

**COMMENTS OF**  
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**METROPOLITAN JEWISH HEALTH SYSTEM**

ON

2008-2009 STATE BUDGET PLANNING

TO THE

DIVISION OF THE BUDGET

NOVEMBER 29, 2007

Good afternoon. I am Eli Feldman, President and CEO of Metropolitan Jewish Health System, one of the most comprehensive systems of subacute and chronic care in New York and the nation.

Metropolitan's participating agencies and programs provide skilled nursing, subacute, short- and long-term home care, hospice, palliative care, adult day health care, Managed Long-Term Care, a Medicare Advantage plan, and research. All together, we provide direct care to some 40,000 residents of throughout New York City and Westchester, Nassau, and Suffolk counties.

For 100 years, Metropolitan has been a pioneer in developing and structuring the delivery of health care services to maximize individuals' independence and enhance their quality of life in a cost-effective manner.

Our achievements include:

- Creating one of the first Adult Day Health Care centers in New York in 1977.
- Opening one of the first Long-Term Home Health Care programs in 1979.
- Launching one of the first hospice programs in New York in 1980 and creating a hospice program designed to meet the specific needs of the Jewish community in 1996—the only home-based program in New York State where patients and their families have the option to delegate medical decision-making to an expert advisor in Jewish law and medical ethics.
- Creating Elderplan as one of the nation's first Social Health Maintenance Organizations in 1985, with a mission to keep seniors health and independent in the community for as long as possible, and evolving it into a Medicare Advantage plan with several Special Needs Plan options.
- Opening one of the first Managed Long-Term Care Plan demonstrations in New York in 1997.
- Hosting one of only five demonstration projects nationwide in Medicare adult day health care.
- Offering the only subacute rehabilitation services in Brooklyn in affiliation with the renowned Rusk Institute of Rehabilitation Medicine at New York University at two of our skilled nursing facilities – Metropolitan Jewish Geriatric Center and Shorefront Jewish Geriatric Center.

All of our skilled nursing, home health, and hospice programs are accredited by the Joint Commission on Accreditation of Healthcare Organizations and all score at or better than state and/or national averages on Centers for Medicare and Medicaid Services' quality measurements.

More importantly, we continue to be forward-thinking.

- With Department of Health approval and funding, we have begun the process of restructuring Metropolitan Jewish Geriatric Center from 510 beds to 354 beds – 191 of them in single rooms, the remainder in semi-private rooms – and dining areas on each patient unit and therapy and recreation areas on each patient floor.
- In addition, Metropolitan Jewish Geriatric Center is one of only nine nursing homes statewide receive a state grant for research and best practice sharing aimed at improving the lives of residents with Alzheimer's Disease and other forms of dementia.
- Metropolitan Jewish Health System has created a Quality Management Institute that will provide hands-on education in quality improvement theories and technique, with a goal of preparing participants to sit for the Certified Professional in Healthcare Quality exam within two years. This Institute is open to both Metropolitan employees and others throughout New York.
- We have invested in the development and testing of technologies for speeding post-acute rehabilitation.

In short, we are a mission-driven, non-profit organization that believes in both community service and social entrepreneurship.

It is in that context that we offer these thoughts on conserving scarce resources while making strategic investment in home- and community-based care and care management. We urge the Administration to work with the Legislature to achieve the following three goals:

- A **reimbursement** system that fully funds the cost of providing quality care and that contains financial incentives to maximize the use of cost-effective home- and community-based programs and reform institutional care.
- **Strategic investment** in expanding piloted and established programs and services that have achieved results.
- **Regulatory/bureaucratic flexibility** that enables providers to innovate and restructure voluntarily, expeditiously, and in response to clinical and demographic trends. The long-term care system, in particular, must be both comprehensive and nimble in order to meet current and emerging needs on both the individual and societal levels.

## **Reimbursement**

With respect to Medicaid reimbursement, first “Do No Harm.”

It is crucial for the State to avoid any impulse to cut what providers are paid or tax what providers spend to care for New York’s frail, disabled, sick, and elderly residents. Nursing homes, home health agencies, and other continuing care providers face a host of challenges that affect our ability to provide care, including the workforce shortage, threatened Medicare rate cuts, and high heating fuel and gasoline prices.

Indeed, ensuring appropriate and adequate reimbursement addresses the single largest problem confronting society today – the diminishing number of health care professionals and workers.

Labor is any health care provider’s single largest expense and most valued resource. Pay, benefits, and working conditions all play key roles in how a particular job or job sector is viewed – and all are tied to reimbursement.

With 75% of nursing home residents and more than half of home care patients reliant on Medicaid, it is crucial that Medicaid rates reflect the true cost of providing quality care.

It is equally important for the State to implement already enacted reimbursement reforms. Specifically, Metropolitan urges the State to:

- Implement the nursing home Medicaid rate methodology as enacted in 2006, as soon as the Centers for Medicare and Medicaid Services approves the corollary Medicaid State Plan Amendment. Although not perfect, the new methodology will rebase and restructure Medicaid reimbursement to reflect contemporary costs of providing care. Moreover, it will ensure a process to regularly update reimbursement to reflect costs, something that is crucial in this fast-paced world.
- Implement the Medicaid home telehealth rates required by the current budget law and apply them retroactively to October 1, 2007 – the date by which initial demonstration rates were required. Using technology to monitor post-acute and chronically ill patients is a win-win-win situation. It is less intrusive for the patients, it helps maximize already scarce human resources, and it’s cost-effective. Most importantly, Medicaid reimbursement for telehealth sends the right signal – pun intended – to other payers.
- Recognize the value provided by true management of care by reimbursing for it in the Managed Long-Term Care, Long Term Home Health Care, and other programs. In this regard, it is also crucial that the expansion of case management services for medically fragile children be implemented. The expansion was mandated by 2006 legislation and is anticipated to be budget neutral but still has not been implemented. In addition, care management and other patient care-

related expenses should not be considered “administrative” expenses and subject to caps.

