2016-17 Health/Medicaid Testimony

Provided by

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Introduction

On behalf of the membership of LeadingAge New York, thank you for the opportunity to testify on the health and Medicaid aspects of the SFY 2016-17 Executive Budget. LeadingAge NY represents over 400 not-for-profit and public providers of long term and post-acute care (LTPAC), aging services and senior housing, as well as provider-sponsored managed long term care (MLTC) plans. This testimony addresses the Executive Budget proposals that apply across the continuum of LTPAC, aging and MLTC services, as well as those that would affect specific types of providers and managed care plans.

The Governor's Budget proposes ambitious investments in transportation infrastructure, housing for homeless New Yorkers, and minimum wage and family leave protections. However, in the face of a soaring population of seniors with growing needs for health care, supportive services and affordable housing, the Budget fails to provide additional financial support for LTPAC, aging services, or senior housing. On the contrary, it imposes new costs and new cuts on our LTPAC and senior services delivery system. These cuts are on top of hundreds of millions of dollars in funding reductions from new and continuing LTPAC cuts over the past three years as well as new fiscal and operational pressures occasioned by upheaval in Medicaid reimbursement methodologies, home care wage mandates and the implementation of mandatory managed care enrollment for Medicaid beneficiaries receiving long term care services. As an example, other than capital cost updates, nursing home rates have had no inflation adjustment since 2007.

The Governor and the Department of Health have laid out a compelling vision for reforming health care in New York, in which care management, prevention and high quality care lead to improved outcomes and reductions in avoidable hospitalizations at a lower overall cost. To achieve this vision, the Department, with federal support, is investing $6.42 billion over five years in the health care delivery system through its Delivery System Reform Incentive Payment Program (DSRIP). Providers across the continuum of care and managed care plans are directed to create collaborations in which they share clinical information electronically and enter into value-based payment arrangements with shared risk.

LTPAC and senior services providers are expected to participate in this health care transformation, implementing innovative models of care and payment and developing the physical, technical and administrative infrastructure to do so. However, neither the State nor the federal government has made available the funding necessary to develop this infrastructure in the LTPAC and senior services sector. As described more fully below, while billions of dollars in public monies are being spent on delivery system reform and the health information technology necessary to enable it, only a minuscule portion is flowing to the LTPAC and senior services sector. The overwhelming majority of public funds has been dedicated to hospitals and physician practices. Further, although the State's policies assume that people with complex health and long-term care needs can be served in community-based settings, it has invested very little money in affordable senior housing with supportive services tailored to the unique needs of seniors.

Given this lack of support for services and housing for seniors, we are concerned about the State's readiness to address the needs of aging Baby Boomers, who will make up 18 percent of the State's population and will be entering their eighties by 2025.[1] As the State pushes providers to adapt to new

[1] NYS Office for the Aging, County Data Book, New York State, Table 1, Demographics, http://www.aging.ny.gov/ReportsAndData/2015CountyDataBooks/01NYS.pdf, accessed Dec. 13, 2015.

payment arrangements and models of care, it must recognize the important role played by aging service providers that furnish long term and post-acute care and social supports to high-risk populations. Investment in these services is essential to the success of efforts to reduce avoidable hospitalizations and ensure better health and better care at a lower overall cost.

I) Cross-Continuum Initiatives

a) Meeting LTPAC Infrastructure Needs

LTPAC providers are in dire need of infrastructure funding to upgrade aging physical plants, rightsize/restructure existing services, add new services, deploy electronic health records and engage in health information exchange, and adopt telehealth and data and analytics platforms, in order to be able to meaningfully participate in DSRIP, managed care initiatives and value-based payment. In spite of these compelling needs, LTPAC providers have not received State financial support for the critical infrastructure necessary to survive in today's changing delivery system. Funding opportunities available through State grants, DSRIP and federal meaningful use incentives have overwhelmingly been aimed at acute and primary care providers and sometimes explicitly exclude LTPAC providers.

