Pursuant to the authority vested in the Public Health and Health Planning Council by Section 3612(5) of the Public Health Law, Section 760.5 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR) is amended by adding new subdivision (l), to be effective upon filing with the Secretary of State.

Section 760.5 is amended by adding new subdivision (l) to read as follows:

Section 760.5 – Determinations of public need.
(l) Notwithstanding the provisions of this section, the Commissioner is authorized to issue a request for applications to establish new certified home health agencies, or expand the approved geographic service area and/or approved population of existing certified home health agencies. Public need, in connection with any such request for applications, shall be found to exist only if the applicant demonstrates, in accordance with the criteria set forth in subdivision (a) of section 709.1 of this title, that approval of the application will:

(i) facilitate the implementation of Medicaid Redesign initiatives designed to shift Medicaid beneficiaries from traditional fee-for- service programs to managed long term care systems, integrated health systems, or similar care coordination models; or
(ii) ensure access to certified home health agency services in counties with less than 2 existing certified home health agencies not including those operated by the county.

Regulatory Impact Statement

Statutory Authority:

Section 3612 of the Public Health Law authorizes the Public Health and Health Planning Council to develop implementing regulations for certified home health providers.

Legislative Objectives:

There are two objectives of this proposed rule: (1) further the Medicaid Redesign initiatives, and (2) increase the number of CHHAs in those areas where patient choice is limited.

The first objective, to further the Medicaid Redesign Team (MRT) initiatives that will facilitate the transition of Medicaid beneficiaries from traditional fee-for-service programs to managed care and managed long term care plans (MLTCPs), integrated health care systems and other types of care coordination models, is primary. MLTCPs are facing an immediate influx of members who require services that may more easily be provided by allowing the MLTCPs to establish a certified home health agency. It is anticipated that many MLTCPs will avail themselves of this opportunity, which will improve their ability to provide care coordination to their members, ultimately resulting in cost savings to the Medicaid program, enhance care coordination, and increase quality and efficiency of providing home health services to Medicaid beneficiaries.

Other MRT initiatives involve a shift to integrated health care systems that rely heavily on care coordination. It is anticipated that CHHAs will play a central role in connection with these models, and that there is a need to allow these systems an opportunity to better provide care coordination within the comprehensive array of services they provide and more fully meet the needs of their patients. This will also result in cost savings to the Medicaid program and increase quality and efficiency of providing home health services to Medicaid beneficiaries.

The second objective of the regulatory change is to increase the number of certified home health agencies in New York State in those areas where patient choice of home health services is limited. A number of upstate counties have closed, are in the process of closing, or have indicated a desire to close, their CHHAs. In many cases, closure of the county operated agencies will leave only one existing CHHA in the county. The expansion of need in these counties will improve patient choice and access as well as quality outcomes. Additionally, increased competition in these areas may result in cost savings to the Medicaid program.

While all potential applicants will have the opportunity to demonstrate need as defined in the rule, it is anticipated that immediate need is primarily focused in those areas referenced above given the current service delivery landscape.

Needs and Benefits:

In conjunction with the MRT initiatives this rule will facilitate the transition of Medicaid cases to care coordination models by allowing MLTCPs the opportunity to provide home health services directly. The rule will also decrease Medicaid costs for patients who are chronically ill by allowing patients to remain in their home and receive home health services through a coordinated approach to care delivery. In addition, the rule will allow existing health systems to establish new CHHAs or to expand the geographic service area of existing CHHAs to enable the health care system the ability to provide a full array of services including home health care more efficiently.

As more county-based CHHAs are closing, the establishment of new CHHAs, and/or the expansion of the geographic service area, and/or the expansion of the population served by existing certified home health agencies, will ensure improved patient choice and access of home health services in these communities. The increased competition of certified home health agencies may lower the costs of home health care services.

Costs:

Costs to Regulated Parties:

The rule does not impose any new compliance costs on regulated parties.

Costs to the Agency and to the State and Local Governments Including this Agency:

This rule should not impose any costs upon this agency, New York State, or its local governments, except for incidental costs that may be associated with the issuance of a request for applications and evaluation of applications received. As discussed above, the rule may result in decreased costs associated with Medicaid expenditures for the State

as a result of decreasing institutional health care costs and increasing community based services.

Local Government Mandates:

This rule imposes no mandates upon any county, city, town, village, school district, fire district, or other special district.

Paperwork:

The rule imposes no new reporting requirements, forms, or other paperwork upon regulated parties.

Duplication:

There are no relevant rules or other legal requirements of the Federal or State governments that duplicate, overlap, or conflict with this rule.

Alternatives:

The Department examined several alternatives including approval of new CHHAs using the current need methodology outlined in 10NYCRR section 760.5, or revision of the current need methodology. These options were rejected for multiple reasons, but primarily because of the limited time table for implementation of MRT initiatives and a lack of evidence suggesting widespread need for additional CHHAs in New York State.

The MRT has suggested, as a primary method of reducing costs and increasing quality and efficiency in the Medicaid program, a rapid shift from the traditional fee-forservice model to care coordination models that will better ensure that Medicaid recipients receive quality care in an efficient manner. MLTCPs and other integrated health systems must be ready to accept a significant number of patients in the near future, and will be better able to provide a comprehensive array of services to meet the needs of individuals receiving care through their systems if they had the ability to establish or expand CHHAs to accommodate these patients. Allowing these provider types to establish a new CHHA or expand an existing CHHA to meet the needs of patients provides a means for a more integrated, cost effective, quality outcome based approach.

In addition to the needs that have arisen in connection with implementation of the MRT initiatives, the availability of upstate home health agency providers has decreased in recent years as more county-based CHHAs have closed in response to fiscal pressures. There are currently 130 CHHA providers in New York State. Of these, 32 are county operated agencies and 16 are sole providers within their county. In recent years, 17 county operated CHHAs have closed, and an additional 18 counties have indicated to the department that they intend to close or have a closure plan in place to occur over the next year. These closures have decreased patient access and choice to home health services, and have made county residents dependent, in many cases, on a single source for their home care needs. Given the potential risks of these limits, there is a need for additional providers in areas that have diminished sources of care. Although the department made efforts to review the number of existing CHHAs against the current need methodology, existing data is insufficient to determine whether the existing methodology accurately reflects need. Addition of existing agencies using the current or a revised methodology would thus require a significant amount of time to collect and analyze data, and make

needed revisions.

Other than these two specific areas of need, the Department has no evidence of unmet need in New York State in accordance with the existing need methodology, nor the data that would be necessary to evaluate the efficacy of that methodology and undertake substantial revisions that may be necessary. As such, and because MRT implementation is extremely time sensitive, the options of lifting the moratorium using the current need methodology or revising the need methodology were rejected due to time constraints and lack of sufficient data. The Department will, however, continue to examine the need methodology for a possible future revision to the regulations.

Federal Standards:

The rule does not conflict with nor exceed any minimum standards of the Federal government for the same or similar subject area.

Compliance Schedule:

None.

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