Home Care Work Group

July 7, 2009

Work Group to Study Key Reform Issues

- Impact of Episodic Pricing on:
  - High Utilization and Outlier Thresholds
  - Special Needs Populations
  - Dual Eligible Patients
- Wage Index Factor Adjustments
- Relationship between/compatibility of Medicare and Medicaid Episodes
  - Billing Procedures and Cash Flow
- Subcontracting between CHHAs and LHCSAs
- Promoting quality

Home Care Work Group Schedule

- July 7th
- August 31st
- September 22nd
- October 23rd
- November 10th
- December 1st Report Due

Principles of Medicaid Reimbursement Reform

- Medicaid Rates should:
  1) Be transparent and administratively efficient
  2) Pay for Medicaid Patients
  3) Encourage cost-effective care and promote efficiencies
  4) Encourage and reward quality care
  5) Encourage care in the right setting
  6) Be Updated Periodically
  7) Comply with Federal Medicaid Rules
  8) Reinforce health systems planning and advance State health care programs
  9) Be consistent with Budget Constraints

Objectives of CHHA Reform

- Rationalize and inform the rate setting system by:
  - Incorporating patient needs (case mix/patient acuity), using elements of existing data set that reflect New York's CHHA Medicaid population
  - Providing incentives to control amount and level of services provided (address utilization anomalies and eliminate rolling cost base)
  - Rewarding quality care and providing incentives to improve quality
- Current spending patterns and utilization compel reform

In 2006 Medicaid Spending Increased Dramatically ~ Growth Is Concentrated in NYC

2003-2007 CHHA Medicaid Expenditures ($000)							
Region	**2003**	**2004**	**2005**	**2006**	**2007**	**% Change from 2003 to 2007**	**Average Annual % Change 2003-2007**
Statewide	**$760,465**	**$806,927**	**$918,776**	**$1,088,055**	**$1,164,802**	**53.2%**	**11.2%**
New York City	$638,340	$679,177	$793,010	$954,052	$1,022,533	60.2%	12.5%
Suburban NYC	$35,725	$38,266	$39,408	$42,151	$43,057	20.5%	4.8%
Upstate Urban	$58,234	$60,195	$58,475	$62,124	$68,113	17.0%	4.0%
Upstate Rural	$27,168	$28,486	$27,096	$28,847	$29,960	10.3%	2.5%

Source: Department of Health DataMart

Over the Same Period, the Number of Medicaid Recipients Declined

2003-2007 CHHA Medicaid Recipients							
Region	**2003**	**2004**	**2005**	**2006**	**2007**	**% Change From 2003 to 2007**	**Average Annual % Change 2003-2007**
Statewide	**92,604**	**89,750**	**89,144**	**89,234**	**88,572**	**-4.4%**	**-1.1%**
New York City	53,800	51,553	51,676	52,468	51,214	-4.8%	-1.2%
Suburban NYC	10,152	10,143	9,896	10,106	9,464	-6.8%	-1.7%
Upstate Urban	16,563	16,219	16,141	15,861	17,428	5.2%	1.3%
Upstate Rural	11,829	11,606	11,223	10,589	10,278	-13.1%	-3.5%

Source: Department of Health DataMart

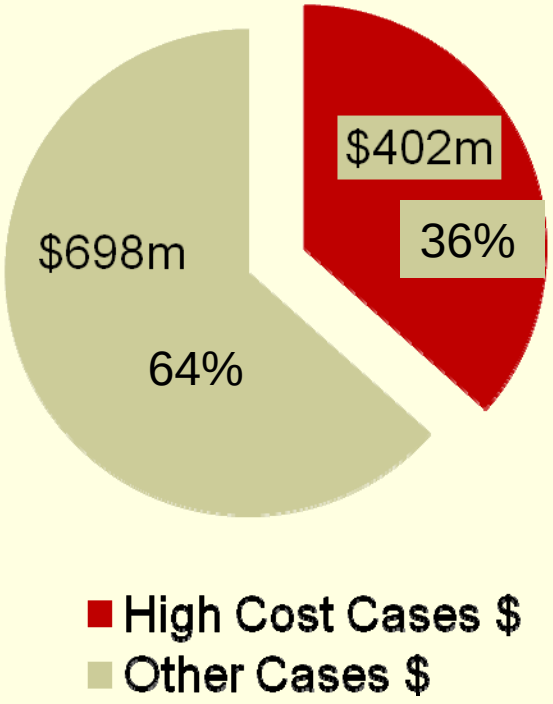
Differences in Payments and Hours Cannot be Explained by Patient Need