For example, we appreciated the Legislature's inclusion of residential health care facilities in the Essential Health Care Provider grant program adopted as part of last year's budget. Unfortunately, the Department of Health interpreted that program to be limited to hospitals and hospital-based nursing homes. While the vast majority of nursing homes were excluded from the Essential Health Care Provider grants because they are *not* hospitals, they were also excluded from the Nonprofit Infrastructure Capital Improvement Grant program (also enacted in last year's budget) because they *are* "hospitals" under Article 28 of the Public Health Law. It seems that LTPAC providers can be caught in a "no man's land" when it comes to eligibility for State funding.

This year's Executive Budget would partially re-program capital funding appropriated last year to support health care facility transformation. Up to $200 million of the funding that had been targeted to Oneida County health care transformation would be re-directed to provide capital grants to general hospitals, nursing homes, diagnostic and treatment centers and clinics, primary care providers and home care agencies "…to replace inefficient and outdated facilities as part of a merger, consolidation, acquisition or other corporate restructuring to create a sustainable system of care." While we are pleased that nursing homes and home care agencies would be eligible to apply for these capital grants, past experience has shown that LTPAC providers (including nursing homes, home care agencies and assisted living providers) will see only a token amount of these funds.

Our review of the DSRIP performing provider system (PPS) spending plans shows that only approximately 9 percent of their incentive payments is projected to trickle down to nursing homes, hospice programs and community-based organizations.[2] Similarly, despite the clear need for sophisticated health IT in today's health care environment, only a tiny fraction of State HEAL funds dedicated to health information technology has been invested in the LTPAC sector. Of approximately

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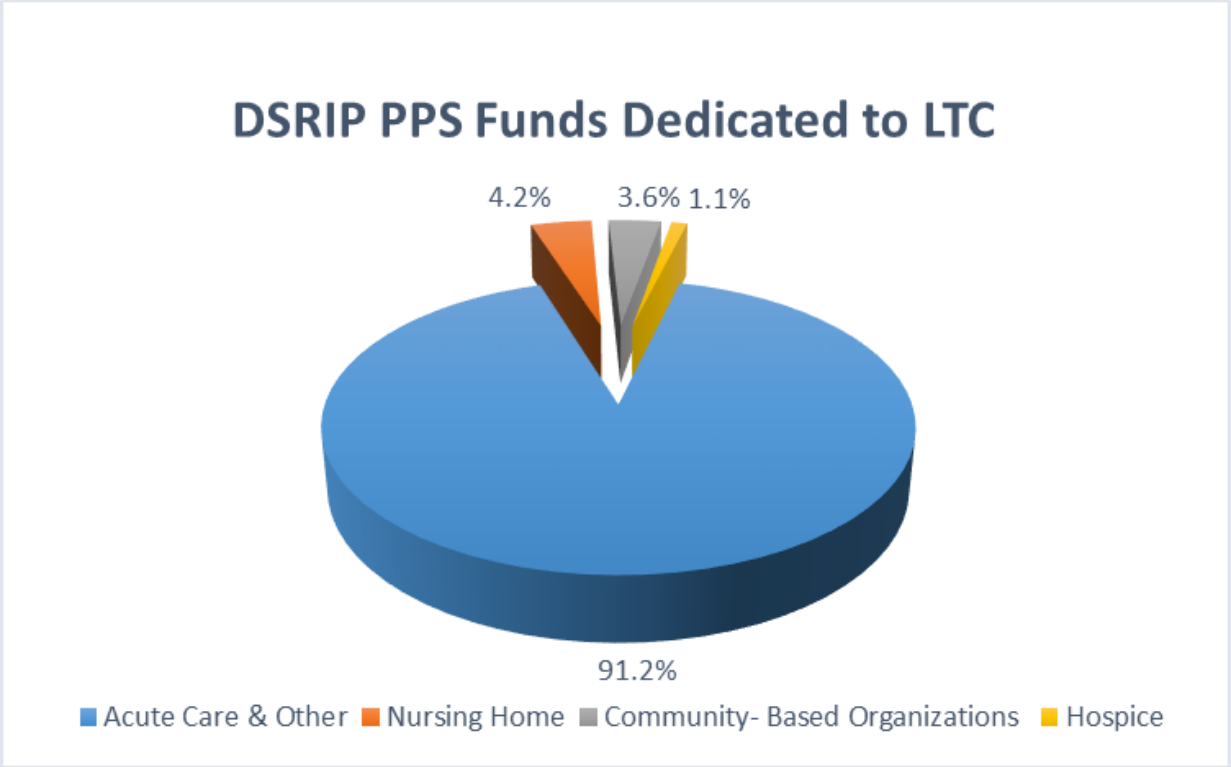
[2] We assume that home care agencies and Medicaid Assisted Living Programs would be included within the "community-based organization" category, as there is no other spending plan category that appears to include these providers.

