Interim Report
Home Health Care Reimbursement Work Group

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EXECUTIVE SUMMARY

Overview

This report sets forth the New York State Commissioner of Health's interim findings of the Home Health Care Reimbursement Work Group charged with studying the Medicaid home health care reimbursement system for Certified Home Health Agencies (CHHAs) as required by Chapter 58 of the Laws of 2009 (Section 125-d of Part C).

The Home Care Work Group was created to further discuss and study the 2009-10 SFY Executive Budget proposals to:

- Reform the cost-based CHHA Medicaid reimbursement system with the implementation of a Value Based Purchasing, Medicare-like Episodic Pricing model.
- Create a Quality Pool to encourage and recognize providers' efforts to provide quality care and improve patient outcomes.
- Eliminate subcontracting by Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCP) for Home Health Aides (HHAs) with Licensed Home Care Services Agencies (LHCSAs) to reduce potential duplicative administrative costs, improve the pay and benefits of HHAs, and assure CHHAs maintain responsibility for the quality of care provided to recipients of services.

The statute provided that the members of the Home Care Work Group shall include representatives of:

- CHHAs,
- LHCSAs,
- Hospice providers,
- Consumers of home health care services,
- Local governments,
- Labor organizations, and
- Other home health care stakeholders

The statute directed the Home Care Work Group to collaboratively study and analyze:

- the impact of episodic payments on high-utilization and outlier thresholds, special needs populations, and dual eligible patients;
- the relationship between, or compatibility of, Medicare and Medicaid episodic payments;
- billing procedures related to the cash flow of episodic payments;
- wage index factor adjustments; and
- subcontracting between CHHAs, LTHHCPs, and AIDS home care programs with LHCSAs.

Appendix A includes:

1. Section 125-d, Part C, Chapter 58 of the Laws of 2009.
2. List of Work Group members.
3. Comments from Work Group members.

The following Principles of Reimbursement Reform were the foundation for developing the proposed Episodic Pricing Reimbursement System. These principles were also consistently applied to the development and implementation of other initiatives to reform Medicaid reimbursement methodologies for other provider types. Following discussions with the Work Group, principle 5) was refined to specifically recognize the importance of access to services as a component of providing care in the right setting. The principles were endorsed by the Home Care Work Group and guided the Group's discussions. The principles ensure Medicaid rates will:

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 and provide access to 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; and
9) Be consistent with Budget Constraints.

Summary of Commissioner's Interim Findings

The Home Care Work Group's analysis and deliberation are evidence that communication can result in reforms that meet the essential principles described above and ensure that Medicaid funds are spent efficiently to deliver the appropriate level of quality care services to recipients. The Work Group expressed serious concerns with the size and scope of the proposed reduction in overall spending for home health care services in the 2009-2010 Executive Budget. This report, and the findings contained herein, will ultimately result in many improvements and refinements.

Finding 1:

The Work Group should continue for another year. Some of the recommendations below involve additional analysis that will further refine some of the detailed, technical aspects of the Episodic Pricing model. The Work Group should continue to discuss and evaluate refinements and then focus on the issues related to the implementation of an Episodic Pricing model.

Finding 2:

New York State should adopt and implement a Value Based Purchasing Episodic Pricing Model that establishes a base price for CHHA Medicaid home care services, adjusts the Base Price for variations in labor costs, uses the Medicare Outcome and Assessment Information Data Set (OASIS) patient assessment tool to adjust the Base Price for patient acuity/case mix and rewards the provision of quality health care services. The use of the OASIS tool is the best available option at this time; however, the Department will continue to evaluate revisions as part of its implementation efforts.

Finding 3:

Rewarding and improving quality is a critical element of reforming the Medicaid CHHA reimbursement system and is an essential component of the Episodic Pricing methodology.

New York must adopt CHHA Medicaid reimbursement reforms that encourage and reward quality care through additional payments from a quality funding pool. To incentivize quality outcomes of service, performance measures for home health care services must be utilized to rank both best performance and most improved performance of home health providers. To ensure the most accurate comparison / ranking of agencies, the Department concurs with the Work Group recommendation to establish separate rankings and funding pools for CHHA-only and combined CHHA/LTHHCP agencies. The issue of short term and long term patients must be addressed in any quality payments. Work Group members expressed an interest in using workforce measures as part of any quality payment program.

Finding 4:
Information from the OASIS patient assessment tool should be evaluated to refine the case mix component of the Episodic Pricing model. This will improve the ability of the model to explain variation in costs among CHHA Medicaid patients and appropriate pricing for high need, high cost patients. This approach will use patient specific measures from OASIS that inform cost of care beyond functional and clinical measures. Several measures are being analyzed for relevance. The use of an assessment tool for the Medicare program in the context of Medicaid payment policy presents certain challenges. The Work Group and the Department will jointly work over the next year to ameliorate those challenges.

Finding 5:
Proceed with refinements to the Wage Index Factor (WIF) to increase the number of regions by using 10 regions used by the Department of Labor. In addition, proceed with the Work Group's recommendation to work together to expand the reporting requirements of CHHAs and LHCSAs to permit for the incorporation of New York State specific information to allow for future refinements to the WIF. Until this data becomes available, the Work Group has agreed to use proxies to reflect fringes in the calculation of wages and the Medicare share (77%) of the price that will be adjusted by the WIF.

Finding 6:
In order to better understand the subcontracting relationship between CHHAs and LHCSAs, the Department will amend the cost reports for CHHAs and LTHHCPs and the statistical report for LHCSAs to obtain data that will improve the transparency of this relationship and allow for informed decisions about reforms that would improve efficiency and the quality, stability, and management of the home health aide workforce. The Work Group will continue to discuss the issues of home health care aide wages and benefits.

BACKGROUND

Current Reimbursement System

The provision of services by a CHHA provider is based on a comprehensive assessment utilized to develop a plan of care and authorized by a physician order. Access to the benefit can be extended every 60 days as long as a physician continues to approve the updated plan of care.

The current CHHA reimbursement system establishes cost-based, provider-specific service rates for 144 CHHAs. Costs are used to establish a home health aide hourly rate and professional services per visit rates for nursing, physical therapy, speech therapy and occupational therapy. Home health aide hours are the predominant services provided by the CHHA Medicaid program and accounted for 80 percent of total 2008 CHHA spending. The cost year used to establish these rates is updated annually and is based upon the most recent cost report available. For example, 2009 rates are based upon costs submitted with 2007 CHHA certified cost reports. Trend factors are then applied to the rates.

Rates are subject to regional peer group ceilings that are increased by 10 percent. The regions are New York City, New York City Suburban (the counties of Nassau, Suffolk, Westchester, Putnam and Rockland) and Upstate (the remaining areas of the State). A ceiling is established for public and non-public providers within each of the three regions. Reimbursement for costs that are attributable to administrative and general charges are capped at the statewide average percent share of such costs to total costs. In 2009, the statewide cap was 23.95 percent. Rates are also subject to a three percent recruitment and retention adjustment to the rate.

Recent CHHA Spending Trends

Based on 2008 Medicaid claims data, CHHAs served approximately 82,222 patients. In 2008, CHHAs spending was about $1.164 billion and accounted for roughly 9.5 percent of New York's Medicaid long term care expenditures. Roughly 88 percent of CHHA spending occurs in New York City.

Recent statewide CHHA spending trends demonstrate significant increases in spending. The spending increases cannot be explained by the growth in recipients served by CHHAs or increases in case mix/patient acuity, suggesting an increase in utilization (the amount of services provided to each patient). The following tables display the growth, by region, of CHHA spending, recipients, and per beneficiary spending over the six-year period 2003 through 2008.

2003 – 2008 CHHA Medicaid Expenditures							
Region	**2003**	**2004**	**2005**	**2006**	**2007**	**% Change 2003 to 2007**	**2008 Preliminary**
Statewide	$760,464,699	$806,926,599	$918,775,967	$1,088,055,030	$1,164,801,676	53.2	$1,164,093,698
NYC	638,340,094	679,176,865	793,010,129	954,052,539	1,008,640,843	58.0	1,020,339,817
Downstate	35,725,238	38,266,184	39,407,568	42,150,681	58,416,552	63.5	50,278,630
Upstate	85,401,257	88,681,125	85,574,666	90,970,264	97,621,298	14.3	93,363,246

2003 – 2008 CHHA Medicaid Recipients							
Region	**2003**	**2004**	**2005**	**2006**	**2007**	**% Change 2003 to 2007**	**2008 Preliminary**
Statewide	92,604	89,750	89,144	89,234	88,572	-4.4	82,222
NYC	53,800	51,553	51,676	52,468	51,214	-4.8	49,517
Downstate	10,152	10,143	9,896	10,106	9,464	-6.8	8,832
Upstate	28,392	27,825	27,364	26,450	27,706	-2.4	23,873

2003 – 2008 CHHA Medicaid Spending Per Recipient							
Region	**2003**	**2004**	**2005**	**2006**	**2007**	**% Change 2003 to 2007**	**2008 Preliminary**
Statewide	$8,212	$8,991	$10,307	$12,193	$13,151	60.1	$14,158
NYC	11,865	13,174	15,346	18,184	19,695	66.0	20,606
Downstate	3,519	3,773	3,982	4,171	6,173	75.4	5,693
Upstate	3,008	3,187	3,127	3,439	3,523	17.1	3,911

- Over the 2003 to 2007 period, CHHA expenditures **increased** by over 53 percent, while over the same period CHHA recipients **decreased** by 4.4 percent.
  - ✓ NYC accounted for approximately 92 percent of the overall growth, and NYC per recipient CHHA expenditures increased 66 percent.
- In 2008, average annual home health aide hours per NYC recipient were 1,381, or approximately three and one-half times the upstate annual average.
  - ✓ The annual Medicaid cost per NYC recipient was $20,606 compared to $4,392 for the rest of the State.
- In 2008, average annual home health aide hours per NYC suburban recipient (by providers located in the counties of Nassau, Suffolk, Westchester, Rockland and Putnam counties) were 2.8 times higher than the upstate annual average.
- In 2008, 4.5 percent, or 3,706 of total CHHA patients had annual CHHA costs that exceeded $75,000 and that accounted for over 39 percent of total spending ($454 million).
  - ✓ Approximately 95 percent or 3,508 of these patients received services from NYC providers.
- Additional information on Medicaid Long Term Care Spending Trends demonstrating variation between downstate and upstate is attached in Appendix B.

Flaws of the Current System

The Department believes that Medicaid should move away from a cost based reimbursement system in order to preserve its sustainability in the long term. The analysis of spending and utilization trends compelled the Department to examine the overall construct of the current CHHA reimbursement methodology. The Department concluded the current reimbursement methodology is inconsistent with the reimbursement principles. Specifically, the Department determined:

- Annual updates to cost base provide no incentive to control costs or promote cost efficiencies.
- A uniform Statewide Administrative and General Costs cap is ineffective. Logical economies of scale are not demonstrated – some of the largest providers exceed the current 24 percent statewide cap.
- The regional ceiling averages are increased by an arbitrary factor of 10 percent to reflect diseconomies of scale for smaller providers – but larger providers operate above the regional average and benefit from the 10 percent add on.
- The current system is not rationalized or informed by the condition (i.e., acuity or case mix) of recipients.
- There is no incentive to encourage the delivery of quality services and there is no provision to reward improvements in quality.
- Provider specific rates per hour/visit provide no incentive to control the amount and level of services provided.
- The public has limited ability to assess or compare the quality of the licensed agencies. The State lacks specific data to determine whether or not the rates paid for home health aide services are in fact used for aide wages and benefits.
- The State lacks enough specific data to determine whether or not the dollars being spent for workforce recruitment and retention are having a true effect on the aide workforce.