NYC Providers	Increase in Payments From 2003 to 2007	2007 Home Health Aide Hours Per Patient	Case Mix (Patient Need)
1	$16,489,200	1,747	.74
2	$151,952,883	1,689	.97
3	$37,358,093	1,578	1.02
4	$39,617,990	1,461	1.05
5	$43,860,488	2,617	1.16
6	$47,314,068	1,202	1.20
7	$35,677,700	1,455	1.24
Others	$69,960,470	1,429	n/a
8	($58,038,196)	1,016	1.04

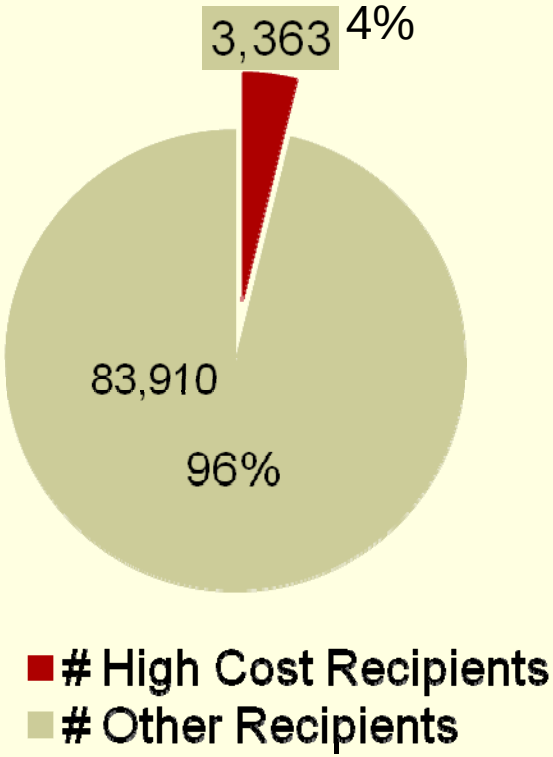
Average Hours Per Patient: NYC 1,417; Non-NYC Downstate 1,078; Upstate 402