$324 million invested in health information technology (health IT) through HEAL New York Phases 1, 5, 10 and 17, only approximately $6 million (less than 2 percent) was awarded to projects targeting LTPAC providers.[3] While some large HEAL awardees included a handful of LTPAC providers among their partners, the overwhelming majority of the funds flowed to regional health information organizations (RHIOs), hospitals, and physician practices or clinics.[4]



Recommendation: *The State should allocate $100 million in funding specifically dedicated to LTPAC infrastructure including health IT and health information exchange, telehealth technologies, and a nursing home redevelopment program aimed at upgrading the State's aging infrastructure and improving quality of life for residents.*

b) Vital Access Provider (VAP) Program

The VAP program is a key source of funding for health care organizations undergoing transformation to adjust to the State's new health care environment and to meet the changing needs of their communities. This funding is a lifeline for certain nursing homes, home care agencies, hospitals and clinics.

The proposed Budget includes an appropriation of $212 million for the VAP program; much of which appears to be devoted to financially-distressed, safety net hospitals. In 2013, funding from the Financially Disadvantaged Nursing Home program, which provided $30 million annually to vulnerable nursing homes, was transferred into the VAP program. This funding was essential to many homes, and

[3] LeadingAge New York analysis of HEAL Phases 1, 5, 10 and 17 awards.

[4] HEAL New York Phase 22 was dedicated to behavioral health providers participating in health homes. Although the list of HEAL 22 awardees does not appear to be available on the Department's website, we understand that it did not benefit the LTPAC sector.

the transfer was made contingent on a minimum of $30 million in VAP funding being earmarked for nursing homes annually.

