

Testimony of:

**NEW YORK STATE  
HEALTH FACILITIES ASSOCIATION**

on the

**2018-19 New York State Executive Budget Proposal  
Health & Mental Hygiene  
Article VII Bill**

Monday, February 12, 2018

Albany, New York

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## **Introduction**

Good afternoon. My name is Stephen B. Hanse, Esq. and I have the privilege of serving as the President and CEO of the New York State Health Facilities Association (NYSHFA) and the New York State Center for Assisted Living (NYSCAL). Joining me today is Nancy Leveille, R.N. ,B.S. ,M.S. the Executive Director of the Foundation for Quality Care (FQC), the research and education arm of NYSHFA/NYSCAL. NYSHFA/NYSCAL members and their 60,000 employees provide essential long-term care services to over 50,000 elderly, frail, and physically challenged women, men, and children at nearly 400 skilled nursing and assisted living facilities throughout New York State.

Amy Kennedy, the Executive Director of the New York State Center for Assisted Living (NYSCAL) and Lauren Pollow, Director of Government Affairs for both NYSHFA and NYSCAL will be providing separate testimony today focusing on the assisted living proposals contained within the budget and discussing the longstanding need for New York State to increase the Supplemental Security Income rate for individuals in Adult Care Facilities.

## **Recent Budgets**

Over the past eleven years, funding cuts to New York State's long-term care providers have exceeded nearly \$1.9 billion. Initiatives implemented by the MRT have forced long term care providers to absorb nearly \$800 million in cuts over the past five fiscal years, and the potential for additional Federal cuts to Medicare and Medicaid continues to place providers in dire straits - all during a time when providers are implementing new Federal Requirements of Participation (ROPs) and numerous quality initiatives, requirements which involve the investment of significant resources.

New York State unfortunately leads the Nation with the largest shortfall between the rate of Medicaid payment and the actual cost of providing resident care in the nursing home (approximately \$61 per day). New York State's providers have now gone a full decade without a trend factor to account for inflation, and have continued to endure mounting budget cuts and growing operational expenses to comply with minimum wage, health insurance increases, and ever rising food and

utility costs. Unlike most all other industries, skilled nursing facilities cannot pass these increased costs on to the consumer.

In the 2014-15 Enacted Budget, the Legislature and the Governor restored the across-the-board 2% provider rate cut for nursing homes which was effective April 1, 2014. 1% of the 2% cut was used by the State to help fund a legal settlement, however, the State has continued to hold onto the other 1% of these funds as providers experience continued fiscal uncertainty. As of today, skilled nursing providers are currently owed a retroactive amount of \$280 million over the last four fiscal years, however, the State has yet to provide even the State share of these necessary funds as has been done with other initiatives such as the Advanced Training Initiative (ATI). As such, NYSHFA strongly supports the payment of the State share of these needed monies until such time as the State receives approval from CMS for its State Plan Amendment on the matter.

### **2018-19 Executive Budget Overview**

Given these concerns, I would like to outline five critical long-term care issues impacting providers contained within the 2018-19 Executive Budget:

- I. NYSHFA's support of a return to Fee-for-Service Medicaid for nursing home residents in a nursing home for six months or greater;
- II. NYSHFA's support of the 1% across-the-board restoration, an administrative proposal that provides a retroactive rate supplement to providers for proceeds derived from the 2014 legislative repeal of the rate cut enacted in 2011;
- III. NYSHFA's opposition to the case-mix rationalization, a proposal that would reduce case-mix rate increases by capping Case Mix Index (CMI) growth, which is derived from an increase in Minimum Data Set (MDS) findings;
- IV. NYSHFA's opposition to the Capital Rate Streamlining proposed to create a 1% cut to nursing home and hospital capital reimbursement;
- V. NYSHFA's opposition to the additional quality penalty imposed on the lower performing nursing homes in the Nursing Home Quality Initiative (NHQI),

which would penalize nursing homes in the lowest and second lowest quintile by an additional 2% Medicaid rate reduction;