2007 CHHA Claims High Cost Cases > $75,000

Total CHHA 2007 Claims $1.1 Billion

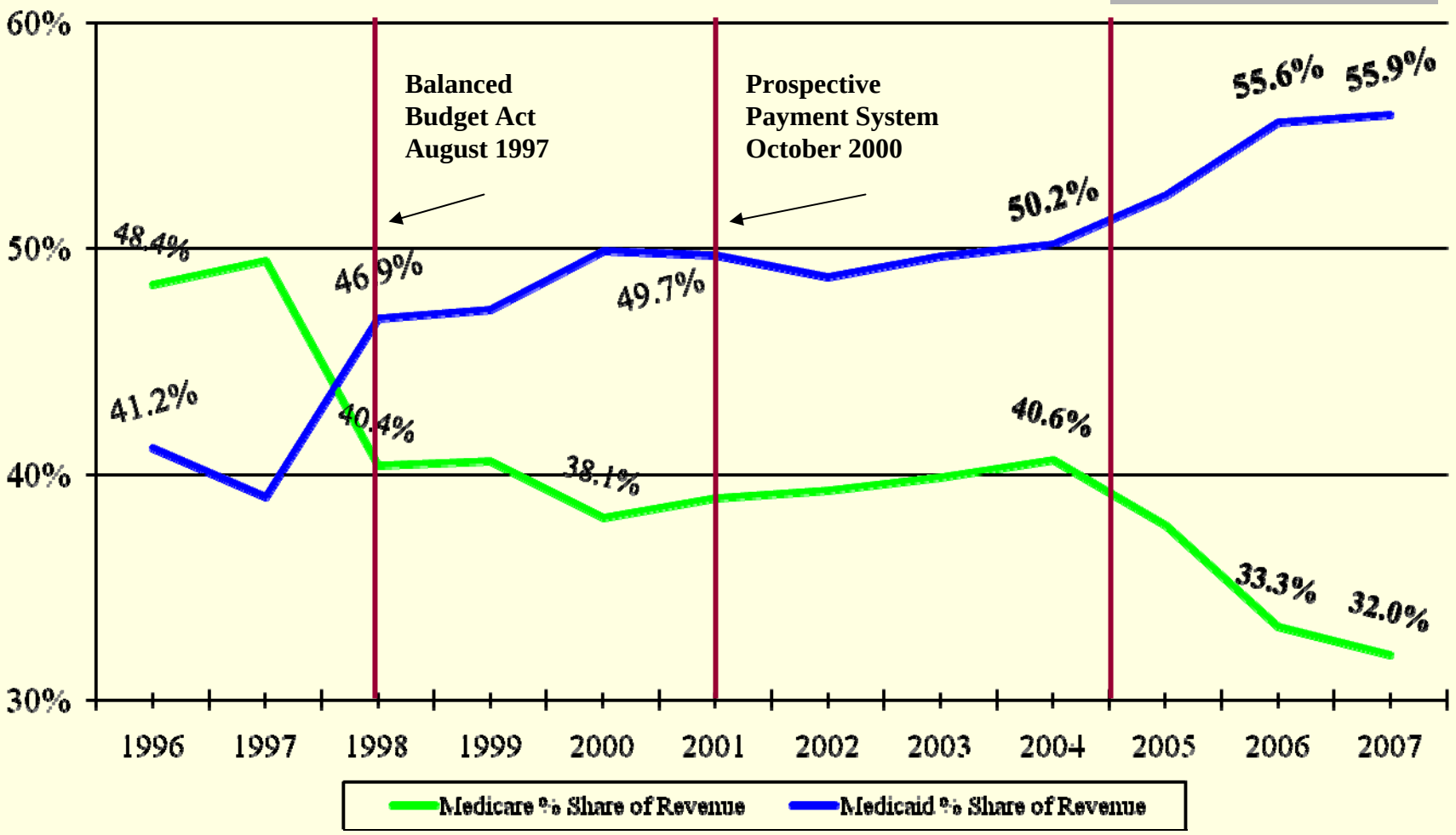


Total CHHA 2007 Recipients 87,273



9 Providers Serve 74% (2,479) of the High Cost Patients

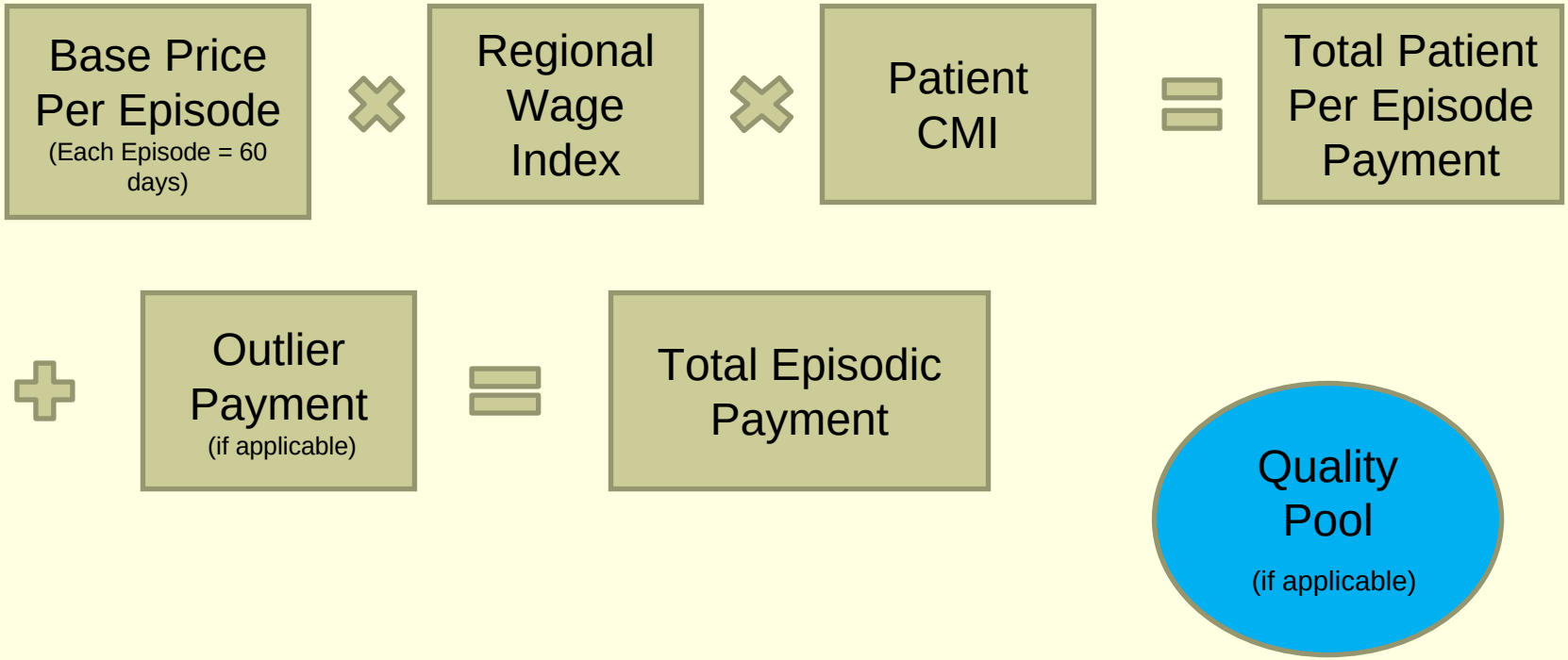
Reliance on Medicaid CHHA Funding in New York has Grown Significantly Since the Implementation of Medicare Reforms