Developing the 2009-10 Episodic Pricing Proposal and Methodology

In response to the spending trends described above, and in concert with the reimbursement principles, the Department sought to reform and rationalize the CHHA reimbursement system. Key considerations included:

- Establishing a price for services.
- Adjusting prices for patient acuity (case mix) by incorporating data from a patient assessment tool that is readily available and currently used by CHHA providers.
- Adjusting prices for variation in labor.
- Providing outlier payments for high cost patients, helping to preserve access and care to those with the highest case mix and more complex service needs.
- Promoting and rewarding the provision of quality care.

Medicare Prospective Payment System ~ A Model for New York State

The 2009-10 Episodic Pricing proposal was modeled after the Medicare Home Health Prospective Payment for home health agencies (HHAs). The Medicare system pays HHAs a predetermined base price or payment for each 60-day episode of care for each beneficiary. The payment is adjusted for patient acuity or case mix (i.e., the health condition and care needs of the recipient) and the geographic differences in wages for HHAs across the country. If a beneficiary is eligible for care, episodes are approved. While payment for each episode is adjusted to reflect the beneficiary's health condition and needs, a special outlier provision exists to provide additional payment for those beneficiaries that have the most expensive care needs. In lieu of a base episodic payment, low utilization beneficiaries that require four or fewer visits are paid a standardized, per visit amount.

The Medicare Home Health Prospective Payment System uses the Outcome and Assessment Information Set (OASIS) instrument to assess the patient's acuity and determine case mix. All HHAs, including HHAs in New York State, have been submitting the OASIS since July 19, 1999 for all payer categories. OASIS items describe the patient's clinical and functional condition, as well as the expected therapy needs, which are used to determine the case-mix adjustment to the standard payment rate.

Components of the Proposed 2009-10 Episodic Pricing Model

There are five key components to the proposed Episodic Pricing Model:

1) A Base Price for each 60-day episode of care for each recipient.
2) A Wage Index Factor (WIF) that adjusts the Base Price to account for the variation in wages across different regions of the State.
3) A Case mix adjustment that adjusts the WIF adjusted Base Price for patient acuity.
4) An outlier payment that, if applicable, is made in addition to the WIF and case mix adjusted Base Price to pay for certain costs above a threshold.
5) Quality incentive payments.

Appendix C provides a detailed description of the Episodic Pricing methodology proposed in 2008 with the 2009-10 Executive Budget.

Subcontracting

The 2009-10 Executive Budget included a proposal to eliminate subcontracting by CHHAs and LTHHCP for HHAs with LHCSAs. This proposal was advanced to reduce potential duplicative administrative costs, improve the pay and benefits of HHAs, and assure CHHAs maintain responsibility for the quality of care provided to recipients of services.

The home health care workforce is one of the fastest growing segments of the workforce and will continue to grow in the coming decade in response to a growing proportion of aged and disabled Americans. The emphasis on moving health care services from institutions to home and

community-based settings is critically dependent on access to a robust community based workforce. The provision of high-quality care depends on agencies' being held accountable for the services provided by these critical workers, a task made more difficult by arms-length arrangements.

According to the Center for Health Workforce Studies at the State University of New York at Albany, between 2002 and 2007, the home health care workforce grew by 38 percent statewide, with growth concentrated primarily in the Hudson Valley and New York City. The home health care sector is expected to experience the fastest growth among health occupations at 4.5 percent annually between 2006 and 2016. HHAs are expected to have one of the largest increases in new jobs, at 49 percent, between 2006 and 2016, ranking it among the top of the fastest growing job markets. (See The Health Care Workforce in New York, 2007: Trends in the Supply and Demand of Health Care Workers, published by the Center for Health Workforce Studies, School of Public Health, SUNY Albany, March 2009, p. 7 & pp. 17-18). Nationally, the Paraprofessional Health Institute (PHI) estimates that one million new direct care jobs (including both personal care aides and HHAs) will need to be created by 2016 and that 64 percent of these direct care workers will perform their duties in home and community based settings by 2016. (See http://phinational.org/policy/about-the-workforce/growing-demand-for-direct-care-workers/, accessed 10/22/09).

It is incumbent upon the State of New York to ensure that these workers are well prepared to provide quality care to every patient. Laws and regulations currently permit CHHAs, LTHHCPs and other home health care programs to contract for home HHA, among others. However, regardless of whether the CHHA or another long term care program provides HHA services directly or through contract, their administrators remain responsible for the quality of care provided to the patient and the compliance of the direct care worker with various federal and state mandates. These mandates include initial and ongoing training, criminal background checks, worker health requirements, and other employment related requirements.

The flow of Medicaid funds paid to the CHHA and forwarded to the LHCSA for providing HHA services must be transparent. The chart on subcontracting (Appendix D) indicates that there is wide variation in the CHHA home health aide rate funded by Medicaid, the contract rates paid to LHCSAs to provide these services and, to a lesser extent, to the starting wage rate provided to HHAs. For example, there is no documented relationship between the CHHA home health aide rate and the starting wage when a CHHA rate of $30.68 results in a wage of $8.50 and a CHHA rate of $19.16 results in the same wage rate. If a higher cost of living results in a higher CHHA rate, it should flow through to the aide in the same high cost area. Conversely, agencies that operate in "living wage" counties should have their CHHA rate reflect the higher cost of providing services. Rationality must be applied to the CHHA rate, the contract rate and the wage rate and the relationship among these rates should be more transparent to the taxpayer.

See **Appendix D** (Chart on Subcontracting)

SUMMARY OF HOME CARE WORK GROUP MEETING AND DISCUSSIONS

The Work Group convened on five occasions (July 7, 2009; August 31, 2009; October 23, 2009; November 10; and November 19). The following discussion provides a summary of the Work Group's discussions and analysis with respect to the components of the Episodic Pricing model, including quality measures and incentives, and the issue of subcontracting between CHHAs and LHCSAs. The Work Group expressed serious concern about the size and scope of the reduction in the overall Medicaid spending for home heath spending that was part of the Executive Budget for 2009-10. This was raised at every meeting of the Workgroup.

Information discussed and provided at each of the Work Group meetings can be located on the Department's website at:
www.health.state.ny.us/facilities/long_term_care/reimbursement/home_health_care_workgroup

Components of Episodic Pricing Model

The discussions of the Work Group primarily focused on how to define the patient acuity (case mix) of the Medicaid CHHA population; the data, regions and methodology used to develop the Wage Index Factor; the outlier population and outlier payments; and quality measures.

Case Mix ~ Patient Acuity

The Work Group indicated it was concerned that the OASIS Medicare grouper (i.e., the use of the clinical and functional groupings from the OASIS grouper) may not sufficiently describe the Medicaid population. These concerns were raised in light of what the Work Group believes are the typical differences between Medicare and Medicaid patients. Generally, Medicare patients are post acute patients that in many cases require relatively short-term care with intensive therapy, while Medicaid patients generally require long term care, limited therapy and in some cases may have higher cost needs, reflective of their higher utilization of home health care services.

To analyze these issues, the Department performed statistical analysis to assess whether the clinical and functional groupings of CHHA patients is a good predictor of patient costs (i.e., within each episode of care, whether costs increase with increases in clinical/functional severity of patients). This analysis was also important for determining if the clinical/functional groupings would continue to be a good predictor of costs given the updates to the OASIS tool implemented by the Centers for Medicare and Medicaid / Medicare on January 1, 2008. The updates to the OASIS patient tool changed how case mix groups were determined with the addition of the number of therapy visits, early/late episode designations and additional diagnoses.

The Department's analysis indicated that the overall predictability of the 2008 model was high as demonstrated by an R-Square of .26. The R-Square is a statistical measure used in regression analysis that defines the percentage of variation explained by a model. Within the arena of Health Care Modeling an R-Square of .20 to .30 is considered a good model that adequately explains variation. In addition, compared to the 2007 results, updating the model from 2007 to 2008 improved its overall predictability (the R-Square increased from .16 to. 26). However, within the model, the degree to which the clinical groupings explained variation in patient costs declined somewhat from 2007 to 2008 (the R-Square declined from .06 to .04) and the case mix

weights did not consistently increase with increases in the complexity/severity of the case mix group. The Department believes that this is due to the 2008 updates to the Medicare OASIS grouper that, when compared to the 2007 grouper, now focus more narrowly on the attributes of Medicare patients.

Although the model is robust (a good predictor of costs), the Department is recommending, and the Work Group concurs, that the overall model be further refined and improved by exploring other elements of the OASIS patient assessment tool that may explain more of the variation in costs among Medicaid CHHA patients. Work Group members have suggested these elements could include Diagnoses, Living Arrangements, Incontinence, Dementia, Neuro/Emotional status, Medication usage, and nature of referral. Elements that are determined to explain the variation in costs could be added to the Clinical and Functional groupings to reflect a complexity dimension in the overall case mix measure. The Department is now in the process of gathering additional elements from the OASIS patient assessment tool to perform additional statistical analysis to identify additional elements that may further explain the variation in costs. With this information, the Department will develop a New York OASIS grouper that would assign patients to a case mix group and develop new case mix weights.

Wage Index Factor

The Work Group raised and discussed the following issues and concerns with the proposed Wage Index Factor (WIF).

- Three regions are not enough to adequately explain variation in wages across the State. Other regions, including New York's Prospective Hospital Reimbursement Methodology (NYPHRM) regions and Core Based Statistical Areas (CBSA) regions should be explored.
- The portion of the price to be adjusted by the wage factor (estimated at 85.35% using cost report data) is probably too high.
- The CHHA cost report data does not include complete data on fringe benefits, which vary across the State and are an important element in determining labor costs.
- Given the limitations of cost report data with respect to wages (lack of consistent reporting, lack of agency contract wage data) other data sources to determine wages should be explored (e.g., Federal Occupational Employment Survey (OES) Data for New York, New York State Department of Labor Data).
- Explore other methods to weight the wage data. In addition to using Full Time Equivalent measures of professional and home health aides to weight the wage data consider Medicaid utilization. In addition, consider using regional, rather than statewide weights.

After further research and discussions the Work Group concluded the following:

- The OES data that is collected by the New York State Department of Labor is the most appropriate (reflects the home care labor market for wages) and reliable wage data available for purposes of calculating the WIF.

- The New York State Department of Labor regions (shown below) appropriately defines and expands the number of regions, and the OES wage data can be calculated using these regions.
- Currently, the data available to estimate the amount of fringes paid (by region and by professional and home health aide staff) and the percentage share of total costs attributable to wages (salaries and fringes) could be improved upon with the collection of New York specific data. To facilitate this effort the Work Group and the Department will work together to amend the CHHA and/or LHCSA cost reports to collect New York data needed to refine these aspects of the WIF. In the interim, the Work Group has agreed to:
    - ✓ Use the current percentage employed by the Medicare Home Care Prospective Payment System to determine the portion of the base price that should be adjusted by the WIF (77 percent).
    - ✓ Work together to determine a proxy for the percentage of wages that is fringes using New York State cost report data that may include fringe benefit data from nursing home cost reports, CHHA cost reports and/or LTHHCP cost reports.
    - ✓ Use Medicaid utilization to weight the fringe adjusted wage data for professional and home health aide staff.