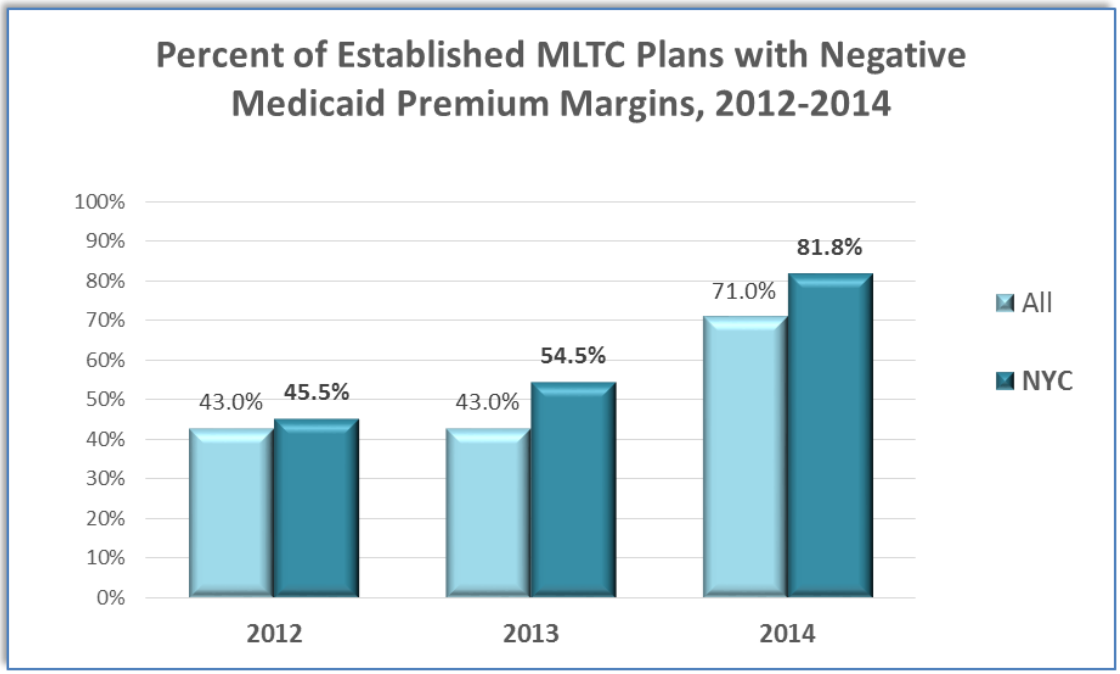
Recommendation: *LeadingAge NY is cognizant of the need to support financially-distressed, safety net hospitals. However, nursing homes and home care agencies are also expected to play a prominent role in transforming the health care delivery system and helping the state to realize the DSRIP goal of reducing avoidable hospital use by 25 percent by 2019. Accordingly, they need access to VAP funding to reconfigure their service delivery and operations to support this goal. The VAP funding allocations should specifically set aside $30 million for nursing homes, as well as specific allocations for home care providers, along with the other specific VAP set-asides.*