- VI. NYSHFA's opposition to the Value Based Payment (VBP) contracting penalties, which would lower the Medicaid benchmark rate for nursing homes that fail to achieve "sufficient" levels of VBP contracting; and,
- VII. NYSHFA's opposition to the forthcoming nursing home bed hold regulations from the New York State Department of Health (DOH).
- VIII. NYSHFA's concerns related to the Geriatric Parole proposals in the Public Protection Budget
- IX. NYSHFA's opposition to the Food Waste Recycling proposal in the Transportation, Economic Development, and Environmental Conservation Budget

### **Summary of Proposals**

#### **I. Support the return to Fee-for-Service Medicaid for nursing home residents in a nursing home for six months or greater**

While there are several proposals contained within the Executive Budget that will negatively impact the provision of quality care and the financial sustainability of providers moving forward, there is one high-impact proposal NYSHFA strongly supports. The Governor proposes excluding nursing home residents from MLTC enrollment after six months of continuous nursing home care, at which time the resident would be switched back to fee-for-service Medicaid. This proposal would be effective April 1, 2018 and is anticipated to save \$73.5 million (\$147 gross) in SFY 2018-19 and \$122.5 million (\$245 million gross) the following year.

NYSHFA strongly supports this proposal and further suggests this threshold period be moved to three months instead of six months. This will create significant additional savings related to the administrative cost component and the savings can be directed to offset the arbitrary cuts to skilled nursing providers set forth in the 2018-19 Executive Budget.

It is usually illustrated early on in a residents' stay if they are able to return to the community or will be placed in a long-term care environment. The decision for the enrollee to return the community within three months will allow for continued State savings on high acuity/high need payments from the MLTC plans and perhaps inviting a value-based incentive for health plans to work with skilled facilities to return clinically sound enrollees back to the community sooner.

## **II. Support the 1% Across-the-Board Restoration**

In 2011, the New York State Legislature passed a law imposing a 2% across the board cut in Medicaid reimbursement to all Medicaid providers (not just SNFs) in New York State. There was, however, an exception for SNFs (and only SNFs) in this law. They were required to pay to New York State an 0.8% non-reimbursable cash receipts assessment in lieu of the cut, having the same impact as the 2% rate cut.

In 2013, the Legislature extended the law for another two years. However, in 2014, the law was repealed for all Medicaid providers. Approximately one-half of that assessment revenue has been set aside by New York to fund a "Universal Settlement" that the State entered into with nursing homes to settle most of the outstanding rate appeals and litigation involving rates in effect prior to 2012. As for the other half (1% of 2% of the original rate cut), State officials agreed to restore the other 1% to the rates and filed a State Plan Amendment (SPA) to accomplish that objective.

DOH intends to increase nursing home Medicaid rates by approximately 1% for a total of \$70 million per year, retroactive to April 2014. In addition to the retroactive increase, the State would increase nursing home Medicaid reimbursement prospectively by \$70 million each of the next three years.

While the State has yet to submit responses to CMS in response to certain questions raised by CMS, NYSHFA respectfully requests the State pay skilled nursing provides the State share of the 1%, similar to how it paid the State share for the Advanced Training Initiative.

## **III. Oppose the 2018-19 Executive Budget Case Mix Rationalization Proposal**

Included in the Executive Budget is an administrative proposal to reduce case-mix adjustments to nursing home providers' Medicaid rate increases in an effort to save \$7.5 million annually (\$15 million gross). The Department of Health (DOH) has been concerned about ongoing Case Mix Index growth as a result of the increases in Minimum Data Set (MDS) findings.

Case Mix Index (CMI) is a direct reflection of residents' acuity in a nursing home. This is used to adjust reimbursement and is the present payment system for Medicaid skilled nursing facilities throughout the Nation. The Federal Government currently uses case mix payment systems for Medicare reimbursement to nursing homes. On the State level, New York State as well as over 34 other states use this system for reimbursing care for residents. Residents are evaluated in the case-mix system based on the level of care they require, and then are grouped with other residents based on like-care needs. Each provider is assigned an average/cumulative "case mix index" by the DOH which indicates resources utilized by the residents. The facility's payment rate is then adjusted by the DOH based on this index.

Case mix is adjusted upwards or downwards based on direct care provided to residents. The benefits are numerous, namely that this ensures access to care for medically complex individuals with significant care needs, it enhances quality of care by linking reimbursement to medical acuity, and it is efficient because providers are paid prospectively.