New York State Department of Labor Regions for WIF	
Region	**Counties**
Capital	**Albany, Columbia, Greene, Rensselaer, Saratoga, Warren, Washington**
Central New York	**Cayuga, Cortland, Madison, Onondaga, Oswego**
Finger Lakes	**Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, Yates**
Hudson Valley	**Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester**
Long Island	**Nassau, Suffolk**
Mohawk Valley	**Fulton, Herkimer, Montgomery, Oneida, Otsego, Schoharie**
New York City	**Bronx, Kings, Queens, Richmond, New York**
North Country	**Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, St. Lawrence**
Southern Tier	**Broome, Chemung, Chenango, Delaware, Schuyler, Steuben, Tioga, Tompkins**
Western New York	**Allegany, Cattaraugus, Chautauqua, Erie, Niagara**

Outlier Payments and High Cost, High Need Patients

The Work Group indicated it was concerned that the proposed methodology for determining outlier payments would create access issues for high cost patients with a high case mix and long-term needs. Hindering access to services, particularly for patients with the highest needs/case mix, is inconsistent with the Principles of Reimbursement Reform. However, given that significant increases in spending trends cannot be readily explained by case mix, it is incumbent upon the Department and the Work Group to ensure the reimbursement system provides incentives that deliver all patients the appropriate level of services. This is a particularly pronounced imperative when one considers that in 2008, 4.5 percent to the total CHHA

recipients (3,706) with annual costs in excess of $75,000 accounted for well over one-third or 39 percent ($454 million) of total Statewide. The outlier thresholds and payment methodology for other patients will require providers to become efficient by ensuring that services reflect patient needs and resources are managed across all patients. Providers will have some flexibility to manage resources by applying revenues from patients where their costs may be less than the Base Price to offset some of the costs of other patients that are not fully covered by the outlier payment.

It is particularly important to note that the proposed outlier methodology is not simply focused on high cost, high case mix populations. Rather, the goal is to have a reimbursement system that focuses on the level of services provided to every patient and identifies when a patient's consumption of services reaches a significantly higher level of costs/services than other patients with the same case mix or condition. Hence, the model has outlier thresholds in each case mix group and across all episodes.

The proposed model sets the outlier thresholds in each case mix group at the 80th percentile. As shown in Appendix C, the outlier thresholds for the highest case mix groups range from almost $14,000 to $25,000. Under the proposed model, one-half of the costs above the threshold are reimbursed.

In addition, both the Department and the Work Group agree that refinements to the case mix grouper/methodology (i.e., expanding the clinical and functional groupings to include a complexity dimension) may result in shifting some costs from "outliers to inliers" and may help address potential access issues for high cost patients.

Additional modifications are being explored by the Work Group including a modification to the threshold level and establishment of a high risk or stop/loss pool for specific patients. Further analysis of this component is warranted.

Special Populations and Unique Characteristic Patients

In addition to high cost, high need patients the Work Group has raised issues with respect to how special needs patients and patients with unique characteristics would be impacted by the Episodic Pricing Model. These populations include pediatric (under 18 years of age), dually-eligible (patients eligible for both Medicare and Medicaid), HIV positive, Office of Mental Retardation and Developmental Disabilities (OMRDD) and Office of Mental Health (OMH) patients.

Since providers are not currently required to submit OASIS assessments for pediatric patients, and it is likely that the OASIS tool would poorly explain the condition and cost variation of these patients, the methodology excludes these patients and assumes they will be reimbursed under the current fee for service methodology. The elements of the current model reflect the variation of costs between dually eligible and non-dually eligible patients through the calculation of separate case mix weights and outlier thresholds for dually eligible and non-dually eligible patients.

As shown below, an analysis of 2008 CHHA claims data for patients with an HIV positive, OMRDD, or OMH indicator on the claim form indicated that the average 60-day cost for each of these three special needs groups was actually less than the average for all other recipients that were not in one of these groups and the Episodic Pricing Model would not selectively impact this group. As discussed above in the Outlier Payment and Case Mix discussions, it is likely that the refinements to the case mix methodology to include a complexity dimension may better capture these special needs patients.

	2008
Total Episodic Claims (All Recipients)	220,806
Total Expenditures (All Recipients)	$1.2 Billion
Average 60-Day Cost (All Recipients)	$5,624
	Average 60-Day Cost
HIV Recipients (17,162 Episodes)	$4,585
OMRDD Recipients (12,427 Episodes)	$3,551
OMH Recipients (73,396 Episodes)	$4,983
All Other Recipients (131,497 Episodes)	$6,156

The Work Group was very concerned about whether certain types of patients will be disadvantaged because of the proposed methodology. As previously discussed, further analysis is underway to further refine the overall outlier methodology.

Quality Pool

The Work Group members have expressed an interest in modifying measures based on short versus long stay patients as well as integrating a workforce quality measure. The members have been asked to submit to the Work Group specific measures to be considered. The issues of reporting/data availability and validity of measures are still outstanding and require additional analysis.

Subcontracting

Several Work Group members shared information about their current practice to illustrate the complex approach to providing assurance between contractor and subcontractor. The Work Group discussed concerns about the data and the method of collecting the data. It was suggested that another survey would be done; however, when all comments were received the Work Group recognized that a survey would take significant time and effort to complete and agreed that collecting specific cost report data for the future would be a more effective approach. Instead, the concept of improving transparency was recommended. As a result, the Work Group and the Department will be modifying cost and statistical reports to gather data that will allow comparisons to be made and to ensure transparency in the subcontracting relationship. Workgroup members concluded that penalties for not filing the reports must be increased to ensure broad compliance.

Implementation

Implementing a new CHHA reimbursement will require the close collaboration of providers, consumers and the Department. Throughout the course of the Work Group's discussion members and providers have indicated that they are concerned with both the speed at which reforms are implemented and their ability to effectuate the required operational changes without a disruption in the important services they provide to their recipients. The Department concurs that a reasonable length of time for implementing these critical reforms to the CHHA reimbursement is required and has already begun to work with claims processing programmers to discuss implementation. Thus, the Department is recommending that the Work Group continue to move forward to refine the Episodic Pricing Model and turn its focus to the implementation process. Implementation items for the Work Group to discuss include:

- Developing more refined case mix groups to describe the CHHA Medicaid population and creating a new New York OASIS Grouper (this work is in progress).
- Amending the current Medicaid claims and billing system.
- Examining the relationship between Medicare and Medicaid Episodic Payments.
- Assessing the impact of cash flow under an Episodic Pricing Model.
- Modifying the annual CHHA cost report and LHCSA statistical report to provide for the collection of data to enhance the Episodic Pricing Model and improve transparency with respect to CHHA and LHCSA subcontracting.
- Refinement of the quality pool measures.

CONCLUSIONS

The Work Group members and the Department have made significant progress; however, additional analysis is needed. It is recommended that the Work Group continue its efforts for another year.

APPENDIX A (1)
Chapter 58 of the Laws of 2009
Section 125-d

§ 125-d. The commissioner of health shall establish a home health care reimbursement workgroup for the purposes of studying the home health care reimbursement system. The commissioner of health is authorized to appoint members to the workgroup, including representatives of certified home health agencies, licensed home care services agencies, long term home health care providers, hospice providers, consumers of home health care services, local governments, labor organizations and other home health care stakeholders.

Such study shall include but not be limited to an analysis of:

(a) the impact of episodic payments on high-utilization and outlier thresholds, special needs populations, and dual eligible patients;
(b) the relationship between, or compatibility of, Medicare and Medicaid episodic payments;
(c) billing procedures related to cash flow of episodic payments;
(d) wage index factor adjustments; and
(e) subcontracting between certified home health agencies, long term home health care agencies, and AIDS home care programs with license home care services agencies.

The commissioner of health shall report to the temporary president of the senate, the speaker of the assembly, the chairs of the senate finance committee and assembly committee on ways and means, and the chairs of the senate and assembly health committees. Such report shall be submitted no later than December first, two thousand nine.

Appendix A (2)
Home Health Care Reimbursement Workgroup (HCRWG) Member Listing

Name	Organization
Kenneth Kilroy	Progressive Home Care Inc.
Bruce Jacobson	People Care Inc.
Todd Branson	WillCare Western NY
Jordan Shames	Neighbors Home Care
Michelle Mazzacco	Northeast Health, The Eddy
Joan Marren	VNS of NY
Indi Shelby	VNS System
Susan Cummins Caputo	Home and Continuing Care for Metropolitan
Victoria Hines	Visiting Nurses Service of Rochester
William Finn	Center for Hospice and Palliative Care
Carol Rodat	Paraprofessional Healthcare Institute (PHI)
Brian Ellsworth	Connecticut Association for Home Care and Hospice (CAHCH)
Suzanne J. Gallagher	Marwood Group & Co.
Valerie Bogart	Self Help
Constance Laymon	CDPAP
Kevin Finnegan	1199
Kira Pospesel, Commissioner	Greene County Department of Social Services
Mary Ellen Polit	Catholic Home Care
Ann Frisch	New York City Health and Hospitals Corporation
Fred Griesbach	AARP
John Ulberg	DOH
Lana Earle	DOH
Pat Roohan	DOH
Mark Kissinger	DOH

Appendix A (3)
Comments from Home Health Care Reimbursement Workgroup Members

December 16, 2009

Comm. Richard F. Daines, MD
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: Appendix to the Interim Report of the Home Health Care Reimbursement Workgroup; Workgroup Member Opinion

Dear Commissioner Daines,

We are grateful for the opportunity to participate in the Home Health Care Reimbursement Workgroup and compliment Mark Kissinger and his staff on their efforts to provide an open forum within which to discuss the proposed change to the reimbursement system for Certified Home Health Agencies (CHHAs). They have worked tirelessly in modeling the proposed system and in responding to questions and concerns raised during Workgroup meetings.

We also appreciate the opportunity to respond independently to the Interim Report, and this letter is a summary of substantive concerns. While the DOH staff has made some important revisions to their original proposal in response to written suggestions made by Workgroup members and submitted previously to the Department, the Interim Report does not sufficiently address the depth of some of our concerns, it ignores some of our prior written comments on the first draft of the Interim Report, and it draws some conclusions with which we do not agree.

We respectfully request that these comments be included in the Appendix to the Department's Interim Report and, further, that a specific reference be made in the introduction to the Interim Report indicating that comments by Workgroup members in disagreement with some of the Department's facts and conclusions are appended.

This letter summarizes the essential points of concern.

Summary of Interim Findings

We cannot overstate the depth of our concern over the size and scope of the $200m cut to current spending that has been integrated into the proposed payment methodology. The Interim Report only references this concern related to the 2009/10 budget. But the cut is deep and lasting as it is embedded in the new reimbursement methodology.

We are not aware of any prior example whereby a reimbursement system was changed by the federal or state government and included a dramatic spending cut simultaneous with the

transition of the payment system. When compounded with the $300m in cuts already imposed on home care over the last 2 years, the total reductions are enormous, disproportionate to any other sector of healthcare and do not reflect the stated goal to support home and community based services as opposed to longer hospital stays and growth in nursing home placements.

Combined with pending deep cuts from Medicare[1], we face an unstable home care industry in New York. A recent joint publication of the Home Care Association of New York State and the New York Association of Homes and Services for the Aging noted that two-thirds of home care agencies already report operating losses and that there has been a 65% increase in the number of agencies serving patients with chronic health conditions that experience operating losses. In fact, since the majority of costs incurred are for the chronically ill, the State's policy should be to invest more in programs that serve the long term care population (including CHHAs and LTHHCPs) and to provide resources for the development of new chronic care management models that will reduce overall costs, rather than perpetuate the thinking that any cuts that occur in hospitals and nursing homes must also be made in home care. Any change to the reimbursement system has the potential to destabilize the industry, and an additional $200m cut is capricious, as it will certainly put some agencies out of business and many agencies in financial jeopardy.