Source: Department of Health ~ Bureau of Long Term Care Reimbursement ~ Cost Reports
New York Certified Home Health Agency Reported Patient Revenue by Payer

Episodic Pricing Model Proposed in 2009-10 Budget

- A Statewide base price (for each 60-day episode of care) is multiplied by the provider regional Wage Index and the individual Patient CMI.
- This total episodic payment is adjusted by any applicable Outlier costs and provider Quality payments



Developing the Episodic Payment System

- 2007 data for New York State CHHA patients was obtained from the Outcome and Assessment Information Set (OASIS).
  - The OASIS data set is administered by the Centers for Medicare and Medicaid Services (CMS), and is currently required to be completed by CHHAs.
- The OASIS "grouper" was used to assign each NY CHHA patient to a "resource group," based on Clinical and Functional status.
- All 2007 NYS Medicaid claims payments for CHHA services (total $1.2B) were grouped into 60-day episodes of care for each patient.
- Medicaid claims (patients) were matched to OASIS data (Clinical and Functional Groups).
- Episodes were classified as first, second, third, etc. episodes of care.
- Calculation of Base Price Excludes:
  - Episodic claims of $500 or less ("low utilization" cases)
  - Dollars in excess of outlier threshold (80th percentile of claims totals)
- Base price for each episode = average costs of claims in each 60 day episode
- Case Mix Index (CMI) for each resource group in each episode = average claim amount for resource group divided by the base price.

Base Episodic Price

- Each episodic payment is for 60-day period
- Base price varies per episode based on current claims (excluding outlier payments above threshold payments and all low utilization payments ($500 or less))
- Earlier episodes are less expensive because they include more Medicare patients and fewer long-term patients
- Later, higher costs episodes include younger, severely disabled patients (e.g., ventilator patients)

Episode	Base Price
1	$2,396
2	$4,034
3	$4,628
4	$5,054
5	$5,372
6+	$5,890

Base Price Adjusted by Wage Index Factor

- Base price is adjusted for regional wage variations (NYC, Downstate, Upstate) ~ 85% of cost affected by wage index
- Proposed WIF uses same three regions as the ceiling calculation in current CHHA reimbursement ~ New York City, Other Downstate (Nassau, Suffolk, Westchester, Rockland and Putnam counties), Upstate (all other counties)
- WIF based on average wages reported in 2006 certified CHHA cost reports
- For each region, average wage was computed for two groups of employees: professional (nursing and therapy) and home health aides (HHA).
- Regional average wage was divided by statewide average to arrive at regional index value
- Weighted average wage was then computed for each region, based on proportion of professional and HHA employees in that region.