- Extend the 30% add-on to rates of payment for continuous nursing services for medically fragile children past its scheduled expiration date of December 31, 2008 for an additional four years. The increase, enacted in 2006 but not implemented until this summer, has shown evidence of improving access to experienced nurses by the families of such children and should continue.

### **Strategic Investment**

The mid-year fiscal analyses prepared by the Division of Budget and Legislature have noted that Medicaid spending is down in the current budget year relative both to actual spending in 2006-2007 and to budgeted spending in 2007-2008, in part because of a decline in utilization of skilled nursing facility care.

Although some of the decline is attributed to a drop in the number of Medicaid beneficiaries, some may also be attributable to alternatives such as the Managed Long Term Care Program, adult day health care, and the Long Term Home Health Care Program and to the management of caring that they provide.

We know from our own research that providing a robust menu of home- and community-based programs in concert with professional care management has a direct correlation with reduced nursing home and hospital utilization – even with a frailer-than-average population with chronic and continuing care needs.

For example, our award-winning managed long-term care plan, HomeFirst, has generated an estimated \$28.8 million in Medicaid savings for the state by averting nursing home care through intensive case management. More than a quarter of HomeFirst’s members qualify for nursing home level care, but are cared for at home and in the community thanks to our care management program. Overall, only 1.2% of HomeFirst enrollees are admitted to nursing homes versus 4.6% of the comparable non-case managed population in New York City, and HomeFirst’s hospital admission rate of 602 per 1,000 members per year is half that of chronically ill New York City residents and about 15% below that of the national nursing-eligible population.

Our Medicare Advantage plan, Elderplan, has achieved similar results with its disproportionately nursing home eligible membership, thereby yielding savings to both Medicare and Medicaid.

Thus, we urge the State to invest in the growth of proven home- and community-based programs as MLTCP, adult day health care, and LTHHCP; in care management; and in crucial housing and social supports such as the Naturally Occurring Retirement Community (NORC) program. These investments could and should include:

- Reimbursement for care management services, as noted above. Payments should be determined by the acuity of the consumer's diagnosis and needs.
- Private pay options on a sliding scale for specific community services such as MLTCP, adult day health care, and LTHHCP, thereby reducing pressure on the Medicaid program while enabling individuals to obtain these services commensurately with their means.
- Grants for acquisition and adoption of home telehealth equipment and for development and deployment of aging services technology. In this context, there is a need for a strategic capital allowance in agencies' reimbursement rates for critical home health technology infrastructure needs such as electronic medical records, disease management technology, point of care technology, and related infrastructure needs. Hospitals and nursing homes have a capital component in their rates and such an allowance would help home care address its capital needs.

Likewise, the deployment of aging services technologies such as motion detectors in NORC apartments and other senior housing could enable frail elderly persons to remain in their homes longer and more safely, thereby averting nursing home utilization and hospitalizations. As currently contemplated, the home telehealth rate policy would not cover motion detectors or similar technologies that are not considered directly related to medical care.

### **Regulatory Reform and Flexibility**

Finally, one key area where the State can reduce costs – both for itself and for providers - is by streamlining regulatory oversight. We believe this can be achieved with no reduction in quality of care. For example:

- Reduce the multiple levels of review involved in health care rightsizing and other construction projects. The Metropolitan Jewish Geriatric Center rightsizing that I referenced at the beginning of my testimony has been delayed for months by the multiple layers of review. These delays are adding to the cost of capital that ultimately will be passed along in rates.
- Streamline and simplify enrollment in Medicaid-supported long-term care programs. “Deputize” more providers to directly enroll medically and financially eligible New Yorkers in programs such as MLTC and LTHHC in compliance with enrollment and eligibility guidelines. Currently, New York City’s Human Resources Administration is hiring newly graduated nurses to meet the requirement that they conduct home assessment visits for LTHHC enrollment jointly with providers. It would be preferable – and less expensive – to have providers do the assessments according to state requirements and free the HRA nurses for jobs involving direct care.

- Encourage and enable online professional and continuing education in the workforce professions. We note with approval that the State Education Department and State University of New York has authorized the first online Bachelor's Degree in nursing, to be offered by SUNY Delhi. But so much more could be done that would enable health care workers get the training they need without disrupting work and family schedules.
- Establish a Home Health Aide Registry that speeds, simplifies, and ensures the hiring of qualified aides.

These are just a few of the ways that the State could trim its own, local governments', and/or providers' burdens, yielding savings with no loss of quality. In fact, by ensuring a greater supply of direct care nurses and speeding construction of approved restructuring and patient-centered projects, they would improve quality.

### **Conclusion**

In summary, Metropolitan Jewish Health System urges the Administration to propose a 2008-2009 budget that contains strategic spending increases in health care, balanced by strategic savings initiatives.

Expanding care management, encouraging and streamlining enrollment in home- and community-based care and telehealth, and streamlining costly regulatory oversight will both yield savings and provide the proper incentives for patient-centered care.