Further, the $200 million cut is taken solely from the "outlier pool" in the Department's proposed PPS model. Several Workgroup members received their claims file from the Department and spent considerable resources modeling the impact on the patients they served. Findings were shared during multiple Workgroup meetings listing the types of patients who would face difficulty accessing services. Workgroup members reported that patients with HIV, Multiple Sclerosis, those with complex, non-healing wounds (including patients with paraplegia and quadriplegia) incurred thousands of dollars in losses every single 60-day period for the remainder of the patient's lifetime. The Workgroup members repeatedly stressed the enormous difference between the outlier model under Medicare PPS (in which losses are incurred for one or two 60-day periods generally for a short-term acute patient population) versus the Department's proposed outlier model for Medicaid PPS. Here, the majority of claims are for long term care patients, many of whom will be with an individual agency for the remainder of their lifetime or as long as they can be kept out of institutions.

Given the current financial state of many home care providers, it will be impossible to allow access to services for those diagnoses which incur thousands in losses every 60-day period, perhaps for decades, without bankrupting an agency. The Workgroup wholeheartedly disagreed with the Department's conclusion that gains made on some patients would cover losses on others in this scenario. And the Workgroup remains alarmed at the potential public policy implications of creating access issues for many young disabled long term care patients who chose to, and have the right to under the Olmstead decision, remain at home. This is an unintended, but very real consequence of the Department's current payment reform proposal.

[1] On the Federal level, CHHAs are facing cuts in Medicare payments to fund health care reform. Pear, Robert. "Senate Clears Way for Home Health Care Cuts". New York Times, December 5, 2009. US Section. http://www.nytimes.com/2009/12/06/health/policy/06health.html

Finally, this reduction in spending available for the new payment system results in an insufficient quality incentive pool that could otherwise be used to assist providers in developing and implementing best practice quality processes and chronic care management models.

We believe that the change in the payment methodology alone will resolve the access to care issues described above, and we strongly urge that the $200m ($100m state share) be restored. A revision to the payment system will result in overall reductions in spending that meet the state's need to control costs in a more rational way. Whether or not the State should move from a fee-for-service based reimbursement system to an episodic payment system is the charge to the Department and the Workgroup. Making substantial cuts in home care reimbursement is a completely different issue, was not included in the Legislature's charge, and should be immediately stricken from the proposed episodic payment model.

Prospective Payment and the OASIS Tool

The Interim Report appropriately represents the principles of reimbursement reform that were agreed to by the Workgroup (pg 4). *However, the Workgroup never had the opportunity to discuss any methods to improve the rationality of the payment system other than the Value Based Purchasing Episodic Pricing Model proposed by the DOH. It is therefore an overstatement in Finding 2 that the state "should adopt and implement…" the proposed model; the Workgroup does not de facto endorse the model.*

The Interim Report appropriately notes that the OASIS tool is the best available option at this time. It is the only standardized assessment tool easily adaptable for the state's purpose in developing a new payment methodology. However, it is woefully inadequate for the long term care population. OASIS was developed to support assessment and payment for short-term acute needs and was not intended to address the needs of chronic, long term care patients. There are significant differences not just between those populations, but in the way the Medicare PPS model is structured versus the proposed Medicaid model. Examples include the treatment of outlier payments (addressed in detail throughout this letter) and the fact that the Medicare benefit restricts total service hours to just 35 hours per week, a strong indication of the differences between the needs of short-term versus long-term patient populations. The Interim Report points to the work that needs to be done to further explain cost variance in the long-term care population and in developing a grouper that would assign patients to a case mix group and develop case mix weights.

We strongly urge the Department to delay implementation of a new pricing system until variation in the cost of caring for long term care patients is further explained. Since so many CHHA Medicaid claims are for long term care patients, ideally, the Department would complete its work on a standard assessment tool for long term care and use that tool as the basis for the new reimbursement system.

Outlier Payments and High Cost, High Need Patients

As noted in the Summary section above, the methodology for the treatment of outliers is seriously flawed. Consumer and provider representatives on the Workgroup cannot support the system as proposed because the modeling conducted by Workgroup members confirmed that the Department's proposed episodic payment system will result in substantial losses every single 60-

day period for the remainder of a young disabled person's lifetime. This will require providers to "balance" the number of these high need, high loss patients with many more patients who might represent a financial gain, thereby creating the need to limit access for patients such as those with HIV/AIDS, Multiple Sclerosis, the OMRDD population and those with complex non-healing wounds (such as individuals with paraplegia, quadriplegia).

The Interim Report cites a table on page 15 as demonstrating that some known outlier and special needs patients have a lower cost per episode than other recipients. But this is misleading and incomplete; the table only includes the costs per episode and does not include the price per episode under the new methodology. The issue at stake is whether there are certain types of patients who will incur substantial losses episode after episode and thereby create an access to care issue. This table does not answer that question.

We believe that the change in the payment methodology alone will resolve the access to care issues described above, and we strongly urge that the $200m ($100m state share) be restored. As recommended in the Interim Report, the Workgroup should continue to refine the outlier analysis. It is also imperative that we find ways to eliminate the disincentive to care for high cost, high need patients and minimize any impact on access to care.

Development of the assessment tool noted above would establish criteria for authorizations of higher hours of home health aide services and rationalize the system without irrationally cutting off payment for services for those who need higher hours of care.

Rewarding and Improving Quality

It is important to remember that the current Medicaid reimbursement system, with caps on A&G costs, creates barriers for providers to invest in areas that could lead to substantial improvements in quality (such as clinical nurse specialists, best practice models, chronic care management models, technology, etc.). Therefore, we agree that the new payment system should provide resources to providers who demonstrate better outcomes by utilizing these approaches. We also believe that patient/caregiver input needs to be obtained prior to finalizing any quality incentive program. Finally, we agree that quality measures should recognize the differences in short term and long term care patients. We look forward to refining this important component of a revised payment methodology.

We strongly urge the Legislature to restore the $200m in proposed spending cuts. We also strongly encourage the Department to designate a quality pool of no less than $20m for the purpose of rewarding top performing agencies and agree that outcomes need to be distinguished for CHHA only providers versus CHHA/LTHHCP agencies as well as for short-term acute patients (i.e., those cared for in 1-2 episodes) versus long term care patients (those served for 3episodes or more.

Subcontracting Between CHHAs and LHCSAs

The Interim Report fails to reflect the fact that the Workgroup achieved near-unanimous agreement that the proposed ban on subcontracting was a poorly conceived idea and that the practice of subcontracting for home health aide service should continue. Subcontracting between CHHAs and LHCSAs is an appropriate business practice that creates efficiencies in the

training, management and deployment of home health aide resources. It also protects the income level of many aides by giving them the ability to work for multiple agencies and maintain a full work schedule when the patients they care for are hospitalized or discharged.

After careful discussion and review of available data, the Workgroup agreed that subcontracting does not result in diversion of monies or duplication of costs and is in fact an economical approach to managing a high volume, specialized component of the home care system. The challenges of hiring, training, deploying and retaining paraprofessional staff are very different from those associated with nurses, therapists and other professional providers. It is prudent business practice to subcontract any specialized service that is outside of core business and expertise, and CHHAs have done just that in subcontracting for aides. Furthermore, a ban on subcontracting services does not exist in any other sector of healthcare or other industries and to do so solely in CHHAs and LTHHCPs would be inconsistent and excessive regulation of service provision.

A significant number of members of the Workgroup, including but not limited to the undersigned members, have suggested that Appendix D be stricken from the "record" as the data are seriously flawed. The Interim Report erroneously cites these data in making the case that there is no documented relationship between the rates that CHHAs are paid by Medicaid and the wages paid to home health aides. The Workgroup discussed the flaws of the survey on which these data were based, including the fact that there were no standard definitions applied to the survey questions, hence the responses obtained do not allow us to compare apples to apples. For example, the term "starting wage" does not take into account wage adjustments that are routinely made based on a myriad of factors including special skill sets, whether the aide has access to a car, whether the aide is willing to travel, and whether the aide is working with a difficult to serve patient. These two flaws alone make it impossible to draw conclusions from the "data" presented in Appendix D.

That said, the Workgroup agrees that the subcontracting relationships must be transparent to assure that the state understands exactly what it is paying for and to assure that government resources are sufficiently directed to the workers providing care to patients. In addition to the transparency that can result from amending cost and statistical reports to obtain essential data (for which the Department staff has indicated it would seek Workgroup input on any such amendments), transparency must also include the costs associated with the regulatory and reporting requirements of CHHAs, LTHHCPs and LHCSAs.

We believe that the question of subcontracting has been resolved by the Workgroup; it is a prudent business practice that should continue.

Background Section

The section on Recent CHHA Spending Trends is misleading as it fails to note certain key findings.

The Interim Report appropriately points to differences in spending trends between Upstate and Downstate and the Workgroup discussed the possible drivers of those differences. A key driver is the availability of home health aides; there is a significant shortage of aide personnel in

Upstate areas and so CHHA patients may receive less service than their Downstate counterparts simply because service is unavailable. The wide variation in utilization across the state also points the lack of utilization standards or guidelines for the CHHA Medicaid population.

Most importantly, the Workgroup discussed the fact that, outside of annual expected inflationary spending, seven (7) NYC agencies accounted for the *entire* increase in spending between 2003 and 2007. The Department and Workgroup Members noted this fact at every meeting of the Workgroup and questioned the need to make sweeping change to a reimbursement system based on spending trends that are attributable to just seven agencies. Several other data deserve attention as we seek to explain spending increases over the last 5 years, including:

- A detailed analysis of the higher utilization patients to conclusively determine whether the patient's needs are truly higher, or that utilization is simply inappropriate due to provider behavior, lack of DOH enforcement, or an unresponsive Fair Hearing process. The Workgroup members felt this was important to understand before designing a new reimbursement system which "assumes" that there is simply inefficiency that will be driven out of the system in order to ensure that real patient needs are not ignored in the model.
- A detailed analysis of the 7 agencies whose growth distorted increases in spending for the entire State in CHHA services to determine whether there were reasonable explanations for such costs, or whether there were inappropriate or abusive practices which needed to be addressed.
- To what degree do other trends in the availability of long term care services (fewer nursing home beds, patients moving to CHHA when they exceed the cap for the LTHHCP, lower need patients moving to MLTCPs) have on CHHA utilization and spending.

It is important to note that Appendix B clearly shows that CHHA spending per recipient ($14,158) is lower than spending per recipient in any other long term care setting. It is completely inappropriate to focus on the growth in CHHA spending in a vacuum; instead, CHHA spending patterns may be necessary in avoiding more costly long term care alternatives.

Implementation

We are grateful that the Department concurs with the Workgroup's concern that implementation of a new payment system must be careful, thoughtful, and of sufficient time to minimize any disruption of service.

In addition to these commitments, we recommend that implementation be delayed until the $200m cut is restored, until an appropriate chronic care assessment tool is developed, until a more appropriate outlier methodology is developed, until the episodic case weights can more fully explain the variation in costs for long term care patients, until Workgroup members can remodel the proposed episodic payment system after such changes are made and confirm that patient access to care issues have been resolved, until appropriate quality measures are defined, and until a "testing" phase can be successfully completed with agencies that volunteer to pilot the methodology.

Again, we appreciate the opportunity to provide commentary on the Interim Report. We will respectfully reserve the right to add future commentary if necessary as the timeframe for Workgroup response to this Interim Report was very tight (three business days).
Each of us remains committed to working collaboratively with the Department to develop a payment methodology that follows the principles adopted by the Workgroup.

Sincerely,

(no electronic signature available)
Todd Brason
President
WillCare

Sue Caputo
President
Metropolitan Jewish Home Care

Vicky Hines
President & CEO
VNS of Rochester

Kenneth P. Kilroy
President
Progressive Home Health Services, Inc.