New York City:	1.032164
Other Downstate:	0.916056
Upstate:	0.836264

Base Price Adjusted for Case Mix

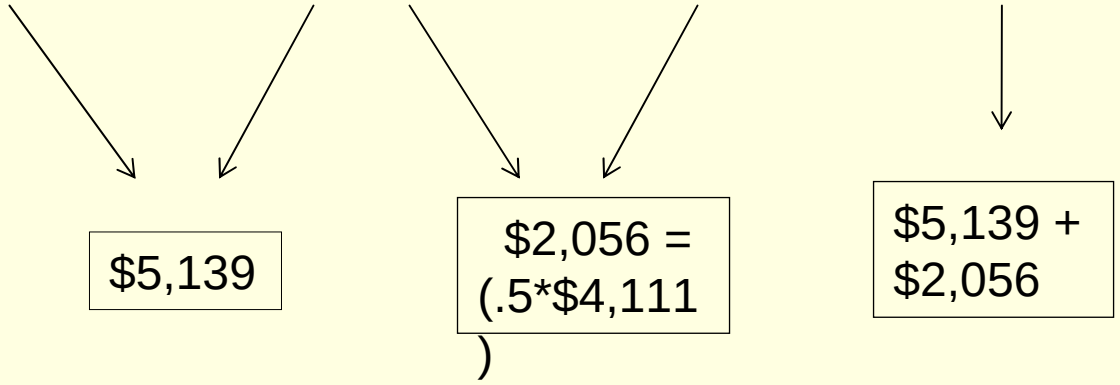
- Each patient is Grouped based on expected resource use ~ higher weight, higher resource needs, Base Price adjusted for case mix
- Classification system is similar to Medicare and includes a total of 42 groups, defined by assessment of Clinical and Functional condition and severity (minimum, low, moderate, high, maximum)
  - Clinical (A-D): Orthopedic, neurological, or diabetic conditions, intravenous or infusion therapy, nutritional and vision status, pain frequency, status of pressure ulcers, surgical wounds, urinary and bowel incontinence, cognitive/behavioral problems
  - Functional (E-I) : Ability to Perform Activities of Daily Living (bathing, dressing, transferring, and locomotion)

Group	Clinical Status	Functional Status	Description	Case-Mix
Patient A	A (Min)	E (Low)	Post pneumonia, Independent in all ADL's except bathing, no therapy	0.58
Patient B	C (Mod)	H (High)	Post cerebral vascular accident, receiving 3 hours of PT, OT, ST per week authorized for 60 days	1.89

