

**The Case for a  
Medicaid Reimbursement Rate Increase  
for  
New York State's AIDS Adult Day Health Care Providers**

**The Program**

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AIDS Adult Day Health Care (ADHC) programs provide easily accessible services and care coordination to persons living with HIV/AIDS in New York City, Westchester and Long Island. There are seven AIDS ADHC programs with a total of 13 sites throughout the region. Currently, there are 1,592 Medicaid recipients enrolled in these programs who visit the facilities, on average, five times every two weeks.

ADHC clients have AIDS or are HIV symptomatic and typically have other chronic illnesses such as mental illness and chemical dependence in addition to histories of homelessness, incarceration, and domestic violence. These programs provide health care coordination and case management services to properly address the health needs of their clients while offering an array of psychosocial care depending on the members' needs. Typical services provided include HIV/AIDS medication management, health care monitoring, case management, mental health and substance abuse services, life skills training, family support counseling, health education, vocational training, and transportation to ADHC and other health care services.

The centers receive a reimbursement for services provided depending on the type of facility: \$158.38 for Diagnostic and Treatment Centers (D&TC) and \$164.80 for Residential Health Care Facilities (RHCF). These rates were established in 1995-96 when the programs were started, and were increased once in 2002 as part of a one-time legislative initiative to provide a cost-of-living adjustment for some health care workers. Otherwise, they have remained frozen.

**The Problem**

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In 1995-96, when initial rates were developed and programs began operating, AIDS was a terminal illness. Today, it is a chronic disease. Over time, the needs of the clients have increased in number and in complexity, thereby driving up the costs of care. *Reimbursement rates, however, have been frozen.*

**The Proposal**

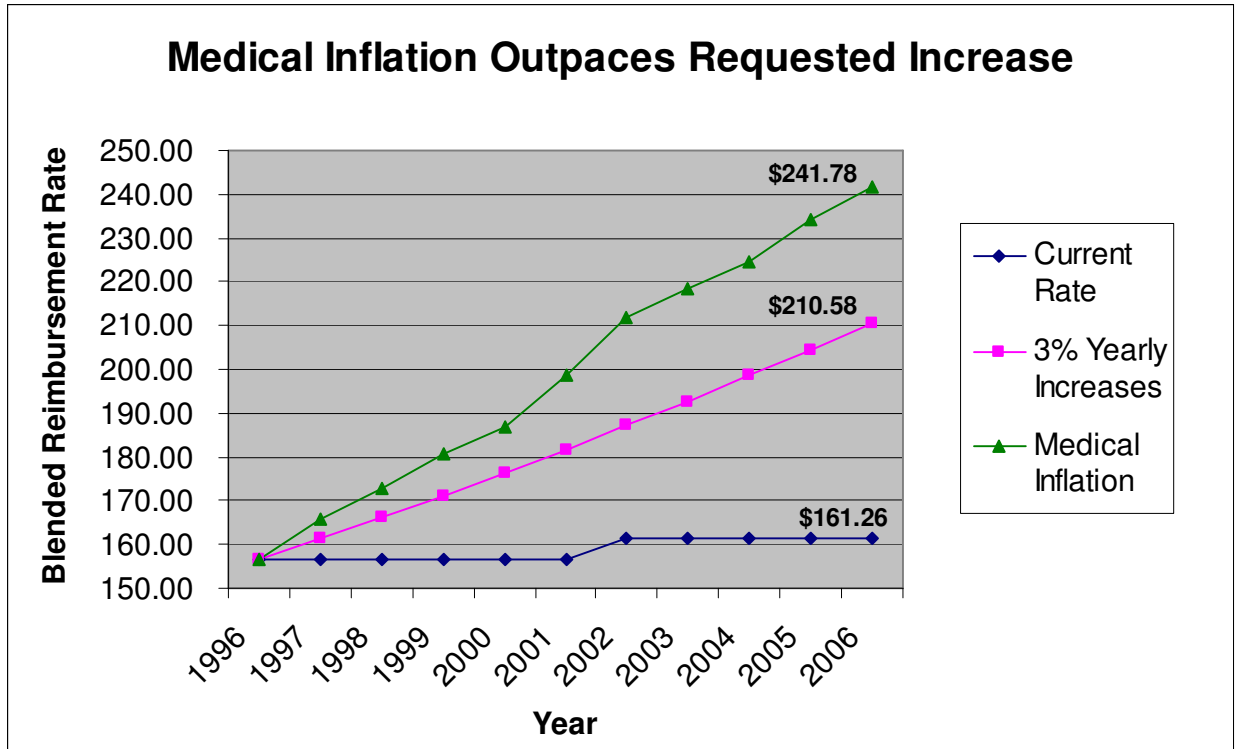
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Without an adjustment to the current Medicaid reimbursement rates, the AIDS ADHC programs will eventually close. To prevent this from happening, the state should *raise the current blended rate from \$161.26 per day to \$210.58 per day* calculated based on 3% compounded increases per year to the initial frozen rates established in 1996. See attachment for complete calculations and methodology.