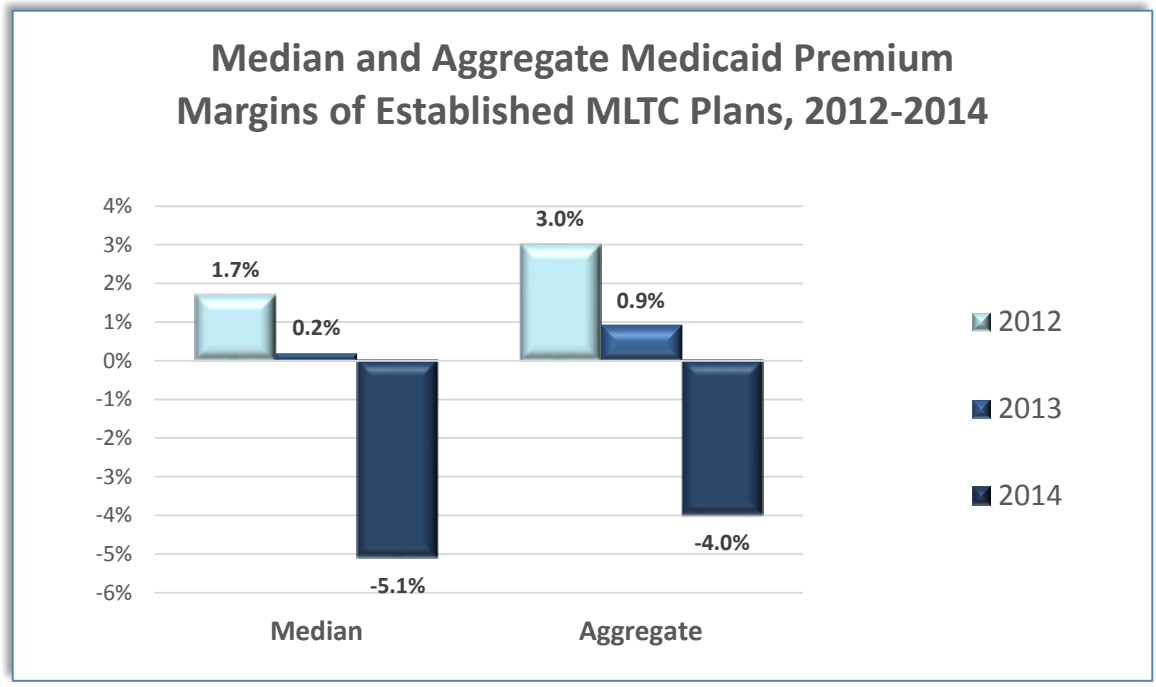
c) Managed Long Term Care

The future of New York's LTPAC delivery system rests largely on managed care and its promise of "care management for all." This promise has been realized through the comprehensive, high-touch care management approach offered by New York's managed long term care program, which include the partially-capitated Managed Long Term Care Plans and the integrated Medicare/Medicaid PACE, FIDA and Medicaid Advantage Plus (MAP) plans (collectively MLTC plans for purposes of this testimony). According to the Department of Health's 2013 Managed Long Term Care Report, 84 percent of enrollees rated their MLTC plan as "good" or "excellent."

Unfortunately, the sustainability of these successful programs is threatened by the inadequacy of MLTC rates. The MLTC rate-setting process has failed to keep pace with the rapidly changing dynamics of the program and the population it serves. Premiums are developed based on data that is two to three years old and are subject to lengthy delays in implementation. With the enrollment of the nursing home population, the expansion of benefits, wage mandates, and new limits on the plans' ability to manage utilization and costs, the expenses of delivering care have outpaced premium revenue. As a result, the aggregate premium margin among MLTC plans has plummeted from a positive 3 percent in 2012 to negative 4 percent based on MMCOR reports for the fourth quarter of 2014.[5] The insufficiency of managed long term care rates likewise poses a threat to the viability of LTPAC providers, many of whom serve primarily Medicaid patients and will ultimately rely on health plans for the majority of their revenue.

[5] This figure does not reflect amounts included in unpaid premium packages. However, it does reflect the actual financial position of the plans based on the relationship between premium revenue and expenses at the close of the year.


Percent of Established MLTC Plans with Negative Medicaid Premium Margins, 2012-2014
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
43.0%
45.5%
43.0%
54.5%
71.0%
81.8%
2012
2013
2014
All
NYC



The Executive Budget proposes a series of cuts targeted specifically at MLTC rates – totaling $22 million (all funds) -- most of which would be implemented administratively. In addition, MLTC rates would be subject to several cuts that are directed at Medicaid managed care rates more generally. We are still analyzing the programmatic and fiscal implications of many of these proposals. However, it is clear that they would result in rate cuts without proportionate reductions in costs for the plans and would further weaken the program, at a time when an increase in rates is needed.

Recommendation: *We ask the Legislature to reject the Governor's proposed $22 million in cuts in MLTC premiums and, in addition to that restoration, we request an increase of $90 million to support the payment of MLTC premiums that are aligned with the expenses of delivering care. In particular, as detailed below, we ask the Legislature to reject the carve-out of the transportation benefit from the MLTC benefit package.*

d) Transportation Carve-Outs

The Executive Budget proposes to carve-out transportation services from the MLTC benefit package, from Adult Day Health Care (ADHC) Program Method 1 rates, and from nursing home rates. Many of our members have invested in their own vehicles to deliver transportation services. Other have long-standing contracts with high-quality transportation providers. They are able to deliver personally-tailored transportation to the frail elderly and disabled individuals whom they serve. For an MLTC member, the driver may shovel the walk so that the member has a safe path from his/her door to the vehicle. For an ADHC program client, the driver may carefully time his/her route to discharge his/her passenger at the precise moment the passenger's caregiver is scheduled to arrive. It is our understanding that the State's contractor is unable to deliver this level of service, resulting in lengthy waits, stranded clients, and missed medical appointments.