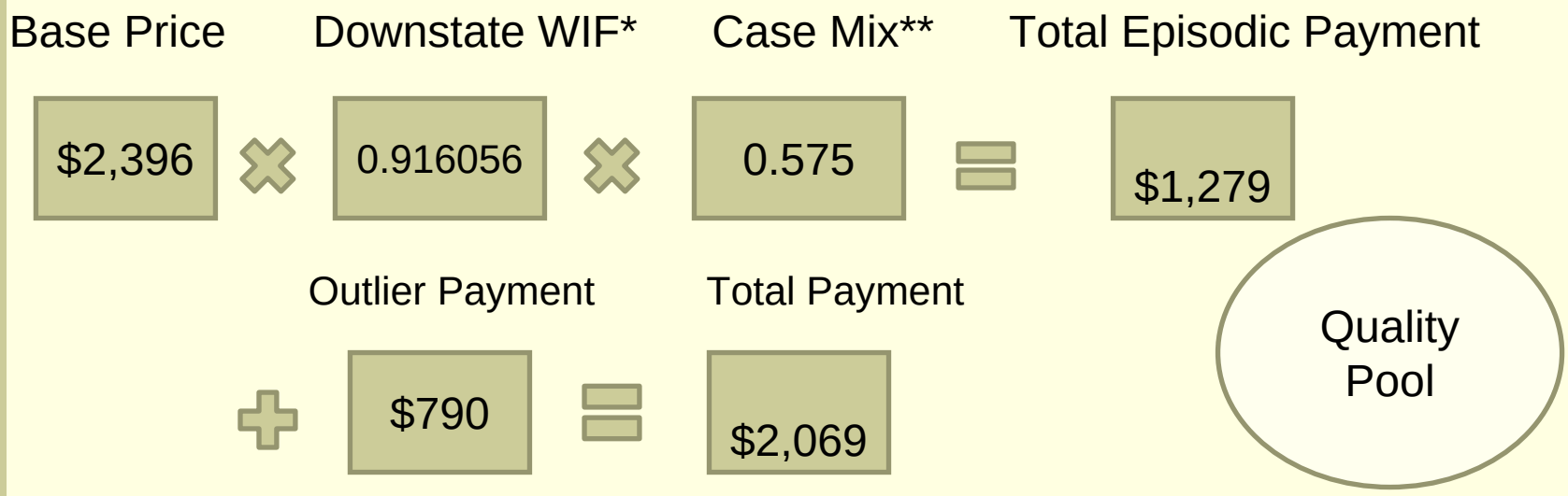
Outliers ~ High Cost Patients

- Additional reimbursement for high-cost cases that exceed episodic payment
- Outlier threshold set at 80th percentile for each case mix group within each episode
- Reimburse 50% of Outlier Costs

Patient A: (2nd Episode; CMI 1.24)	Episodic Payment	Outlier Threshold	Total Cost	Total Payment
	$5,139	$9,889	$14,000	$7,195



Example:
Episode 1, Downstate Patient, Clinical A, Functional E, Outlier Payment



Calculation of Outlier Payment			
Episodic Payment	Episode 1 Outlier Threshold	Total Cost	Outlier Payment
$1,279	$2,421	$4,000	$790

*Applied to 85% Base Price
**Applied to 100% Base Price

Rewarding Quality

- Quality Performance Measures were selected based on:
  - Importance to patient well-being and efficient delivery of care
  - Validity and reliability
  - Information that is publically reported
  - Endorsement by IPRO and OASIS technical expert panel
  - Readily available and familiar to agencies' quality assurance programs
  - Ability to affect results within the agencies
  - Ability to assure comparisons to address like populations for two distinct provider types:
    - CHHA-Only
    - CHHA with a LTHHCP

- Quality Measures are nationally standardized risk-adjusted measures:
  - Improvement in medication management
  - Less pain
  - Improvement in transferring
  - Improvement in bathing
  - Remain in community after episode
  - Improvement in breathing

Subcontracting

- Administrative costs at the contractor and subcontractor level significantly impact the rate available for compensation of the worker.
- Contractor is accountable for the quality of services provided to their clients regardless of service provider, it is unclear how there is transparency for the consumer. This arrangement results in consumers having multiple agencies during their care.
- Based on a telephone survey of CHHAs/LHCSAs the average CHHA receives a rate of $24, retains $9.22 and pays the LHCSA $14.54. LHCSA pays the direct care worker an average of $8.22 an hour.

Comparison of Certified Home Health Agency HHA Rates/Contract Rates/Hourly Wage Rates of HHAs

Certified Home Health Agency	CHHA HHA Rate	Contract Hourly Rate to LHCSA	Differential b/t CHHA Rate and Contract Rate	Wage Rate	Differential b/t Contract and Wage Rates
A	$23.89	$14.60	$9.29	$13.00	$1.60
B	$20.19	$12.50	$7.69	$7.15	$5.35
C	$29.60	$14.60	$15.00	$8.25	$6.35

* 2007 CHHA rates include WRR, RTR and AQE, contracted rates reported to DOH, wage rates are starting rates, does not include differentials, fringe or other benefits

Key Methodology Issues

- Impact of Episodic Pricing on:
  - High Utilization and Outlier Thresholds
  - Special Needs Populations
  - Dual Eligible Patients
- Wage Index Factor Adjustments
- Relationship between/compatibility of Medicare and Medicaid Episodes
  - Billing Procedures and Cash Flow
- Updates to OASIS and OASIS Grouper
  - Pediatric and maternity patients

Updates to OASIS and OASIS Grouper

- Effective January 1, 2008 CMS made changes to OASIS and OASIS grouper
- DOH is currently matching 2008 OASIS data with 2008 claims data
- Data will help analyze how predicted therapy need and episode timing (“early” vs. “late”) affect clinical and functional scoring