*Blended Rate.* When the AIDS ADHC programs were established in 1996, two Medicaid reimbursement rates were set, one for D&TCs and one for RHCFs. This proposal combines the two rates, establishing one blended rate between the two types of facilities. This blended rate is a weighted average of the adjusted rates based on enrollment figures in the programs.

*New Adjusted Rate.* The current rates have been frozen for nine years except for a small 3% increase in 2002 designed to cover workforce costs. To calculate a new adjusted rate, the proposal assumes a 3% compounded increase for the past nine years based on the original rates. The new rate is \$210.58 per day compared to the frozen blended rate of \$161.26. This new reimbursement is a blended rate between the two programs.

Since the state is responsible for 25% of the D&TC reimbursement and 40% of the RHCF reimbursement, the total state share of the costs to implement the new rate is \$ 3,191,920.06.



**The Policy**

***AIDS ADHC Programs Save the State Money***

AIDS ADHC programs save the State of New York money because of the comprehensive system of health care coordination and case management they provide for their clients. By coordinating care and improving health, the programs prevent inappropriate utilization of high-cost services like emergency rooms, nursing homes and inpatient hospital, psychiatric or substance abuse treatment. In most cases, AIDS ADHC programs reduce or eliminate the need to access other medical or psychosocial systems, as many needed services are provided directly on-site.

*Nursing Homes.* AIDS ADHC programs were designed to keep their clients out of nursing homes, and they have succeeded. Some clients transition directly from nursing homes into day programs, while others receive stabilizing care that prevents institutionalization. Without AIDS ADHC services, many clients would end up in a nursing home receiving care at far greater cost

than a day program. Nursing home costs range between \$350 to over \$600 per day depending on the program. The AIDS day programs cost a fraction of that.

*Hospitals and Emergency Rooms.* Because AIDS ADHC programs provide health care monitoring and case management, they are able to identify medical conditions early and prevent problems from escalating. In doing so, these centers have been able to treat many conditions during day visits or make quick primary care referrals, reducing or eliminating clients' use of the emergency room as a primary care clinic.

*Chemical Dependence and Mental Health.* In 2003 in response to growing mental health and substance abuse problems in the HIV/AIDS population, the Department of Health implemented new regulations allowing AIDS day programs to admit HIV-positive patients who are actively abusing substances and/or have mental illness. In some programs, over 90% of members have serious mental illness, chemical dependency, or both. By coordinating care and treatment and providing outpatient substance abuse and mental health counseling directly to these patients, AIDS ADHC programs eliminate the need for these individuals to access those systems elsewhere, thereby reducing additional costs to the state.

#### ***1995-96 Reimbursement Rates Do Not Cover 2006 Costs***

Since initial rates were developed in 1995-96, program costs have increased due to a number of factors. These rising costs have placed immense strain on already fragile day programs.