***Recommendation**: We request that the MLTC, ADHC and nursing home carve-outs be rejected. We further request that language be inserted in the Article VII bill to prohibit the carve-outs from the ADHC and nursing home rates, just as similar language was inserted last year to bar the MLTC transportation carve out.*

e) Workforce Measures

- **Minimum Wage Increase:** LeadingAge NY has worked with other associations representing hospitals, nursing homes, and home care services to collaboratively estimate the impact of a $15 minimum wage on our sectors. Based on the best currently available data, our preliminary estimate is that the proposal would increase the cost for health care providers in these sectors by a conservative estimate of $3 Billion when fully implemented. Nursing homes would realize a cost of $600 million and home care/personal care agencies would incur a $1.72 billion cost. Absent a substantial increase in Medicaid reimbursement, this could force providers to cut direct care staff, threaten the viability of many facilities and agencies, and adversely affect access to high quality services.

Long term care services are labor-intensive, with an estimated 70 percent of the total cost of delivering care attributable to staffing. Medicaid funds more than three quarters of nursing home care and the vast majority of the personal care in the state. And, as the predominant payer, New York has not provided any additional Medicaid funding in 8 years to support increases in the costs of providing services. Without additional funding, an increased wage mandate could force providers to reduce their staffing, which could adversely affect both the availability and quality of services. It is important to recognize that these costs will also be borne by MLTC plans, as a major payer for long term care services. In light of the MLTC premium concerns discussed above, MLTC plans will not have sufficient funding to compensate providers for a new wage mandate.

***Recommendation:** LTPAC providers will already struggle to maintain quality staff as they compete with other sectors that are providing $15 minimum wages. Since Medicaid is the predominant payer of LTPAC providers, the Legislature must fully fund the associated costs of increased wages that will be incurred by Medicaid providers and not-for-profit organizations.*

- **Fair Labor Standards Act:** Effective, October 13, 2015 there was a modification to the companionship exemption under the federal Fair Labor Standards Act (FLSA) regulations requiring that home care aides with overtime hours be paid time and a half based on their actual wage rather than the minimum wage. Home care providers have been paying these increased overtime costs since October, but have yet to see any additional reimbursement. The Department of Health has indicated that, as an interim measure, it will pay MLTC plans an additional 34 cents per hour of personal care. However, these funds have not yet been paid. Further, there does not appear to be any provision in the budget to support the increased wages.

***Recommendation:** The Legislature should ensure adequate Medicaid funding to cover the new costs associated with the changes to the FLSA regulations.*

II) *Nursing Home Supplemental Advanced Training Initiative*

The nursing home Advanced Training Initiative (ATI) was authorized in 2015, with total funding of $46 million in each of the SFYs 2015-16 and 2016-17. Under the ATI program, participating nursing homes will offer training to front-line workers on detecting early changes in a resident's status that could lead

to a decline in health status and/or hospitalization. The Department of Health (DOH) was authorized to administer the ATI program.

DOH has conditioned nursing home eligibility for the program on two factors: (1) each facility's reported direct care employee retention rate being above the statewide median; and (2) the facility not being either hospital-based nor in receipt of VAP funding (see above description of VAP program). As a result of these criteria, direct care staff in over 60 percent of all nursing homes in the State are ineligible to receive this State-supported training, and 81 percent of the total ATI funding is allocated to the downstate region (i.e., NYC, Long Island and Westchester).

Recommendation: *The SFY 2016-17 budget should include authorization for a Supplemental ATI program. This proposal would extend ATI eligibility to staff in 125 additional nursing homes whose retention rates are higher than regional median turnover rates, including hospital-based homes and VAP recipients that would otherwise qualify. The added annual cost would be $26 million gross ($13 million State share). Addressing resident decline and avoiding hospital use will likely result in overall Medicaid savings and improved quality of life.*

III) Home and Community-based Services (HCBS)

Home and community-based services are vitally important in supporting frail elderly New Yorkers to remain in their homes and communities for as long as possible. Unfortunately, home care agencies continue to struggle with an untenable level of operational uncertainty as they experience the effects of mandatory MLTC enrollment of many of their patients and unfunded wage mandates. In addition, across-the-board cuts, provider taxes, elimination of inflation adjustments and unfunded mandates, which would be continued from previous budgets, are exacerbating the operational and financial uncertainty facing many of the State's HCBS providers.

