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MEMORANDUM

TO: Community Services Members

FROM: Patrick Cucinelli, Senior Financial Policy Analyst
Anne Hill, Community Services Policy Analyst

DATE: February 27, 2009

SUBJECT: **DOH Clarifies CHHA Reimbursement Proposal**

ROUTE TO: Administrator, CFO

ABSTRACT: DOH issues additional details on proposed CHHA reimbursement changes.

Introduction

NYAHSA and other provider associations recently met with the Department of Health (DOH) to ascertain further details on the proposed changes to the certified home health agency (CHHA) reimbursement system. As members are aware, DOH is proposing to implement a Medicaid episodic pricing system (EPS) along the lines of the current Medicare prospective payment system (PPS) to take effect on January 1, 2010. This was our second meeting with DOH intended to provide additional details on the proposed EPS. The first meeting was summarized in NYAHSA Doc ID# n00003043.

Remaining Concerns

NYAHSA still has several concerns about the proposed system, including the following:

1. The system was developed solely by DOH staff with no provider community input;
2. Implementation of the EPS would result in an overall loss of approximately $100 million to providers on a statewide basis, stemming primarily from the allocation of outlier payments;
3. Critical questions regarding the new system remain unanswered; and
4. DOH is looking to implement the system on a statewide basis as of January 1, 2010 with no transition or demonstration phase. Therefore, any unanticipated problems will not be uncovered until the system is being implemented, which may then be too late to avoid serious problems for some providers. If the system is agreed to in spite of our concerns, the provider community is advocating strongly for some transition or demonstration phase-in. NYAHSA maintains it is ill-advised to go live with an untested system.

The Outlier Threshold

The single biggest area of concern expressed during the meeting was the arbitrary setting of an outlier threshold at the 80th percentile of total claims. Similar to the Medicare PPS system, DOH intends to include additional reimbursement for high-cost cases (outliers) that exceed the episodic payment. However, for any outlier a limit is set at 80 percent, at which point the system will only reimburse 50 percent of the outlier costs. In the example cited by DOH, the patient is in a 60-day episode which pays $5,137. The actual cost incurred by the agency is $14,000. The 80 percent outlier threshold is $9,889. The agency's reimbursement in this example is:

$5,137 base payment + ($14,000 actual cost - $9,889 outlier threshold)*50% = $7,193.

In this example, provided by DOH, the agency is reimbursed only slightly more than 50 percent of its actual costs.

The 80 percent threshold was deliberately set by DOH in order to achieve a $100 million savings. According to DOH, any adjustment of the threshold would have to be budget neutral. Therefore, any adjustment that would allow for more costs to be covered would also have to result in fewer cases qualifying for the outlier payment.

An interesting statistic presented by DOH is that in 2007 only 4 percent of cases, or 3,363 clients, comprised 36 percent of the total Medicaid CHHA dollars paid. What DOH is viewing as a disproportionate expenditure on a small number of clients is a major consideration behind their outlier threshold proposal. It is important to keep in mind, however, that in all probability many of these high-cost cases would be institutionalized at comparable or greater costs if they were not receiving home care.

DOH's expectation is that agencies will lose money on outliers, but make up for the loss on the other end. From the provider's perspective, however, this raises a serious question as to the incentive to care for these cases, and the possibility that this could result in individuals back-logged in hospitals or unnecessarily placed in institutions.

Only Three Regions

As currently proposed, regional rate adjustments across the state will be based on only three regions: 1.) New York City; 2.) Downstate (non-NYC); and 3.) Upstate. This was also raised as a major concern with DOH. In particular, the grouping of Upstate as one single homogeneous group is unrealistic. DOH expressed their willingness to consider alternatives, including the wage index regions as used in Medicare. This is a critical piece of the pricing scheme as 85 percent of the costs are impacted by the regional wage index.

DOH did cite a problem with developing wage data for Upstate, given that many counties may have only one agency, but, again they stated their willingness to address the concern about having too few wage regions.