Nursing homes are always growing in their clinical skill set to accept residents with more comorbidities and higher medical acuity than ever before. Hospitals are able to comfortably discharge individuals earlier knowing that there are nursing homes capable of providing advanced care to their patients. For example, hospitals can often discharge an individual shortly after cardiac surgery to a sub-acute rehab following surgery; this reflects an evolving health care industry. Nursing homes should always be able to receive payment for the actual cost of care they are providing, and not be impeded by arbitrary reductions imposed by the State.

From 2006-2009, case mix payments were frozen at 2006 levels during the State's transition from the prior Patient Review Instrument (PRI) screening tool to the Minimum Data Set (MDS). As a direct consequence, nursing home admissions were often directed at less medically complex individuals due to their reimbursement

not having been tied to the actual cost of providing more intensive care to residents. Once this freeze ended, providers transitioned to the MDS, and facilities were finally able to take medically complex residents and be paid adequately for such.

- The State must ensure that it does not repeat the mistakes of the past. Arbitrary cuts in case mix can result in the following: Decreased access to necessary skilled nursing care for New York State's individuals in need, as increased nursing/therapy services for medically complicated residents is not reimbursed for the true cost of care;
- Diminished ability of nursing homes to care for the increased needs of high-acuity residents resulting in an increase in re-hospitalizations, which runs contrary to the goals of the MRT and the Delivery System Reform Incentive Payment Program (DSRIP); and
- Erosion of the underlying principles of a case-mixed system because the proposal creates a disincentive to admit the neediest and costliest residents due to a lack of reimbursement for this intensive care. Providers are already managing the impact of a Medicaid payment shortfall of approximately \$61 dollars per day.

#### **IV. Oppose the 2018-19 Executive Budget Capital Streamlining Proposal**

The Governor has proposed that the New York State Department of Health (NYSDOH) hold a workgroup of DOH, nursing home, and hospital constituencies with the goal of reducing nursing home and hospital capital expenditures by 1% for SFY 2018-19. This reduction includes nursing home specialty units and adult day health care (ADHC) program capital expenditures.

Regardless of creation, acceptance, and implementation of such workgroup recommendations, the Governor's Executive Budget authorizes the Department to reduce capital reimbursement to achieve this savings goal annually as of April 1, 2018. The target savings figure for the Governor is a \$13.4 million capital reduction to providers annually, with approximately \$7.6 million in cuts to nursing homes.

This proposal runs contrary to the entire process by which providers have been historically reimbursed for capital expenditures. While there are very few new nursing homes being built, there are numerous aging physical plants in the long-term care provider community that are in need of upgrades for the provision of safe resident care as well as compliance with Life Safety Codes.

Skilled nursing providers undergo an extensive Certificate of Need (CON) approval process and a two-year reimbursement delay for these necessary upgrades and have simply followed the methodology created by the State of New York. These projects are reimbursed through the nursing home daily rate via a capital rate adjustment added to the Medicaid inpatient rate to eventually reimburse the provider. The 2018-19 Executive Budget proposal to arbitrarily cut nursing home capital reimbursement runs contrary to the methodology created and implemented by the State in the first place. Providers will now be expected to make upgrades during a time where they are facing ongoing cuts, the largest Medicaid payment shortfall in the Nation, and now additional cuts proposed by the Executive Budget. We strongly urge you to oppose the proposed 1% capital reduction.

**V. Oppose the 2018-19 Executive Budget 2% Quality Penalty**

The Governor has proposed a reduction in the Medicaid reimbursement by 2% to providers scoring in the lower two quintiles of the Nursing Home Quality Initiative (NHQI) in New York State. This proposal is expected to impact about 100 nursing homes, and there is a potential waiver for homes under extreme financial hardship. This proposal will net an estimated \$10 million in savings (\$20 million gross).

The current NHQI is a provider-funded initiative where providers all pay into a “quality pool” and are measured on a pre-defined set of quality measures outlined by DOH (below) and are provided a score placing them in one of five quintiles. The top two quintiles receive a Medicaid rate increase funded by the lowest two quintiles over and above their funding contribution, the middle quintile is neutral in that the exact amount funded is returned, and the lower two quintiles are left with the funding rate reduction and no return. For the lower two quintiles, this amounts to a double penalty.