Michelle Mazzacco
VP/Director, Eddy Visiting Nurse Assoc.
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Jordan Shames
President and CEO
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Valerie Bogart
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December 16, 2009

Richard F. Daines, M.D.
Commissioner, New York State Department of Health
New York State Department of Health
Corning Tower
Empire State Plaza,
Albany, NY 12237

RE: Consumer Representatives Appendix to the Interim Report of the Certified Home Health Reimbursement Work Group

Dear Commissioner Daines:

As two of the Workgroup members appointed to represent interests in Consumers, we submit these comments to the Final Report to highlight concerns that the reductions in spending built into the proposed payment methodology will seriously reduce access to care for those consumers who, because of complex chronic long-term physical or mental impairments, in combination with social and environmental factors, need higher amounts of home health aide services on a long-term basis. The proposed methodology will potentially undermine the ability of New York State to comply with the U.S. Supreme Court's 1999 *Olmstead* ruling, which holds that the *Americans with Disabilities Act* requires that services be offered in "the most integrating setting" appropriate to a person's needs. Moreover, these changes potentially negate this Administration's "patient first" agenda, with the goal of shifting funding from acute to community-based settings that are more cost-efficient and produce good outcomes.

These comments supplement the earlier statement submitted to DOH by Constance Laymon and Valerie Bogart as consumer representatives, dated October 21,2009, which we request be appended to the Interim Report. We support and do not repeat here most of the comments submitted by Victoria Hines and other Workgroup members. We wish to reinforce a few points particularly important to Consumers.

Finding 2: We do not join in DOH's recommendation that the State adopt and implement an Episodic or Prospective Payment System (PPS), because of concern for access to care by the "outliers" who need extensive services at home. There has not been a consensus that a prospective payment system is the sole method to improve rationality of the payment system. The proposed PPS is nominally about reimbursement rates, but it is actually about reducing the number of hours of home health services that will be provided to people with chronic long term disabilities who may need services for a long period of time. Because of the disincentives for providing care to "outliers," those individuals who need more hours of service because of complex or severely disabling chronic conditions will not receive the care they need. This will

disproportionately impact people with AIDS/HIV, mental retardation and developmental disabilities (MR/DD), and seniors and younger people with chronic long term physical and/or mental disabilities.

Characterization of these changes as merely about the reimbursement system is a euphemism for the more drastic nature of these changes. If a policy decision is to be made about reducing the availability of round-the-clock care, which has been a hallmark of New York State's program for decades, then this discussion should be about that service reduction, not couched in more benign "reimbursement" terminology. Moreover, PPS accomplishes this reduction in an irrational way, by reducing services without any individualized assessment. Changes in determining the number of hours authorized are best addressed through revising the system for individualized assessment of need, rather than through the back door, by eliminating reimbursement across-the board for higher-need individuals. Development of an assessment tool that would establish criteria for authorizations of higher hours of home health aide services would also rationalize the system, without irrationally cutting off payment for services for those who need higher hours.

- ***Use of the Proposed System Raises Spectre of Violations under the Americans with Disabilities Act and Section 504 for "Outliers" who may be denied adequate services***

While the proposed PPS system doesn't expressly disqualify outliers from eligibility for Medicaid home care, it will, in effect, deny them access to home health services by limiting Medicaid payment for higher hours, without which many will not be able to remain in the community. In this way, it is really no different than "fiscal assessment," the law enacted in 1991 that limited home heath or personal care services to those that cost less than 90 percent of a nursing home, unless certain exceptions were met. N. Y. Soc. Serv. L. 367-j, -k, and-l. This law was challenged in the personal care context for violating the Americans with Disability Act [ADA] and Section 504 of the Rehabilitation Act. In *Sanon v. Wing*,[1] the State Supreme Court remanded the case, requiring the State to

> "… address the requirements of the ADA in considering the provision of services. Unless [the State] can demonstrate that accommodating Medicaid recipients who otherwise qualify for 24-hour home care would result in a fundamental alteration in the Medicaid program, [the State] must provide services in 'the most integrated setting appropriate to the needs of' petitioners. 28 CFR 35.130(d)."

Because the law expired under a sunset clause, the State never conducted this ADA analysis. The reduced access to home care created by PPS may well revive these same ADA claims for people with extensive needs.

Finding 2: Designing a PPS Model -- Use of OASIS --If Episodic PPS model is used, use of the OASIS tool, which is used for Medicare, must be done carefully -- and must be supplemented -- because of the differences between the Medicare and Medicaid home health benefits. The differences are not only in the population served and their medical needs (short-term acute rehabilitation vs. long-term chronic care) but in the *scope of benefits* provided. By definition, the Medicare home health benefit is limited to part-time or intermittent home health services. This generally means at most 20 hours per week, with up to 35 hours per week in a rare case. Medicaid home health services can be as much as 168 hours per week, depending on need. While OASIS-c has some improvements in taking mental status into account, it still does not assess chronic care needs fully. For example, it does not assess the need for assistance with toileting, transfer or ambulation during the evening or night, because these needs are irrelevant to the Medicare benefit. Yet the span of time and frequency of need for assistance certainly is a clinical and functional measure that must be considered in a Medicaid pricing model.

[1] 2000 N.Y. Misc. LEXIS 139, Index No. 403296/98 and 402855/98 (Sup. Ct. N. Y. Co., Moskowitz, J.) (N.Y.L.J. Mar. 3, 2000 p. 27 col. 2)

Current Reimbursement System -- CHHA Spending Trends

We agree with our fellow workgroup members that the statistics showing dramatic growth in expenditures for Medicaid CHHA services are misleading, since almost all of this growth since 2003 is concentrated in just the seven of 144 CHHAs. The Table on page 7 gives the impression that CHHA expenditures are skyrocketing out of control. Yet, during the Workgroup sessions, DOH documented that when the designated "problem" seven of 144 CHHAs were disregarded, CHHA spending *decreased* by 7 percent statewide 2003 to 2008. The expenditures by these seven CHHAs must be examined in detail, and corrective action taken if warranted by any findings of irregularities, including the provision of care that is not medically necessary. Further, this examination should consider the nature of ownership and other characteristics of CHHAs that show excessive expenditures, with consideration given to limiting certification or for imposing prior approval mechanisms or other oversight for CHHAs of particular types, if these patterns are observed. The fact that only normal growth, or even reduction of services, is observed in the vast majority of CHHAs calls into question conclusions that the current system lacks accountability or incentives to provide cost-effective care.

As to the relative growth of CHHAs compared to other long-term care services, we commend DOH for including Appendix B Tables 1 - 3-C, showing the changes since 2003 in usage and number of recipients of other long term care services, both institutional and home care. Notably missing from these tables are figures for the total number of Medicaid recipients in each region, which is useful for context; more than twice as many Medicaid recipients live in New York City than in the rest of the state (2.367 million compared to 1.086 million). Also missing are statistics on use of waivered services other than the Long Term Home Health Care Program (LTHHCP). Waivered services, primarily given through OMRDD and OMH, fund care in quasi-institutional facilities, such as Individualized Residential Alternatives (IRAs) and Community Residences, that in many cases are more institutional than they are community-based. Many residents of these facilities upstate would live independently and receive care through Special Needs CHHAs if more available. Growth in these services is has been much greater than any other long term care service. Expenditures on waivered services have more than doubled in five years, to over $3.1 billion statewide in 2008, compared to $6.7 billion for skilled nursing facilities. CHHA expenditures were under $1.5 billion.

One point of looking at these other programs is to understand that lower costs on one service -- CHHA -- has ripple effects in increasing other costs. Twice as many individuals receive these waiver services outside of New York City as in New York City, where CHHA and personal care usage is higher. If CHHA services are reduced, usage of waiver and other long term care services is likely to increase. DOH should study these relationships.

MEDICAID WAIVER SERVICES

	MEDICAID EXPENDITURES			MEDICAID AVERAGE MONTHLY BENEFICIAIRIES		
	2003	2008	% growth	2003`	2008	%
NYS	$1,580,458,907	$3,176,254,279	101.1%	43,159	56,990	32.0%
NYC	455,914,406	912,434,014	100.1%	14,507	19,598	35.1%
Rest of state	$1,124,544,501	$2,263,820,265	101.3%	28,652	37,392	30.0%

Data from Medicaid Quarterly Reports of Beneficiaries, Expenditures, and Units of Service by Category of Service by Aid Category by Region http://www.health.state.ny.us/nysdoh/medstat/quarterly/aid/quarterly.htm

Retention of Fee-for-Service or Stop-Loss for High-cost Consumers

Fee-for-service must be available for those consumers whose costs exceed the payment system (even with sound outlier payments). As stated above, an assessment tool and mechanism must be developed that adequately accounts for consumer's needs on a 24/7 span of time. The criteria should also include an assessment as to whether other community-based alternatives are available and appropriate (less costly), such as personal care or Consumer-Directed Personal Assistance Program (CDPAP) services. If criteria are set carefully to qualify for services that would cost above the 80th percentile outlier threshold, then the system is still rationalized and providers will be precluded from authorizing unnecessary services.

The Report mentions establishment of a stop/loss or high risk pool, which consumers believe is absolutely essential to protect high risk consumers. The prospective payment system should not be implemented until this is addressed.

Special Needs of Medicaid-Only Recipients who Do Not Also Have Medicare, or Do Not Qualify for the Medicare Home Health benefit.

The proposed base rates do not consider the fact many Medicaid recipients are not "dual eligibles" and do not have Medicare benefits for the first 120 days or two episodes of care. Even some dual eligibles, who have Medicare, do not qualify for the Medicare home health benefit because its eligibility criteria are so strict, requiring "homebound" status, for example. In the proposed system, lower base rates were calculated across the board for the initial and second 60-day episodes of care, because on average, Medicaid has paid less during these periods in which Medicare is billed. However, these base rates do not adequately calculate costs for Medicaid-only recipients, whose costs in the initial 120 days are higher because Medicare is not billed.

The impact of this discrepancy will fall on Special Needs CHHAs, which serve a disproportionate number of Medicaid-only individuals -- with diagnoses of HIV/AIDS, mental illness and mental retardation, and developmental disabilities. This is a flaw in the proposed methodology for a specialty CHHA. The State is not capturing the acute or chronic needs of post hospital discharges from day 1 for these special needs populations. Therefore, the base rates being considered are considerably less for these special needs populations and will affect their ability to receive services within a specialty or general CHHA.

Subcontracting and Worker Recruitment and Retention -- We agree with Victoria Hines and other colleagues that the State did not demonstrate that a ban on sub-contracting would necessarily increase worker wages. We agree that CHHAs and LHCSAs do not duplicate functions, and that there are convincing reasons to maintain the current structure. We are also concerned, however, that the quality of the care that consumers receive is a function of the continuity in the worker/client relationship and the support the aides receive, including compensation and benefits. The personal care workforce in New York City is more stable and has much lower turnover than the home health aide workforce, a function of the wages and benefits the home attendants receive.

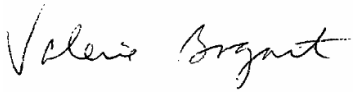
There must be more transparency and accountability to ensure that state funds paid to CHHAs for worker recruitment and retention are actually spent on aide compensation. Medicaid payment should be conditioned on assurance of payment of adequate wages and benefits, and the rates must take this into account, not only in those counties with a living wage ordinances.

* * *

Thank you for the opportunity to participate in this effort.

Signature on following page

Very truly yours,



VALERIE J. BOGART
Director, Selfhelp Community Services, Inc. Evelyn Frank Legal Resources Program

CONSTANCE LAYMON
CEO, Consumer Directed Choices, Inc
President, Consumer Directed Personal Assistance Association of New York State, Inc.

Cc: Mark Kissinger, Deputy Commissioner, DOH Office of LTC Programs

.