*Rates Cover All Costs.* The Medicaid reimbursement rate for AIDS ADHC programs covers **all** medical, administrative, and capital costs. Since capital reimbursement is not an add-on (as it is for D&TCs and general hospitals), the ADHC programs must use their capped day rate to cover all capital costs. This has placed an enormous strain on the programs. In the aggregate they have made over \$18 million in capital expenditures since 1998 that are essentially uncompensated. A large portion of this burden is debt service for outstanding DASNY financing.

*Attracting and Retaining a Quality Workforce.* Flat reimbursement rates limit the programs' ability to attract and retain quality staff. Most programs continue to offer small cost of living adjustments to their staffs, just to maintain a quality workforce. When staffing vacancies arise, one program noted that instead of replacing the vacancy, they sometimes spread the cost savings among the existing staff in order to retain their workers.

*Staffing Levels Have Changed.* In 1996, AIDS ADHC programs focused almost exclusively on basic survival skills with their clients, essentially administering medications and providing other HIV/AIDS treatment. The average length of stay was under a month. Over time, lifesaving antiretroviral medications and combination therapies have allowed clients to live longer, while the needs of these survivors have changed, requiring the programs to hire additional staff to provide clinical and psychosocial services.

*Clinical Needs.* Day programs have evolved from merely treating HIV/AIDS towards managing care for HIV/AIDS as well as a variety of conditions that have emerged in the longer-living client population. Ensuring compliance with often-complex treatment

regimens is a foundation of care, requiring careful monitoring and education. The clinical needs of patients have become more complex due to the side-effects of HIV/AIDS medications. These include diabetes, lipodystrophy, anemia, anxiety/depression, and sleep disturbances. Other chronic conditions, like hypertension and cholesterol problems, have become more prevalent and require monitoring and care on-site. In order to maintain medical stability for these clients and to monitor their treatment plans, the day programs have expanded and re-tooled staff over the past nine years to add professional and credentialed staff with expanded health care expertise.

*Psychosocial Needs.* An increasing number of patients enroll with mental health and/or chemical addiction illnesses requiring integrated treatment for these issues as part of the program. In order to facilitate a smooth transition back into society, the ADHC programs provide their clients a variety of counseling services, family assistance, life skills training, and vocational training. To service their clients' needs, the programs have hired additional staff members to cover these areas. In 2003, the AIDS Institute advised the programs that only Masters-level clinicians could complete psychosocial assessments thereby requiring the ADHCs to hire more expensive employees.

*Administrative Burdens.* In the last year, the State Department of Health instituted administrative procedures that place additional uncompensated financial burdens upon the ADHCs. These new regulations include the mandatory uniform reporting system and the HIV QUAL quality standards reporting. Both of these requirements have forced the programs to either hire more staff or to reassign current staff resources to cover these additional responsibilities, without any added resources.

*Transportation and Utility Expenses Have Skyrocketed.* In 1996 the cost of a one-way trip on the NYC Subway was \$1.50; in 2005, the cost is \$2.00. This fare increase, along with costs of other modes of transportation and recent increases in fuel prices, has caused a significant increase in transportation expenses. One program reports a 139% jump in the costs of transporting its members from 1998 to 2005. Additionally, most programs have seen their utility expenses double over the time period reflecting the nationwide inflation of utility prices.

### ***Programs Are Not Financially Viable***

*Rate Freeze Hits the Bottom Line.* In 2004, four of the seven programs recorded net losses. The amounts lost range from \$85,000 to \$302,000. As a percentage, the net losses range from 6.5% to 14.7% of their total revenue. If the rates remain frozen, more programs will lose money.

*When Programs Close, System & State Costs Increase.* In the past eight years, five programs have closed as a direct result of increasing costs and frozen reimbursement rates. Since rates have not kept up with inflating costs, some ADHC organizations have shut down their AIDS day programs, thus placing increased strain on other programs. Some have seen former clients migrate into more expensive forms of treatment, such as nursing homes and emergency rooms. Additionally, a number of these stranded clients return to harmful social lifestyles and eventually end up incarcerated at the state's expense or falling into high-risk behaviors that can spread HIV infection.