## NHQI Background

The Nursing Home Quality Initiative (NHQI) is an annual quality and performance evaluation project where nursing homes are awarded points for quality and performance measures in terms of quality, compliance, and efficiency. Deficiencies in the nursing home are incorporated into these results, and points are calculated annually to create an overall score out of 100. Nursing homes are separated by ranking into five quintiles with the 5<sup>th</sup> quintile being the lowest-performing.

NHQI is structured out of 100 points as follows:

- 70% of the points on quality components;
- 20% of the points focused on compliance components; and,
- 10% of the points focused on efficiency components.

On November 7, 2017, the Department of Health released the 2017 NHQI results as follows:

- 93% nursing homes improved on one or more quality measures (QMs) by at least one quintile and gained an extra scoring point;
- Ten (10) out of twelve (12) quality measures (QMs) improved over last year's results statewide (categories that remained the same or worsened were low-risk bladder/bowel control and percent of long-stay residents who received pneumococcal vaccine);
- The number of Potentially Avoidable Hospitalizations per 10,000 long stays is decreasing;
- Between the years of 2012-2017, antipsychotic drug use rates in nursing homes dropped by 41.9%;
  - The prevalence rate is now 11.1% (15.5% is the national average);
  - This rate was 12.8% in 2016;

- This rate was 14.0% in 2015;
- The long stay (LS) influenza vaccination rate is up to 84% statewide 2017;
- The LS pneumococcal vaccination rate is up to 80% statewide in 2017;
- Facilities with Immediate Jeopardies (J, K, and L deficiencies) are down from 4% to 1.5%
  - In 2017, 9 nursing homes received an IJ;
  - In 2016, 22 nursing homes received an IJ;
  - Peer facilities across the nation have seen the opposite trend from 4.9% to 6.2% during most recent survey;
- For long-stay, high-risk residents with pressure ulcers, this figure dropped to 7%;
  - In 2016 residents with pressure ulcers were 7.2%;
  - In 2015 residents with pressure ulcers were 7.8%;
- Overall re-hospitalizations rates are down to 13.7% in long-stay residents, which is better than the national average;
- Re-hospitalizations are down to 16.4% in short stay (SS) residents, compared to the national average of 17%.

It is the position of NYSHFA/NYSCAL that the 2% additional cut set forth in the Executive Budget proposal is not only unjust , but it inequitably penalizes nursing homes that are already struggling to meet mounting quality requirements imposed by the NHQI and the ROPs. This is compared to diverting resources away from a D+ student to provide more assistance for tutoring to an A+ student. It defies logic and ultimately may negatively impact nursing home residents.

Additionally, there are occasions when poor performing nursing homes are acquired by new owners better equipped to manage the mounting complexities of providing nursing home care. This provides a disincentive for those providers to take

over financially distressed and lower-quality nursing homes in hopes of turning them around to better serve the community. These facilities will face a 2% quality penalty in addition to the NHQI cuts in funding after already committing considerable time and resources to necessary quality improvement initiatives.

We urge your strong opposition to this measure as the quality pool was designed to be budget neutral to the State, and there has been no discussion concerning the pass through back to providers should these additional penalties be recouped.

**VI. Oppose the proposed Value Based Payment (VBP) contracting penalties**

The Governor has proposed an administrative measure to establish a new Medicaid benchmark rate for both fee-for-service and managed care providers should providers fail to meet a “sufficient” level of VBP contracting. This proposal is effective July 1, 2018 for a total cost savings of \$7.5 million annually (\$15 million gross). Among other things, this proposal is vague as the term “sufficient” is not defined and it anticipates an unwillingness on the behalf of nursing home providers to join ongoing VBP and DSRIP initiatives in New York State.