Appendix B

Long Term Care Spending Trends

The Work Group requested the Department provide data from 2003 to 2008 on Medicaid spending and recipient trends in other sectors of Long Term Care (LTC) (e.g., Nursing Homes, LTHHCP, Personal Care, Managed Long Term Care, etc.). As shown in the tables below, the overall number of LTC recipients has not significantly increased. Spending per recipient for nursing homes and personal cares beneficiaries reflect trends similar to those of the CHHAs – spending per recipient is increasing sharply while at the same time the number of recipients receiving services is declining. Spending per recipient for CHHAs grew by 72.3 percent, which is more than 50 percent above the next largest area, personal care, of 39.1 percent. Spending in the areas of MLTC and LTTHCP are within their per recipient provider caps – MLTC spending has remained almost flat between 2003 and 2008 (with a significant increase in recipients) and LTHHCP has grown within its per recipient spending caps.

Increases in Medicaid spending, particularly in LTC spending areas where the number of recipients is declining, cannot continue to be sustained in the long term. Efforts to rationalize Medicaid reimbursement methodologies, including Episodic Pricing for CHHAs, is critical to ensuring that every Medicaid dollar is spent efficiently by delivering the appropriate level of quality care, in the right setting, to all LTC recipients.

LTC Spending Trends ~ Total Spending ($ Millions) and # of Recipients				
	2003	**2005**	**2008**	**% Change 2003 to 2008**
Nursing Homes	$5,947	$6,364	$6,662	12%
# NH Recipients	139,080	137,146	131,300	-5.6%
ADHC (Adult Day Health Care)	$266	$264	$324	$21.5%
# ADHC Recipients	16,365	16,726	17,626	7.7%
LTHHCP	$510	$592	$666	30.6%
# LTHHCP Recipients	26,804	27,904	26,404	-1.5%
Personal Care	$1,825	$2,151	$2,328	27.6%
# PC Recipients	84,823	84,201	77,800	-8.3%
MLTC	$444	$647	$1,078	142.7%
# MLTC Recipients	12,293	16,648	29,967	143.8%
ALP (Assisted Living Program)	$50	$65	$82	62.5%
# ALP Recipients	3,538	4,035	4,393	24.2%
CHHA	$760	$921	$1,164	53.1%
# CHHA Recipients	92,553	89,116	82,222	-11.2%
LTC Spending Trends ~ Spending Per Recipient				
	2003	**2005**	**2008**	**% Change 2003 to 2008**
Nursing Homes	$42,759	$46,404	$50,740	18.7%
ADHC (Adult Day Health Care)	16,269	15,780	18,360	12.8%
LTHHCP	19,036	21,230	25,235	32.6%
Personal Care	21,512	25,546	29,932	39.1%
MLTC	36,146	38,856	35,986	-.4%
ALP (Assisted Living Program)	14,270	16,045	18,671	30.8%
CHHA	8,215	10,338	14,158	72.3%

Table1
NYS Medicaid Expenditures for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
Statewide

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	5,946,988,634	6,204,383,236	6,364,167,565	6,462,032,412	6,644,409,734	6,662,124,878	12.0%	2.3%
Adult Day Care	266,248,393	277,288,587	263,935,099	276,583,435	261,504,429	323,610,541	21.5%	4.0%
Home Care Services (CHHA)	760,347,037	806,846,267	921,264,277	1,109,288,444	1,174,064,341	1,174,466,838	54.5%	9.1%
Personal Care	1,824,729,342	1,965,848,242	2,150,967,725	2,248,747,370	2,336,577,721	2,328,004,451	27.6%	5.0%
CDPAP	147,992,482	178,716,350	207,182,784	235,186,072	270,465,807	295,083,805	99.4%	14.8%
Non-CDPAP	1,676,736,860	1,787,131,891	1,943,784,942	2,013,561,298	2,066,111,914	2,032,920,646	21.2%	3.9%
LTHHC	510,250,258	574,694,492	592,398,018	637,427,252	662,032,065	666,303,990	30.6%	5.5%
ALP	50,487,798	58,539,329	64,739,762	73,861,028	79,280,192	82,020,215	62.5%	10.2%
Managed LTC	444,340,799	559,296,840	646,880,141	735,169,733	910,208,151	1,078,384,012	142.7%	19.4%
Partial	357,095,154	455,232,997	529,544,490	603,804,374	767,461,156	921,306,867	158.0%	20.9%
PACE	87,245,646	104,063,844	117,335,651	131,365,359	142,669,501	150,231,810	72.2%	11.5%
Advantage Plus (MAP)	0	0	0	0	77,494	6,845,335	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)
Questions: Woopill Hwang or Peter Gallagher @518-473-2230

Table1-A
NYS Medicaid Expenditures for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
NYC

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	3,140,047,388	3,234,182,812	3,318,618,306	3,371,729,005	3,442,639,196	3,458,171,484	10.1%	1.9%
Adult Day Care	179,799,361	188,301,174	175,024,348	182,872,724	167,989,250	202,425,548	12.6%	2.4%
Home Care Services (CHHA)	638,073,780	679,080,124	794,905,229	972,953,404	1,030,262,516	1,039,101,700	62.8%	10.2%
Personal Care	1,549,772,714	1,658,224,765	1,812,511,752	1,877,153,026	1,931,114,048	1,898,140,234	22.5%	4.1%
CDPAP	66,543,746	75,294,538	84,928,968	94,646,413	107,439,128	112,398,666	68.9%	11.1%
Non-CDPAP	1,483,228,967	1,582,930,227	1,727,582,784	1,782,506,613	1,823,674,920	1,785,741,568	20.4%	3.8%
LTHHC	355,904,172	413,584,869	435,713,944	467,232,043	487,130,277	492,295,055	38.3%	6.7%
ALP	25,621,944	30,560,723	34,520,010	40,705,285	43,856,925	44,582,588	74.0%	11.7%
Managed LTC	377,098,614	479,165,998	560,528,127	646,902,181	814,014,636	978,898,262	159.6%	21.0%
Partial	322,441,391	412,280,407	481,520,634	554,004,985	710,781,893	863,268,124	167.7%	21.8%
PACE	54,657,223	66,885,591	79,007,493	92,897,196	103,155,249	109,682,268	100.7%	14.9%
Advantage Plus (MAP)	0	0	0	0	77,494	5,947,870	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)

Questions: Woopill Hwang or Peter Gallagher @518-473-2230

Table1-B
NYS Medicaid Expenditures for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
Downstate (Nassau, Suffolk, Westchester, Rockland and Putnam counties)

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	1,108,975,667	1,177,053,929	1,212,638,180	1,230,294,053	1,263,144,721	1,261,619,569	13.8%	2.6%
Adult Day Care	38,674,573	39,434,972	39,211,469	42,285,448	42,440,667	55,294,701	43.0%	7.4%
Home Care Services (CHHA)	36,194,554	38,677,315	39,965,387	43,894,964	44,406,292	38,559,328	6.5%	1.3%
Personal Care	154,857,065	169,382,031	187,396,190	211,167,523	232,798,427	248,003,242	60.1%	9.9%
CDPAP	32,499,935	40,287,068	47,678,331	57,531,194	68,643,132	76,172,020	134.4%	18.6%
Non-CDPAP	122,357,130	129,094,963	139,717,859	153,636,329	164,155,294	171,831,223	40.4%	7.0%
LTHHC	78,303,464	82,186,411	80,793,108	88,797,635	94,708,774	95,529,904	22.0%	4.1%
ALP	4,626,009	6,206,642	7,801,526	9,137,502	10,317,988	11,624,774	151.3%	20.2%
Managed LTC	26,736,955	30,756,377	34,323,285	38,766,114	45,150,987	46,285,340	73.1%	11.6%
Partial	21,044,943	23,784,083	27,000,457	31,278,238	37,711,519	38,644,717	83.6%	12.9%
PACE	5,692,012	6,972,294	7,322,828	7,487,876	7,439,468	7,640,623	34.2%	6.1%
Advantage Plus (MAP)	0	0	0	0	0	0	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)

Questions: Woopill Hwang or Peter Gallagher @518-473-2230

Table1-C
NYS Medicaid Expenditures for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
Upstate

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	1,697,965,579	1,793,146,495	1,832,911,078	1,860,009,355	1,938,625,817	1,942,333,826	14.4%	2.7%
Adult Day Care	47,774,458	49,552,441	49,699,283	51,425,263	51,074,512	65,890,292	37.9%	6.6%
Home Care Services (CHHA)	86,078,703	89,088,827	86,393,661	92,440,077	99,395,534	96,805,810	12.5%	2.4%
Personal Care	120,099,563	138,241,445	151,059,784	160,426,821	172,665,247	181,860,975	51.4%	8.7%
CDPAP	48,948,800	63,134,744	74,575,485	83,008,465	94,383,547	106,513,120	117.6%	16.8%
Non-CDPAP	71,150,763	75,106,701	76,484,299	77,418,356	78,281,700	75,347,855	5.9%	1.2%
LTHHC	76,042,622	78,923,212	75,890,965	81,397,574	80,193,013	78,479,030	3.2%	0.6%
ALP	20,239,845	21,771,964	22,418,227	24,018,241	25,105,279	25,812,853	27.5%	5.0%
Managed LTC	40,505,230	49,374,465	52,028,729	49,501,438	51,042,528	53,200,409	31.3%	5.6%
Partial	13,608,820	19,168,507	21,023,399	18,521,151	18,967,744	19,394,026	42.5%	7.3%
PACE	26,896,411	30,205,959	31,005,330	30,980,287	32,074,784	32,908,919	22.4%	4.1%
Advantage Plus (MAP)	0	0	0	0	0	897,465	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)

Questions: Woopill Hwang or Peter Gallagher @518-473-2230

Table 2
NYS Medicaid Recipient Counts for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
Statewide

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	139,080	138,124	137,146	134,898	132,773	131,300	-5.6%	-1.1%
Adult Day Care	16,365	16,975	16,726	16,894	16,601	17,626	7.7%	1.5%
Home Care Services (CHHA)	92,553	89,669	89,116	89,795	85,986	81,423	-12.0%	-2.5%
Personal Care	84,823	85,270	84,201	81,971	79,550	77,800	-8.3%	-1.7%
CDPAP	5,672	6,587	7,341	8,120	8,592	9,105	60.5%	9.9%
Non-CDPAP	79,766	79,321	77,553	74,644	71,683	69,491	-12.9%	-2.7%
LTHHC	26,804	27,992	27,904	27,648	26,560	26,404	-1.5%	-0.3%
ALP	3,538	3,712	4,035	4,159	4,269	4,393	24.2%	4.4%
Managed LTC	12,293	14,479	16,648	20,724	25,680	29,967	143.8%	19.5%
Partial	10,103	11,979	13,814	17,502	22,193	26,080	158.1%	20.9%
PACE	2,194	2,514	2,840	3,248	3,541	3,665	67.0%	10.8%
Advantage Plus (MAP)	0	0	0	0	9	448	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)
Questions: Woopill Hwang or Peter Gallagher @518-473-2230

Table 2-A
NYS Medicaid Recipient Counts for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
NYC