### ***Broad Support Exists***

The Department of Health and the AIDS Institute have identified the rate freeze as a problem as have the Senate and Assembly leadership and consumer organizations. Year after year, for almost a decade, the needs of these small but vital organizations have gotten lost in the pressured dynamics of State Budget negotiations. We are seeking the Governor's support in the Executive Budget to ensure that this year the AIDS ADHC programs receive the relief required to sustain their operations.

### **The People**

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The follow individuals have been enrolled in and treated at AIDS ADHC programs in New York State. Their stories present a compelling case for this type of healthcare coordination and treatment for those who demand these services. These cases also show how their enrollment into AIDS ADHC programs have saved the state thousands of dollars.

#### ***Mr. LL***

Mr. LL is a 48 year old single Caucasian. He has a host of medical issues, a psychiatric disorder, a history of substance use and is enrolled in a Methadone Maintenance Program. Mr. LL was diagnosed HIV-positive in 1994 and has been a client of an AIDS ADHC program since June 1997.

Prior to entering the AIDS ADHC program, Mr. LL had a series of repeated admissions to Jacobi Hospital psychiatric and medical emergency rooms. Mr. LL recalls being hospitalized a number of times for psychiatric, medical, and substance issues that were never adequately resolved. Mr. LL reported that he received overlapping but inadequate services from his primary care physician, methadone maintenance program, Human Resources Administration, CHAMPS and the Jacobi Hospital Mental Health Clinic.

While in attendance at the AIDS ADHC center, Mr. LL receives health care monitoring and coordination together with support and assistance in private sessions with the nurse, doctor, psychiatrist, case manager, substance counselor and social worker. He also participates in health education, mental health counseling, nutrition classes, substance/harm reduction counseling, and HIV support groups.

Since his participation in the ADHC program, Mr. LL has been able to stop his substance use, stabilize his psychiatric issues, address his social issues, and manage his medical care with the assistance of the ADHC staff. This has decreased his utilization of psychiatric and medical emergency rooms, eliminated inpatient detox/rehab admissions, and reduced inpatient hospitalizations. Mr. LL also has strengthened relationships with family and friends and has stable housing.

The AIDS ADHC environment and the services provided have improved Mr. LL's health and social functioning while saving the state tens if not hundreds of thousands of dollars in medical costs.

**Mr. BJ**

Mr. BJ is a 48 year old African-American who was referred to the AIDS ADHC by Elmhurst Hospital. In addition to his AIDS treatment, he receives general wound care for a Sacral Ulcer-Stage Two and assistance with urinary catheterization for his neurogenic bladder. The client is also treated for pain due to myelopathy, paraplegia, and neuropathy. He has received psychiatric services for medication management and mental health counseling for AIDS dementia and depression.

Prior to entry into the program, Mr. BJ reported repeated emergency visits for wound and urinary tract infections. He received primary medical and psychiatric care at Elmhurst Hospital and through the Visiting Nurse Services, but was unable to maintain stable and consistent connections with care.

Currently, Mr. BJ relies heavily on the AIDS ADHC program's nurse to order necessary medical supplies, coordinate medical appointments, and maintain contact with collateral providers such as doctors, wound care providers, transportation providers, and his COBRA case manager. AIDS ADHC staff has collaborated with those close to Mr. LL to address issues of safety and hygiene within his home, including extermination of insects and rodents and disposal of garbage and clutter.

ADHC staff is currently working to obtain home care services, and provide medication adherence counseling to ensure compliance with HIV treatment. In addition, Mr. BJ meets with the ADHC psychiatric nurse practitioner for counseling to reduce psychosocial stressors. His social functioning has improved, and his emergency room and inpatient hospital visits have dropped dramatically.

The AIDS ADHC environment and the services provided have improved Mr. BJ's health and social functioning while saving the state tens if not hundreds of thousands of dollars in medical costs.

***For more information, please contact Deborah Bachrach or Anthony Fiori at Manatt, Phelps & Phillips at 212-790-4500.***

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