- ***Advanced Home Health Aide:*** While the Governor's Briefing Book includes support for the authorization of an Advanced Home Health Aide (AHHA), the proposal appears to have been omitted from the budget bills. The Briefing Books suggest that under the proposal, an AHHA would be authorized to perform specific tasks under the supervision of a licensed registered professional nurse in home care, hospice and new this year – an enhanced assisted living residence (EALR). This new role would support recruitment and retention efforts and advance the field of direct care workers, while increasing efficiencies.

  Recommendation: *LeadingAge NY fully supports the authorization of AHHAs and urges the Legislature to consider the recommendations that were advanced by a DOH AHHA workgroup, on which LeadingAge NY was represented, and include enabling legislation in the final enacted budget.*

- ***Certified Home Health Agency (CHHA) Episodic Payment System (EPS)***: LeadingAge continues to be concerned with the unexpectedly steep cuts CHHAs experienced as a result of rebasing the CHHA EPS using the 2013 base year. In last year's budget, the Legislature agreed to an estimated $30 million cut to CHHAs, as a result of moving the base year from 2009 to 2013. This represented a 12 percent cut to the existing EPS rates. The rates actually implemented by the State represent an annual funding cut of more than twice the $30 million approved, resulting in reductions of 28 percent or more. Cuts of this magnitude are unsustainable.

Recommendation: *The Legislature should allocate additional Medicaid funding to mitigate the impact of the CHHA rebasing.*

IV) Adult Care Facilities and the Assisted Living Program

Adult Care Facilities (ACFs) and Assisted Living provide options for seniors who cannot remain in their own home, but do not need the continual skilled nursing services of a nursing home. These services are less expensive than nursing home care, and offer a more home-like environment than a nursing home. Such options are thus becoming increasingly important in the context of state and federal priorities, as well as consumer preferences.

ACFs and Assisted Living Programs that serve low-income individuals are struggling in the face of rising costs and increasing responsibilities. They serve a critical function, providing housing and supportive services and preventing unnecessary and costly nursing home placements. We urge the Legislature to provide more support to these residences to ensure their viability in the years to come.

We are extremely disappointed that the Executive Budget failed to include an increase in the State's portion of the Congregate Care Level 3 Supplemental Security Income (SSI) rate. The SSI rate of approximately $41 per day falls far short of what it costs to provide the services that ACFs are, by regulation, required to provide. Because there is no cost of living adjustment (COLA) to the State portion of the rate, the gap between the SSI rate and ACF costs actually grows with each passing year. The State has not increased the SSI rate in *eight years*. At the same time, ACFs have had to comply with new mandates. The Executive proposal's minimum wage increase will further exacerbate the gap between what is paid and what it costs to provide care.

Some of our not-for-profit ACF members are having difficult discussions with their boards now about *whether or not to close this year*. The consistent financial loss, year after year, is unsustainable. It is critical that the Legislature understand that if the State fails to take action this year, facilities will close and low-income seniors will be displaced. Because these seniors are Medicaid eligible and cannot live in their own homes, most will go to nursing homes at greater cost to the State. Clearly, this makes no financial sense- nor does it comport with State and federal policies that aim to serve people in the lowest level of care appropriate to their needs. But most of all, it is unfair to 13,000 New Yorkers who rely on SSI to pay for the services they receive in ACFs and assisted living.