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	61,060	60,858	60,441	59,750	58,670	57,852	-5.3%	-1.1%
Adult Day Care	9,956	10,379	10,347	10,561	10,361	10,524	5.7%	1.1%
Home Care Services (CHHA)	53,770	51,543	51,679	52,841	51,234	49,054	-8.8%	-1.8%
Personal Care	63,332	62,881	61,623	59,404	56,964	55,053	-13.1%	-2.8%
CDPAP	1,645	1,772	1,959	2,192	2,287	2,310	40.4%	7.0%
Non-CDPAP	61,793	61,225	59,773	57,325	54,765	52,827	-14.5%	-3.1%
LTHHC	15,194	16,535	16,716	16,956	16,390	16,289	7.2%	1.4%
ALP	1,415	1,522	1,747	1,905	1,965	1,932	36.5%	6.4%
Managed LTC	10,067	12,057	14,085	17,917	22,714	26,785	166.1%	21.6%
Partial	8,826	10,572	12,300	15,766	20,301	24,088	172.9%	22.2%
PACE	1,245	1,499	1,790	2,177	2,465	2,574	106.7%	15.6%
Advantage Plus (MAP)	0	0	0	0	9	346	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)
Questions: Woopill Hwang or Peter Gallagher @518-473-2230

Table 2-B
NYS Medicaid Recipient Counts for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
Downstate (Nassau, Suffolk, Westchester, Rockland and Putnam counties)

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	24,421	24,478	24,174	23,785	23,487	23,151	-5.2%	-1.1%
Adult Day Care	2,151	2,333	2,421	2,443	2,402	2,749	27.8%	5.0%
Home Care Services (CHHA)	10,286	10,251	10,069	10,367	9,601	8,315	-19.2%	-4.2%
Personal Care	7,495	7,843	7,934	8,072	8,139	8,396	12.0%	2.3%
CDPAP	1,201	1,409	1,517	1,743	1,888	2,047	70.4%	11.3%
Non-CDPAP	6,449	6,541	6,527	6,456	6,366	6,458	0.1%	0.0%
LTHHC	4,299	4,367	4,308	4,333	4,188	4,210	-2.1%	-0.4%
ALP	346	393	445	467	475	640	85.0%	13.1%
Managed LTC	727	788	845	1,028	1,140	1,251	72.1%	11.5%
Partial	601	628	679	861	960	1,063	76.9%	12.1%
PACE	126	160	166	167	182	191	51.6%	8.7%
Advantage Plus (MAP)	0	0	0	0	0	0	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)

Questions: Woopill Hwang or Peter Gallagher @518-473-2230

Table 2-C
NYS Medicaid Recipient Counts for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
Upstate

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	53,599	52,788	52,531	51,363	50,616	50,297	-6.2%	-1.3%
Adult Day Care	4,258	4,263	3,958	3,890	3,838	4,353	2.2%	0.4%
Home Care Services (CHHA)	28,497	27,875	27,368	26,587	25,151	24,054	-15.6%	-3.3%
Personal Care	13,996	14,546	14,644	14,495	14,447	14,351	2.5%	0.5%
CDPAP	2,826	3,406	3,865	4,185	4,417	4,748	68.0%	10.9%
Non-CDPAP	11,524	11,555	11,253	10,863	10,552	10,206	-11.4%	-2.4%
LTHHC	7,311	7,090	6,880	6,359	5,982	5,905	-19.2%	-4.2%
ALP	1,777	1,797	1,843	1,787	1,829	1,821	2.5%	0.5%
Managed LTC	1,499	1,634	1,718	1,779	1,826	1,931	28.8%	5.2%
Partial	676	779	835	875	932	929	37.4%	6.6%
PACE	823	855	884	904	894	900	9.4%	1.8%
Advantage Plus (MAP)	0	0	0	0	0	102	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)

Questions: Woopill Hwang or Peter Gallagher @518-473-2230

Table 3
NYS Medicaid Dollars per Recipient for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
Statewide

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	42,759	44,919	46,404	47,903	50,043	50,740	18.7%	3.5%
Adult Day Care	16,269	16,335	15,780	16,372	15,752	18,360	12.8%	2.4%
Home Care Services (CHHA)	8,215	8,998	10,338	12,354	13,654	14,424	75.6%	11.9%
Personal Care	21,512	23,054	25,546	27,433	29,372	29,923	39.1%	6.8%
CDPAP	26,092	27,132	28,223	28,964	31,479	32,409	24.2%	4.4%
Non-CDPAP	21,021	22,530	25,064	26,976	28,823	29,254	39.2%	6.8%
LTHHC	19,036	20,531	21,230	23,055	24,926	25,235	32.6%	5.8%
ALP	14,270	15,770	16,045	17,759	18,571	18,671	30.8%	5.5%
Managed LTC	36,146	38,628	38,856	35,474	35,444	35,986	-0.4%	-0.1%
Partial	35,345	38,003	38,334	34,499	34,581	35,326	-0.1%	0.0%
PACE	39,766	41,394	41,315	40,445	40,291	40,991	3.1%	0.6%
Advantage Plus (MAP)	n.a.	n.a.	n.a.	n.a.	8,610	15,280	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)
Questions: Woopill Hwang or Peter Gallagher @518-473-2230

Table 3-A
NYS Medicaid Dollars per Recipient for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
NYC

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	51,426	53,143	54,907	56,431	58,678	59,776	16.2%	3.1%
Adult Day Care	18,059	18,143	16,915	17,316	16,214	19,235	6.5%	1.3%
Home Care Services (CHHA)	11,867	13,175	15,382	18,413	20,109	21,183	78.5%	12.3%
Personal Care	24,471	26,371	29,413	31,600	33,901	34,478	40.9%	7.1%
CDPAP	40,452	42,491	43,353	43,178	46,978	48,657	20.3%	3.8%
Non-CDPAP	24,003	25,854	28,902	31,095	33,300	33,804	40.8%	7.1%
LTHHC	23,424	25,013	26,066	27,556	29,721	30,223	29.0%	5.2%
ALP	18,107	20,079	19,760	21,368	22,319	23,076	27.4%	5.0%
Managed LTC	37,459	39,742	39,796	36,105	35,838	36,547	-2.4%	-0.5%
Partial	36,533	38,997	39,148	35,139	35,012	35,838	-1.9%	-0.4%
PACE	43,901	44,620	44,138	42,672	41,848	42,612	-2.9%	-0.6%
Advantage Plus (MAP)	n.a.	n.a.	n.a.	n.a.	8,610	17,190	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)
Questions: Woopill Hwang or Peter Gallagher @518-473-2230

Table 3-B
NYS Medicaid Dollars per Recipient for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
Downstate (Nassau, Suffolk, Westchester, Rockland and Putnam counties)

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	45,411	48,086	50,163	51,726	53,781	54,495	20.0%	3.7%
Adult Day Care	17,980	16,903	16,196	17,309	17,669	20,114	11.9%	2.3%
Home Care Services (CHHA)	3,519	3,773	3,969	4,234	4,625	4,637	31.8%	5.7%
Personal Care	20,661	21,597	23,619	26,160	28,603	29,538	43.0%	7.4%
CDPAP	27,061	28,593	31,429	33,007	36,358	37,212	37.5%	6.6%
Non-CDPAP	18,973	19,736	21,406	23,797	25,786	26,607	40.2%	7.0%
LTHHC	18,214	18,820	18,754	20,493	22,614	22,691	24.6%	4.5%
ALP	13,370	15,793	17,532	19,566	21,722	18,164	35.9%	6.3%
Managed LTC	36,777	39,031	40,619	37,710	39,606	36,999	0.6%	0.1%
Partial	35,017	37,873	39,765	36,328	39,283	36,354	3.8%	0.8%
PACE	45,175	43,577	44,113	44,838	40,876	40,003	-11.4%	-2.4%
Advantage Plus (MAP)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)

Questions: Woopill Hwang or Peter Gallagher @518-473-2230

Table 3-C
NYS Medicaid Dollars per Recipient for Long Term Care Services
Service Date: Calendar Year 2003 through 2008
Upstate

Service Type	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008	% Change between 03 and 08	Annual % Change per Year (Compounded)
Nursing Homes	31,679	33,969	34,892	36,213	38,301	38,617	21.9%	4.0%
Adult Day Care	11,220	11,624	12,557	13,220	13,308	15,137	34.9%	6.2%
Home Care Services (CHHA)	3,021	3,196	3,157	3,477	3,952	4,025	33.2%	5.9%
Personal Care	8,581	9,504	10,315	11,068	11,952	12,672	47.7%	8.1%
CDPAP	17,321	18,536	19,295	19,835	21,368	22,433	29.5%	5.3%
Non-CDPAP	6,174	6,500	6,797	7,127	7,419	7,383	19.6%	3.6%
LTHHC	10,401	11,132	11,031	12,800	13,406	13,290	27.8%	5.0%
ALP	11,390	12,116	12,164	13,441	13,726	14,175	24.5%	4.5%
Managed LTC	27,022	30,217	30,284	27,825	27,953	27,551	2.0%	0.4%
Partial	20,131	24,607	25,178	21,167	20,352	20,876	3.7%	0.7%
PACE	32,681	35,329	35,074	34,270	35,878	36,565	11.9%	2.3%
Advantage Plus (MAP)	n.a.	n.a.	n.a.	n.a.	n.a.	8,799	n.a.	n.a.

Source: NYS DOH OHIP Datamart (based on claims paid thru 10/2009)

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Appendix C

Components of the Proposed 2009-10 Episodic Pricing Model

The following discussion provides a detailed description of the methodology used to develop the five components of the Episodic Pricing Model. Subsequent to that discussion are some examples of how payments would be calculated under the proposed Episodic Pricing Model.

There are five key components to the proposed Episodic Pricing Model:

1) A Base Price for each 60-day episode of care for each recipient.
2) A Wage Index Factor (WIF) that adjusts the Base Price to account for the variation in wages across different regions of the State.
3) A Case mix adjustment that adjusts the WIF adjusted Base Price for patient acuity (i.e., the case mix).
4) An outlier payment that, if applicable, is a payment that is made in addition to the WIF and case mix adjusted Base Price to pay for certain costs above a threshold.
5) Quality payments.

It should be noted that when the model was initially proposed in 2008 (with the 2009-10 Executive Budget), 2007 claims data and 2007 OASIS data were used to develop the model. This past Fall, and in the context of discussions with the Work Group, the model was updated to use 2008 claims and 2008 OASIS data. As discussed in more detail below, this update was also necessary to ensure that analysis was consistent with the most recent OASIS data set and Medicare "Grouper" (i.e., the tool used to translate patient specific OASIS data into a code that classifies patients in a case mix or patient acuity group).

Component 1: Establishing a Base Price for Each 60 Day Episode of Care

The following steps were taken to calculate the episodic base prices.

- Total annual 2008 CHHA Medicaid claims were culled, identifying $1.16 billion of expenditures related to 82,222 recipients.
- Each claim was grouped into a 60-day episode of care by applying the following protocols:
  - ✓ A first episode begins from the actual date of service and the following episodes are constructed in 60-day increments.
  - ✓ The counter is reset when there is a 60-day gap in service.
  - ✓ A change in CHHA providers in the course of CHHA services does not reset the 60-day counter.
  - ✓ Where necessary, a look-back to January 2007 claims was applied to assign a 2008 claim to the proper episode (i.e., first, second, third, etc.).

  This process results in six groupings of 60-day claims, covering the 12 months in the 2008 year.
- The following adjustments were made to total claims:

- ✓ Expenditures related to low utilization claims (claims of $500 or less) were excluded. These claims would continue to be paid through current fee for service program.
- ✓ Expenditures related to claims from recipients under 18 years of age were excluded. As discussed in more detail in Component 3 and the Summary of Work Group Discussions, there is no OASIS record for these recipients. These claims would also continue to be paid through current fee for service program.
- ✓ Dollar amounts in excess of the outlier threshold in each case mix group in each episode were excluded (see Component 4 more details).

- For each episode a Base Price is calculated by dividing total dollars from the claims assigned to each episode by the total number of claims. Each of the base prices was further adjusted to account for other Medicaid dollars (i.e., recruitment and retention rate adjustments) that relate to 2008 but were paid after 2008 and thus not reflected in the claims data. This resulted in the following Base Prices. The Base Price for episode 6 is applied to all subsequent episodes (i.e., episode 7 and thereafter). Please see the table attached at the end of Appendix B that provides additional information on the unadjusted and adjusted Base Price.