The Episodic Payment

The foundation of the proposed system is the 60-day episodic payment. The formula for the episodic payment is:

[Base Price per Episode (approximately $2,400) x Regional Wage Index x Patient CMI =Total Patient Per Episode Payment] + Outlier Payment (if applicable) = Total Episodic Payment.

The base price would increase with each 60-day episode, ranging from approximately $2,400 for the first 60 day period to almost $6,800 for the sixth period and leveling off from that period forward.

The calculation of the base price excludes episodic claims of $500 or less ("low utilization" cases) and dollars in excess of the 80 percent outlier threshold. With these claims excluded, DOH then took the average costs of claims in each 60 day episode to come up with the base price.

Proposed EPS base prices are as follows:

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

Using actual claims data, DOH calculated a lower base price for earlier claims which are impacted by Medicare coverage and do not include long-term patients. NYAHSA questions whether this is appropriate since it ignores the start-up costs incurred in taking on a new client, especially in the case of a client with no Medicare coverage. This pricing scheme could create a disincentive to take patients with high start-up costs and no Medicare coverage.

2007 calendar year Outcome and Assessment Information Set (OASIS) data and all Medicaid claims for the period were correlated to develop the pricing scheme, with each CHHA patient assigned to a resource group based on clinical and functional status. One concern with this methodology is that 2007 claims were paid based on 2005 cost report data. By the time this system would be implemented that data would already be 5 years old. NYAHSA believes that the claims data should be updated. Otherwise, given the recent trend to cut or eliminate inflationary adjustments in Medicaid rates, providers could be locked into an already outdated base year, without adequate trend factor adjustments.

Case Mix Adjustment

The resource utilization groupings (RUGs) will drive much of the reimbursement in the proposed system. DOH attempted to design their system along the lines of the current Medicare model. They are proposing 42 RUGs defined by OASIS assessment of clinical and functional condition and severity (minimum, low, moderate, high, and maximum).

The clinical components (A-D = min-max) include: orthopedic, neurological, diabetes, intravenous or infusion therapy, nutrition and vision status, pain frequency, pressure ulcers, surgical wounds, urinary and bowel incontinence, and cognitive/behavioral problems.

The functional components (E-I = min-max) are based on the ability to perform activities of daily living.

Quality Pool

In addition, the final rate can be augmented by a quality incentive payment add-on, in which a set pool of statewide dollars would be distributed based upon an agency's relative performance in a set of quality performance measures, including survey results and nationally standardized risk adjusted measures. The payment is limited to 10 percent of an agency's annual Medicaid revenue. The pool would be split between CHHAs and CHHAs with a Long Term Home Health Care Program (LTHHCP).

The first year allocations of the quality pool dollars will be for "best performers." Subsequent year allocations will be split between best performers at 75 percent of the pool and most improved at 25 percent of the pool. DOH is describing a selection methodology based on performance in the top 70 percent overall weighted with the top 20 percent in each measure.

As proposed, the factors that would disqualify a provider from the pool include:

- Failure to file required cost reports;
- Failure to file required statistical reports;
- A conditional level finding in the most recent survey;
- A final determination of fraud or abuse; and
- Change of ownership in the last 15 months.

Of these factors, the issue of the determination of fraud or abuse is the most controversial from the provider's perspective, given the fact that much of what is now being labeled under the heading of fraud and abuse would have traditionally been considered routine and straightforward audit findings. In addition, the proposal envisions leaving much of the determination as to a disqualifying finding up to the discretion of DOH. Under the current proposals, providers would have to ensure that any stipulations stemming from any audit findings specifically state that the provider is not excluded from receiving quality pool dollars. This factor remains vague and the provider associations are advocating for more specifics.

Conclusion

While DOH is making the effort to reach out to provider associations, the proposal for the new system still raises more questions than are answered, and the provider community remains concerned over the plan to go "live" without any transition or demonstration phase. As part of our current budget advocacy, NYAHSA intends to continue to make the case that more transparency and provider community input is needed before lawmakers can commit to implementing this new system.

If you have any questions or comments regarding the contents of this memo, you may contact Anne Hill at ahill@nyahsa.org or 518-449-2707, ext. 141, or Patrick Cucinelli at pcucinelli@nyahsa.org or ext. 145.