Currently, nursing homes have been provided with a VBP level 1 contract addendum from the MLTCs effective January 1, 2018. This rollout was sudden, and providers were most often prescribed a metric from the plan instead of working in a collaborative manor proposed by the New York State VBP Roadmap. The metric was Potentially Avoidable Hospitalization (PAH) and left no room for discussion based on the high-impact areas individual to each provider. There are nursing homes that already have very low PAH, and they were not provided any other options by plans for meaningful Value Based participation. This mirrors the nursing home industry’s overall experience with VBP and DSRIP thus far- providers had innovative ideas but found significant difficulty in substantively engaging with their Performing Provider Systems (PPS) in their catchment areas.

Additional issues concern how is a provider intended to determine whether it has no chance of hitting the quality target without clearly defined and understood measures and targets. In certain areas of the State, based on limited or challenging

demographics or in certain rural settings, there is a concern that providers facing these challenges will be left behind or that they are being asked to gamble with their future as they lack any meaningful way of assessing how they would do under the VBP arrangements that are being proposed. The current VBP amendment content is too indefinite, poses more questions than it answers and is being presented as a unilateral demand rather than a collaboration between the health plans and the providers.

Given NYSHFA's opposition to this vague and unfair penalty, we would advocate for an assessment of how providers can be better engaged in meaningful VBP mechanisms, including collaborative discussions with plans.

## **VII. Oppose the forthcoming Bed Hold regulations from the NYSDOH**

NYSHFA opposed the 2017-18 Executive Budget proposal to eliminate Medicaid payments to skilled nursing providers to hold beds for residents who are temporarily hospitalized. Previously, New York State reimbursed skilled nursing providers with at least 95% occupancy at 50% of their Medicaid daily rate for up to 14 days in a calendar year for residents who are admitted to a hospital.

The costs of nursing homes do not decrease simply because one bed is vacant. Moreover, as a consequence of the 2011 MRT cuts to skilled nursing providers, Medicaid pays only half of the daily rate to reserve a bed for a hospitalized resident.

The 2017-18 Budget included an initiative to eliminate bed hold reimbursement. The Legislature responded by unanimously passing a bill A.8338 (Gottfried)/S.6559 (Hannon) to restore the bed hold payments to skilled nursing providers. This legislation was vetoed by the Governor, indicating this could be discussed during the upcoming budget process. The Executive budget is silent on the bed hold issue and we have been told there will be draft regulations released by the DOH could negatively impact providers. We urge the Legislature to advance its 2017 legislative position during the 2018-19 budget negotiations

## **VIII. NYSHFA's concern with the Geriatric Parole Proposal (PPGG Bill)**

The Executive has included a geriatric parole proposal in the Public Protection and General Government Article VII legislation. While NYSHFA does not oppose

the intent of this proposal, we have concern related to the voluntariness of such a proposal for providers serving vulnerable populations.

This proposal allows an inmate over fifty-five years of age and suffering from a chronic or serious condition exacerbated by age to apply for parole. This individual must be incapable of providing self-care within a correctional environment in order to apply to the Board of Parole. Placement and discharge plans may include placement in a skilled nursing facility.

While this proposal focuses on non-violent offenders, there are many non-violent offenses that are of concern such as abuse against vulnerable populations (children, elderly) and theft that are of major concern to nursing home providers trying to provide a safe environment to all residents. This proposal should emphasize the voluntariness of accepting an individual on geriatric parole, and discharge planning must work to provide as much information as possible to a potential placement facility to ensure a facility is sufficiently prepared to take on an individual with potential behaviors.

There have been many cases when nursing homes are not provided crucial information on a potential resident with problem behaviors to ensure they are accepted into the facility, only to find they are unable to safely provide care and supervision while protecting the rights of other residents and families. We urge you to add in voluntary language to this proposal, to ensure that providers willing to take on a geriatric parolee are prepared for any potential challenges associated with such a placement.

#### **IX. NYSHFA's Concern with Mandated Food Waste Recycling**

The Governor has included a proposal to reduce and manage food waste by “large food waste generators” in the State of New York. This involves diverting excess food to food banks, and food scraps to organics recycling facilities. This proposal, effective January 1, 2021 would require those generating an annual average of two tons per week or greater in excess food scraps to divert this excess food to animal feed operations, composting facilities, anaerobic digesters, and/or other organics recycling facilities. Under this proposal, nursing homes and assisted living providers will qualify as “large volume waste generators”, and while we

appreciate intent of reducing food waste, we have major concerns about how this process will interact with State Survey for health care facilities, subsequent changes in policies and procedures, staff training to adhere to new requirements, all with no specific Medicaid reimbursement for any associated costs.

