to individuals diagnosed with acquired immune deficiency syndrome (home care impact: \$2.01 million state share and \$4.02 million state and federal shares).

HCA will continue to argue that these direct cuts are devastating enough to New York's home care system in an environment where 70 percent of home care providers are already operating in the red, due to past budget cuts and unfunded mandates, according to HCA and NYAHSAs financial analysis. Our findings are based on a review of home care Medicaid cost reports for 2008, the most recent year available. Yet home care providers have been hit with \$434 million in state and federal share cuts since 2008, meaning that the devastation of nearly half-a-billion cuts enacted since that time, as well as the new onslaught of direct-cut reductions under the MRT proposal, will debilitate New York's home care system.

Living Wage Mandates

The Governor's amended budget includes the following home care living wage mandates:

- Mandates a three-year phase-in of home care worker wages based on any local living wage laws or local collective bargaining agreements covering home care workers, and provides that the Commissioner of Health

may further increase mandated pay rates; the budget further mandates attestation, agency enforcement and other requirements associated with the wage mandate.

- The three-year phase-in will require home health providers, including CHHAs, LTHHCPs and Licensed Home Care Services Agencies (LHCSAs) to begin paying 90 percent of the total compensation mandated by the living wage law of the municipal government or local collective bargaining agreements covering home care workers effective March 1, 2012 through February 28, 2013. Effective March 1, 2013 through February 28, 2014, home health providers must pay 95 percent of the total compensation mandated by the local living wage law and by March 1, 2014, providers must begin paying 100 percent.
- CHHAs, LTHHCP and managed care plans will be required to sign a written certification to DOH (on forms prepared by DOH) attesting that they are in full compliance with this new requirement. CHHAs, LTHHCP and managed care plans that provide home health aide services through contracts with LHCSAs or through third parties will be required to obtain a written certification (prepared by DOH) from the LHCSA attesting that the LHCSA is in full compliance with this requirement.
- DOH will also be required to distribute to all CHHAs, LTHHCPs and managed care plans official notice of the new minimum rates of home health aide compensation at least 120 days prior to the effective date of each minimum rate for each social service district covered by this proposal.

While HCA supports a payment system that provides for adequate reimbursement for the cost of delivering services and compensating direct care personnel, this proposal would unfairly link providers to local wage laws without the state being simultaneously required to reflect Medicaid payment increases that would fully fund the increases required by these laws. An unprecedented form of state wage control for a single class of workers, these proposals would also add significant costs to the health care system in the context of a MRT process ostensibly aimed at lowering costs.

Though the Governor and DOH have not provided any provider cost impact estimates related to this new proposal, an analysis done last year by HCA's allied home care organization, the New York State Association of Health Care Providers (HCP), **estimated a potential cost impact of \$418 million for home care and managed care in the 2011-12 state fiscal year.**

Mandatory Managed Care and other Managed Care Provisions

The Governor's amended budget includes the following managed care provisions:

Enrollment and Covered Services

- Mandates enrollment in managed long term care (MLTC) or "other care coordination program specified by the commissioner" for individuals age 21 and older who need community-based long term care services for more than 120 days. HCA is continuing to request specification in the legislation that "other care coordination programs" equally include LTHHCPs and CHHAs. Without such specification, LTHHCP and CHHA chronic care management models would no longer independently exist and LTHHCP/CHHA chronic care patients would be forced to transfer to managed care – the same being the case for Personal Care and Consumer Directed Personal Assistance Program patients (home care impact: \$8.3 million state share and \$16.6 million state and federal shares). This provision is effective 180 days after enactment of the budget.

- Requires MTLC enrollment applications to be processed by DOH or its designee and not by the local departments of social services.
- Eliminates the current restriction on health maintenance organizations (HMOs) or Medicaid managed care plans from receiving Medicaid capitated payments for nursing facility, home care or other long term care services. This provision would allow any HMO to provide home care/long term care services.
- Mandates or allows broader Medicaid managed care enrollment by eliminating various current exemptions and exclusions of populations from Medicaid managed care enrollment and authorizing automatic enrollment in managed care if a plan is not chosen by a recipient required to enroll. Some groups that **may** be required to enroll in managed care include LTHHCP patients; persons with a developmental or physical disability who receive home and community-based services or care-at-home services through existing 1915(c) waivers or who have characteristics and needs similar to such individuals; and nursing home residents.