Recommendation: *To support ACF and assisted living programs to serve low income seniors in the most integrated setting possible, we recommend an increase of at least $15 per day in the State's Supplemental Security Income (SSI) Congregate Care Level 3 rate. As discussed below, a portion of this increase could be funded with monies appropriated in prior years for the QUIP and EnAble programs that was never distributed to ACF operators.*

We appreciate that the Executive budget proposal maintains level funding for the Enhancing the Quality of Adult Living (EQUAL) quality program for ACFs $6.5 million, as well as the Enriched Housing Subsidy at last year's level of $475,000. Both programs provided needed support to ACFs that serve recipients of Supplemental Security Income (SSI) or Safety Net Assistance; a population that is generally Medicaid-eligible.

Recommendation: *We urge the Legislature to support the Governor's proposal to include funding for the EQUAL and Enriched Housing Subsidy program at last year's levels, or more.*

LeadingAge New York has fought hard to ensure that funding, *appropriated and promised to ACFs through prior budget processes,* is ultimately paid out. Sadly, each year, these funds have been chipped away, and none of it has been distributed to ACFs. While we appreciate that the Executive budget proposal includes a reappropriation of $1.6 million of the EnAbLE funding from 2009, it is just a fraction of what is owed from the now defunct QUIP and EnAbLE programs. These funding programs support facilities that serve SSI recipients, and aim to improve the quality of life for residents.

Recommendation: *ACF operators are owed millions for past years for these programs, which support facilities that serve SSI recipients. We recommend that the State take these funds that should have been distributed to providers and use it to help fund an SSI increase.*

V) "Housing is Healthcare"

As the Department of Health has repeatedly emphasized, "housing is healthcare." Providing low-income seniors with access to affordable housing with support services can have a significant impact on their ability to remain in the community and not have to move into nursing homes at a significant cost to the State's Medicaid program.

For many years, operators of senior housing were able to access federal dollars for service coordinators through the U.S. Department of Housing and Urban Development (HUD). Research has shown that services like this in senior housing promote emotional well-being and stronger social supports, higher resident awareness of services, and better linkages between residents and needed services. Unfortunately, the HUD funding never met the demand across New York State, and has been reduced significantly in recent years. Without State investment, this successful model may become extinct.

By funding the Resident Advisor Program, which is currently authorized by section 220 of the New York State Elder Law, the State could expand on the successful HUD service coordinator program. The program was developed over twenty years ago to encourage the state Office for the Aging to create community linkages that would support seniors in aging in place. It is the perfect avenue to directly fund resident advisors to assist residents in accessing supportive services and organize non-medical supports such as transportation, exercise classes, and social events. Such services have been described as "light-touch" services, not nearly as intensive or expensive as services provided in supportive housing or assisted living. These services, together with safe and affordable housing, nevertheless provide what is needed by many seniors to optimize their health and independence in their communities.

Recommendation: Allocate $10 million to fund the Resident Advisor Program. This investment in affordable senior housing will provide low-income seniors with access to basic supports in the community, allowing them to age in place and delay or prevent them from becoming high Medicaid users. Ultimately, this proposal represents a modest investment that will save Medicaid dollars and help the State implement its ambitious Olmstead Plan.

Conclusion

As this testimony illustrates, there are a number of concerns and unanswered questions relative to how the Executive Budget would affect elderly and disabled New Yorkers, and the not-for-profit and public providers that serve them. We are very concerned that the Executive Budget offers little opportunity or investments for LTPAC providers and plans, while imposing new cuts, costs and mandates. We urge the Legislature to remedy this by ensuring the final enacted budget includes infrastructure investments and additional Medicaid funding to accommodate increased costs to providers and the MLTC plans that pay them. LeadingAge NY looks forward to working with the Legislature and Executive on the 2016-17 budget and the State's ongoing reform initiatives. For questions or concerns, please feel free to contact the LeadingAge NY advocacy and policy staff at 518-867-8383.

Founded in 1961, LeadingAge New York is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public continuing care including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living programs and Managed Long Term Care plans. LeadingAge NY's 400-plus members serve an estimated 500,000 New Yorkers of all ages annually.