Unlike other businesses impacted by this change, health care is a heavily regulated industry currently in the midst of complying with Phase 2 of the Requirements of Participation from the Centers for Medicare and Medicaid. The number of large-scale changes our providers are making to come into compliance with this laundry list of Requirements of Participation is impressive but large-scale and comprehensive. Asking them to comply with yet another significant regulation regarding their handling and disposal practices in a way that isn't related to direct patient care is simply unrealistic for nursing homes.

Because this proposal aims to increase the donation of edible leftover food, set aside food scraps for animal feed, promote composting, etc., experts on implementing "source separation" typically advise facilities engage in training, recordkeeping, reporting, proper cold storage and source reduction. It is unclear at this time if this will result in additional FTEs for dietary staff/techs, and there is no mention of how to safely ensure food touched by residents with communicable diseases should be managed. Additionally, proper cold storage may be difficult for smaller providers with limited physical plant space. We urge you to oppose this proposal for health care providers.

## **Conclusion**

In conclusion, the New York State Health Facilities Association (NYSHFA) is thankful for the New York State Legislature's time and attention on these critical issues to ensure the continued delivery of high-quality, cost effective long-term care to our most vulnerable individuals.

I would like to reiterate our support for the return to fee-for-service Medicaid for those in long-term care for three months or greater as well as the restoration of the 1% repayment to providers as promised by the Department of Health.

It is vitally important that the New York State Legislature protect and enhance access to the crucial services provided by skilled nursing facilities for our rapidly

aging population. Longer lifespans and better chronic disease management will contribute to the need for increased long-term care services as the baby boomer generation is aging. Worldwide those aged 60 and over are expected to double by 2050. New York cannot continue to cut funding to essential long-term care and assisted living programs and expect to be able to adequately serve this aging population. Please see the attached population growth statistics from the American Health Care Association (AHCA) for further details.

As always, the New York State Health Facilities Association will continue to work together with the Governor, the Legislature and all affected constituencies to ensure the continued delivery of high quality, cost effective long-term care services throughout New York State.

Thank you.

### **Attachment 1**

FY 2019 Health Care Savings Proposals- Executive Budget  
State Investments/ (Savings) \$ in millions

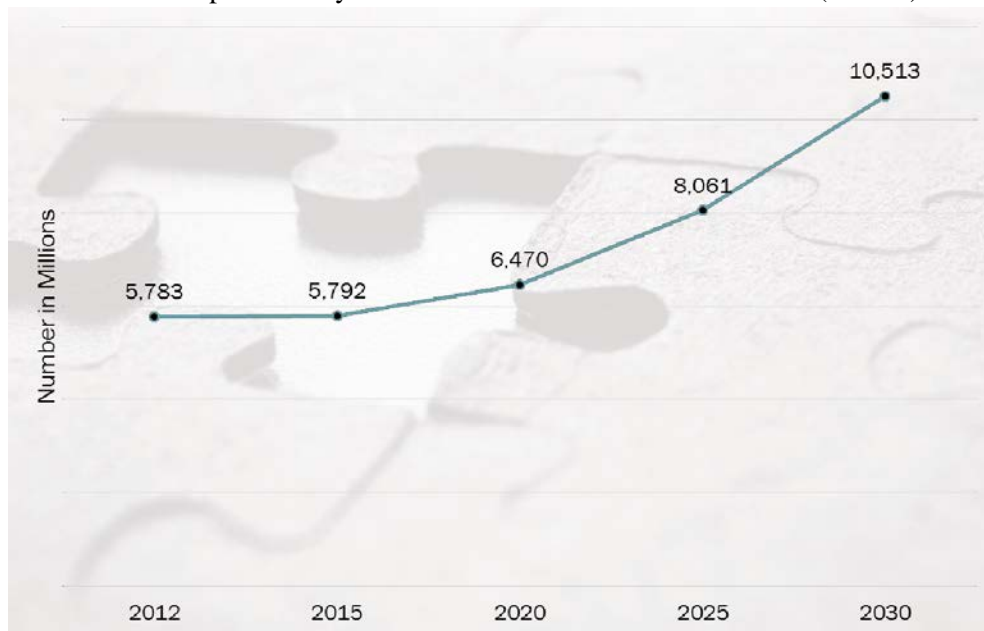
Initiative	Effective Date	Legal – Admin	Description	FY 2018-19		FY 2019-20	
				Gross	State Share	Gross	State Share
Nursing Home 1% Across-the-Board Restoration	April 1, 2018	Admin.	Stretches out the repayment schedule of the Nursing Home 1% ATB retroactive payment	\$70.00	\$35.00	\$70.00	\$35.00
MLTC eligibility to six months or less	April 1, 2018	Legal	Requires resident in a nursing home six months or greater to transition back to Fee-For-Service Medicaid	(\$147.00)	(\$73.50)	(\$245.00)	(\$122.50)
Rationalizing Case Mix Index (CMI) Increases	April 1, 2018	Admin.	Revisits current MDS census collection process, relies on reduction of audit findings	(\$15.00)	(\$7.50)	(\$15.00)	(\$7.50)