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Contract Restrictions

- Requires that managed care plans may *only* cover home care services if delivered under contract to providers that have been expressly approved by DOH or its designee to provide home care services to managed care beneficiaries in the social services district where the beneficiary resides. This would apply to all beneficiaries **newly** enrolling in managed care plans in New York City on or after April 1, 2012; **all** beneficiaries enrolled in managed care plans in New York City on or after April 1, 2014; and for all beneficiaries mandated to enroll in managed care plans. The requirement would apply to all beneficiaries whose managed care is financed, in whole or in part, by the Medicaid program.
- Mandates that approval for eligibility to provide home care services to managed care beneficiaries must take the form of a certified provider agreement between the provider of home care services and DOH or its designee, specifying the terms of the provider's eligibility to provide home care services to managed care beneficiaries, its rights and obligations in relation to the managed care plan authorizing such services, and any contingencies necessary to ensure that the provider of home care services delivers satisfactory performance throughout the duration of the agreement. DOH or its designee would have responsibility for overseeing all approved agencies' compliance with the terms and conditions of their provider agreements on an ongoing basis.
- Further provides that no provider agreement would be valid for periods greater than three years, with no limit placed on the number of times a provider may be reapproved for eligibility to serve managed care beneficiaries. DOH or its designee would have the right to revoke any approval to provide home care services to managed care beneficiaries at any time in instances where the approved agency has been in material non-compliance with the terms of the certified provider agreement.
- Stipulates that no provider of home care services will be approved to serve managed care beneficiaries unless the home care provider meets at least one of the following minimum criteria:
 - The provider, or an affiliate of the provider, has an established record of providing home care services to the Medicaid personal care program and under contract with the Human Resources Administration (HRA) in New York City;
 - The provider is affiliated with an LTHHCP or MLTC; or

- The provider or its affiliate has an exceptional prior record of investing in the quality and sustainability of the long term care work force, including, but not limited to, the provision of training through a DOH approved training program and the provision of health and education benefits to employees.
- Allows all providers of home care services to the Medicaid personal care program under contract with HRA as of January 1, 2011 to be approved for subcontracting with managed care plans in New York City through March 31, 2015 unless there are “material instances of non-compliance with program requirements.”
- Prohibits a provider from being approved to provide home care services to managed care beneficiaries unless it compensates all its home care employees in compliance with the provisions of the proposed new wage mandate.
- Mandates that no provider may be approved for the New York City social services district unless the total dollar value of all employee compensation paid by the provider to its home care employees who were employees in the Medicaid personal care program as of January 1, 2011 is inclusive of wages, benefits, payments in lieu of benefits, and paid time off, calculated on an average hourly basis, and is no less than the most common prevailing level of total compensation paid to employees by agencies providing Medicaid personal care program services under contract with HRA as of January 1, 2011.

Personal Care Program

The amended budget includes the following Personal Care Program changes:

- Requires the Commissioner of Health to adopt standards for the provision and management of personal care services for individuals whose personal care needs exceed a specified level to be determined by the Commissioner.
- Requires personal care recipients to enroll in managed care and authorizes the Commissioner to provide assistance to persons receiving personal care who are transitioning to receiving care from an MLTC plan.
- Restricts personal care services from exceeding eight hours per week for individuals whose needs are limited to nutritional and environmental support functions (Personal Care Level I).

Program Integrity Measures

- Mandates a “preclaim review” of Medicaid claims for every CHHA, LTHHCP and Personal Care provider with total Medicaid reimbursements exceeding \$15 million annually, requiring review and verification by a “verification organization” prior to submission of a claim. The verification organization will have to declare each service or item to be verified or unverified, and each participating provider would receive and maintain reports from the verification organization containing data on: verified services or items, including whether a service appeared on a conflict or exception report before verification and how that conflict or exception was resolved, as well as services or items that were not verified, including conflict and exception report data for these services (home care impact: estimated at \$45 million state share and \$90 million state and federal shares).

Other Service Models or Programs

- Authorizes the DOH Commissioner to establish a multipayor Patient Centered Medical Home program that provides enhanced payments to certified medical homes for the purpose of improving health care outcomes and efficiencies in the provision of services to certain Medicaid enrollees; encourages collaborative and integrative arrangements among payors; and authorizes the Commissioner to contract with one or more entities to assist the state in planning and implementing the medical home program.
- Authorizes the DOH Commissioner to establish: (i) standards for the provision of health home services to Medicaid enrollees with chronic conditions; (ii) payment methodologies for health homes; and (iii) criteria under which a Medicaid enrollee will be designated for this program.
- Provides for state action immunity under the state and federal antitrust laws with respect to activities undertaken by health care providers and others to collaborate and integrate care under a new public health law article called “Improved Integration of Health Care and Financing.” This is intended to encourage cooperative, collaborative and integrative arrangements, under the active supervision of the DOH Commissioner, between health care providers, payors and others who might otherwise be competitors.
- Authorizes the DOH Commissioner to seek federal approvals to establish payment methodologies for accountable care organizations and establish regulations related to quality standards and reimbursement.
- Establishes the Public Health Services Corps (PHSC) to support non-physician health professionals dedicated to delivering public health and health care services to underserved communities outside their regularly scheduled employment. PHSC participants will be non-physician clinical service providers, including mental health specialists, dentists and dental hygienists, nurse practitioners and physician assistants, dietitians, public health nurses and other registered nurses, licensed practical nurses, epidemiologists, public health educators and graduate students in public health who want to provide service to state and local health departments via an internship.

PHSC participants may receive up to fifteen thousand dollars annually on an individual basis to provide clinical, health promotion and disease prevention investigation, analysis and services to medically indigent populations and communities in New York State, and shall provide up to three hundred hours of services in existing venues such as hospitals, free-standing clinics, county health departments, schools, nursing homes, town halls and any other venue in a rural or inner-city area.

Medicaid Eligibility and Coverage Changes

- Eliminates the right of spousal or parental refusal under which one spouse or parent refuses or fails to make his or her income and resources available to the person applying for Medicaid. The change requires the spouse or parent to both refuse/fail and be absent from the home (\$28.3 million state share and \$56.6 million state and federal shares).
- Expands the definition of “estate” to include assets that normally bypass probate so that additional monies can be recovered from assets.

- Establishes a housing “disregard” for individuals who enroll in a MLTC after leaving a nursing home. Under this change, a certain portion of the housing expenses would be deducted from an individual’s income in determining Medicaid eligibility. HCA believes and has advocated in the past that a housing disregard should be available to all home care patients.
- Limits the Medicaid co-insurance amount for Medicare-covered Part B services when the total co-insurance amount would exceed the Medicaid rate.
- Eliminates Medicaid coverage of certain drugs if not on the Medicare Part D formulary, including atypical anti-psychotics, anti-depressants, anti-retrovirals used in the treatment of HIV/AIDS, or anti-rejection drugs used for the treatment of organ and tissue transplants.
- Increases the Medicaid co-payment amounts charged for certain services, includes additional services subject to co-payments and increases the limit (from \$200 to \$300) on the amount that Medicaid recipients can be charged for all copayments in a given year.

Other Changes

- Mandates that home care agencies, hospitals, nursing homes and other providers establish policies and procedures to provide access to information and counseling regarding palliative care and pain management options to patients with advanced life limiting conditions and illnesses. Policies must include provisions for providing information to persons legally authorized to make medical decisions on behalf of patients who lack capacity to make medical decisions. Providers are also required to facilitate access to appropriate palliative care and pain management consultations consistent with a patient’s needs and preferences.
- Increases the tax credit from 20 to 40 percent of the premiums paid by those who purchase long term care insurance policies.
- Reduces the required period of nursing home coverage from three to two years for individuals who exhaust their long term care insurance policies under the New York State Partnership for Long Term Care and can qualify for Medicaid coverage with any amount of assets.

HCA will continue to analyze the budget language, seek clarification where needed, and inform the membership of any updates in our analysis. In the meantime, **we need every member to be aggressively engaged in all-out advocacy to press the Legislature for a scale back of this disproportionate assault on home care and to pursue more responsible reform measures during the Legislature’s negotiations with the Governor.** As budget talks continue to take shape in the coming weeks, HCA will likewise strenuously advance our advocacy arguments and alternative legislative language to: mitigate the proposed rate and reimbursement reductions; maintain existing provider-based models within the state’s care-management infrastructure and stem the potential collapse of CHHA and LTHHCP care-management models; and overturn the Executive’s unprecedented intrusion of home care wage mandates and interference in home care contractual arrangements.

For more information, contact HCA Policy staff.