Capital Rate Streamlining	April 1, 2018	Legal Admin	DOH plans to establish a workgroup to develop options for streamlining capital rate expenditures, intends to achieve 1% cut	(\$13.40)	(\$6.70)	(\$13.40)	(\$6.70)
Quality Penalties	April 1, 2018	Legal	Uses NHQI scoring, imposes additional 2% cut to two lowest quintiles	(\$20.00)	(\$10.00)	(\$20.00)	(\$10.00)
VBP Contracting Penalties	July 1, 2018	Admin	Establishes a new benchmark rate for nursing home providers without “sufficient” level of VBP contracting to achieve targeted savings	(\$15.00)	(\$7.50)	(\$15.00)	(\$7.50)

## Attachment 2

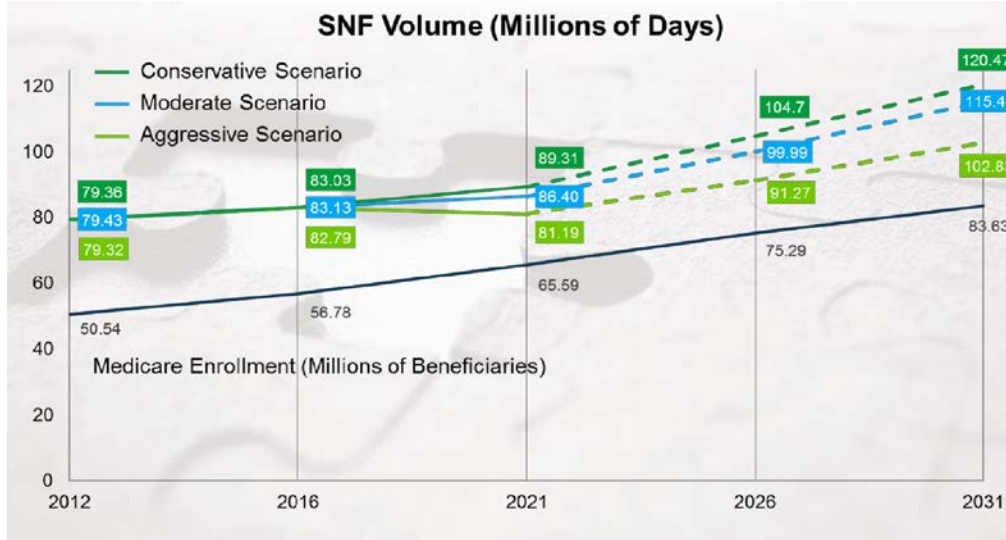
### Population Growth 80-84 Years

Information provided by the American Health Care Association (AHCA)





## More People Will Need Post-Acute Services



Note: 2021 – 2031 projections account for changes to age distribution (65-74, 75-84, 85+ years) but assume enrollment in alternative payment models remains proportionally constant at 2021 levels.

Sources: SNF Volume from Avalere projection model; Medicare enrollment from 2015 Trustees' Report.