60-Day Episode	**Base Price *(Adjusted)***
1	$3,441
2	5,045
3	5,710
4	6,135
5	6,273
6+	6,435

Component 2: Wage Index Factor

The percentage share of the Base Price (which is based on statewide claims data) estimated to be attributable to labor costs is adjusted to reflect variation in wages across the State. The 2009-10 proposed model developed a Wage Index Factor (WIF) that:

- Employed the same three regions, New York City, Downstate Suburban (Nassau, Suffolk, Westchester, Rockland and Putnam), and Upstate, that are used to calculate ceilings in the current fee-for service CHHA reimbursement methodology.
- Was based on average wages reported in 2007 certified cost reports required to be submitted by all CHHAs.
  - ✓ The ratio of total Statewide wages and contracted labor to total Statewide costs, or 85.35 percent, was used to estimate the portion of the base price to be adjusted by the WIF.
  - ✓ Average wages for each of the three regions was computed for the two groups of employees that provide CHHA services, professional staff (including nursing and therapy aides) and home health aides. Regional average wages were divided by the Statewide average to calculate a regional index value. The values were then weighted by the portion of professional and HHA staff in each region.

The calculated WIF for each of the three regions is reported below.

Region	WIF
New York City	1.037696
Downstate Suburban	.915305
Upstate	.813683

As discussed above, the WIF is applied to 85.35 percent of the Base Price. For example, the WIF adjusted Base Price for Episode 1 for a New York City provider would be $3,552. (Base Price Episode 1=$3,441) ($3,441*.85*1.037696)+($3,441*.15)=$3,552). Please see the table attached at the end of Appendix B that provides additional information on the WIF and adjusting 85.35 percent of the Base Price for the WIF.

Component 3: Case Mix Adjustment

The Base Price is also adjusted to reflect patient acuity or case mix. To develop case mix weights the following steps were taken:

- 2008 data for New York State CHHA Medicaid patients was obtained from the 2008 OASIS.
- The Medicare OASIS grouper was used to assign a resource group to each CHHA patient based on three Clinical groups (A, B, C Group) and three Functional groups (F,G, or H Group). In addition, dual and non-dual patients were identified. The Clinical and Functional groupings depend on the number of therapy visits and whether the episode of care is an early episode (the first or second 60-day episode) or late episode (third or subsequent episode). The clinical grouping assesses conditions, including orthopedic, neurological or diabetic conditions, and the functional groups asses a patient's ability to perform Activities of Daily Living (bathing, dressing, transferring and locomotion). For example, a patient with an OASIS score that resulted in the lowest clinical grouping and highest functional grouping would be assigned a resource group of AH.
- The average claim amounts for each case mix group (within each episode) is divided by Base Price for that episode to develop a weight for each case mix group.
- This approach to grouping patients results in 20 different case mix groups for each of the six episodes (3 Clinical * 3 Functional * 2 dual or non~dual patient designation) + 2 dual and non dual groups for claims for which no OASIS match was found).

The following chart provides an example of how the case mix weight for Episode 2, case mix group AH (dual patients) is calculated.

Episode 2: Case Mix Weight for Case Mix Group AH (Dual)	
# of Claims Case Mix Group AH (excluding those $500 or less and attributable to patients under 18)	263
$ Amount Below 80th Percentile Outlier Threshold in Case Mix Group AH	$1,919,300
Average	$7,298
Base Price 2nd Episode (unadjusted, please see Component 1)	$4,868
Case Mix Weight for AH = Average/Base Price	1.499

Component 4: Outlier Payments

- The proposed Episodic Pricing Model provides additional reimbursement for high cost cases that exceed the adjusted (for WIF and case mix) Base Price. Under the proposed model, 50 percent of the costs above the outlier threshold are reimbursed. As described above, when the Base Price is calculated (Component 1) the dollars above an outlier threshold (i.e., the dollar amount of claims over the 80th percentile in that case mix group) are excluded. In the example provided in Component 3, the dollars above the 80th percentile and excluded from the Base Price calculation were $390,569. Please see the tables attached at the end of Appendix B that provides the outlier thresholds for each case mix group and each episode.

Below is an example of how an outlier payment is calculated for a patient in their second episode with in case mix group AH (i.e., a case mix weight of 1.499).

Outlier Payment for Patient A in Episode 2 and in Case Mix Group AH with Case Mix Weight of 1.499 (NYC Provider)	
Episodic Base Price Adjusted for WIF and Case Mix	$7,806
Outlier Threshold	$14,217
Total Cost of Patient A	$15,663
Outlier Payment (Total Cost – Outlier Threshold)*50%	$723
Total Payment	$8,529

Examples of the Calculation of Episodic Payments						
Patient	**Base Price**	**WIF Adjusted Price**	**Case Mix Adjusted Price**	**Total Costs of Patient**	**Outlier Payment**	**Total Payment***
NYC Case Mix AH (dual eligible) Episode 1	$3,441	$3,552	$6,405	$4,000	N/A	$6,405
NYC Case Mix BF (non-dual) Episode 5	$6,273	$6,475	$2,973	$7,000	$508	$3,481
Upstate Case Mix CH (non-dual) Episode 6	$6,435	$5,412	$6,039	$5,000	N/A	$6,039
* Does not include Quality Payments						

Component 5: Quality Payments

An essential and critical component of the proposed Episodic Pricing model is to encourage and reward the provision of quality care. With budget limitations on available health care dollars, it is imperative that payers consider Value Based Purchasing to promote quality outcomes of service rather than volume of service. Accordingly, the Department developed a proposal to establish four incentive pools to recognize quality attainment and improvement in two types of CHHAs: those with a LTHHCP and those without. The development of this proposal is described below.

CHHAs would be eligible for incentive payments rewarding them for their quality of care by 1) achieving a level of performance on one or more selected quality measures reported in 2010 that places them in the top quintile of all agencies in the state; and/or 2) achieving a level of improvement in one or more selected performance measures over the base year (2008-09) placing them in the top quintile of all improving agencies.

Funding for the pool would be established through Medicaid and would be distributed as incentive awards. Three-quarters of the pool would be earmarked for best performers and distributed on a weighted basis for each quality indicator. In addition, one-quarter of the pool would be distributed on a weighted basis for each measure based on best improvement. Agencies could not receive a payment for both best performance and greatest improvement on the same measure. However, agencies could receive multiple awards based on their performance on different measures. The amount of the pool distributed to agencies in any category would be proportional to the number of Medicaid recipients served by each "winning" agency.

When identifying the performance measures upon which the incentive program would be based, the Department determined indicators must be: 1) measurable; 2) within the agencies' ability to control; 3) publicly reported; 4) based on data readily available to the Department and the agencies; 5) valid and reliable; and 6) important to patient well-being and the efficient delivery of care. The OASIS home health quality measures established by the Centers for Medicare and Medicaid Services are risk-adjusted and currently reported on a public website, thus fulfilling these standards.

Department staff carefully reviewed all twelve publicly reported OASIS measures and ultimately rejected those that could be perceived to unfairly hold agencies accountable for poor patient outcomes. These rejected measures included hospitalizations; urgent, unplanned medical care; wound care; ambulation (2 measures), and urinary incontinence. The Department decided to exclude institutionally-based LTHHCPs in the first year of the incentive program, as IPRO consultants indicated that none of the existing publicly reported measures were appropriate, and instead stabilization measures should be used to fairly compare these programs. Consultation with IPRO, an independent, not-for-profit health care consulting organization dedicated to quality improvement and the enhancement of value in the delivery of health care, indicated that the remaining six OASIS measures were the most appropriate of the 12 for ranking purposes of CHHAs and CHHAs that also offer a LTHHCP. A review of postings of the technical expert panel for OASIS data posted to the Agency for Healthcare Research and Quality (AHRQ) website confirmed these findings. The proposed indicators are noted below; weights are noted in parentheses to reflect the importance of each measure to the efficient and effective delivery of home health care and the perceived opportunity for improvement.

Physical functioning performance indicators:
Percentage of patients who get better at getting in and out of bed (weight=.20)
Percentage of patients who get better at bathing (weight=.20)

Clinical performance indicators:
Percentage of patients who are short of breath less often (weight=.15)
Percentage of patients who have less pain when moving around (weight=.15)
Percentage of patients who get better at taking oral medications (weight=.15)

Utilization performance indicators:
Percentage of patients who remain in the community after an episode of home care ends (weight=.15)

Agencies would be grouped separately, as listed on New York State's *Home Care Compare* website (i.e., CHHA and CHHA/LTHHCP). This process will allow CHHAs with similar case mixes to be more equitably compared. Agency performance would be measured for each indicator and those agencies that perform among the top 20 percent in their respective groups will be eligible for an incentive payment. No agency would be eligible for an incentive payment if findings of 'condition level non-compliance' during the last survey cycle were cited or its performance falls within the bottom 30 percent of all home care agencies in its respective group on any performance indicator. The publicly reported outcomes data posted on the CMS website

for the time period covering April 2008 through March 2009 would serve as the base year for determining performance improvement. The data posted for the time period of April 2009 through March 2010 would serve to measure both performance improvement and best performance in determining awards.

Funds appropriated to support the program would be allocated among qualifying CHHAs using the weights assigned to each measure and distributed among top performers and the most improved agencies. In recognition of the complexity and magnitude of determining fair, risk-adjusted allocations weighted by recipient count and grouped by provider type, these methods will be modeled, tested, and analyzed prior to finalizing the precise rules for making awards.

Every effort was made to establish a means to fairly compare agencies on measures that are based on the best data currently available. The quality pools' criteria will evolve with the data as it becomes more transparent, more appropriate for specific agency populations (i.e., institutionally-based LTHHCPs will be able to participate when stabilization indicators are publicly reported), and better related to the provision of quality care. Finally, the quality pools are intended to motivate administrators and staff to regularly consider how they can improve and maintain the best quality patient care, not to reimburse solely on the basis of how well clients fare in their health outcomes. In fact, quality incentive payments are intended to supplement regular Medicaid reimbursements, not supplant them.

NEW YORK STATE DEPARTMENT OF HEALTH
APPENDIX C

Certified Home Health Agencies
Proposed Episodic Payment System

MODEL BASED ON 2008 PAID CLAIMS - PATIENTS UNDER AGE 18 EXCLUDED

Wage Index Factors - calculated from 2007 certified cost reports:

New York City	1.037696
Other Downstate	0.915305
Upstate	0.813683

Percent of cost affected by wage index: 85.35%

Calculated from 2007 certified cost reports - total of wages, benefits, and amounts paid to contractors, divided by total operating cost.

Adjustment for unpaid portions of RTR (Recruitment, Training & Retention) and AQE (Accessibility, Quality & Efficiency) add-ons:

Percent to be added to standard prices 3.64%

Unadjusted base price per episode (2008) after removing claims of $500 or less and claim amounts above outlier thresholds:

Episode 1	$	3,320.26
Episode 2	$	4,868.05
Episode 3	$	5,509.72
Episode 4	$	5,919.78
Episode 5	$	6,052.92
Episode 6+	$	6,208.78

Base prices with addition of 3.64%for RTR and AQE:

Episode 1	$	3,441.10
Episode 2	$	5,045.23
Episode 3	$	5,710.24
Episode 4	$	6,135.23
Episode 5	$	6,273.21
Episode 6+	$	6,434.74

Breakdown of base prices into portion affected by Wage Index (85.35%) and other:

	Labor	Non-Labor	Total
Episode 1	$ 2,936.98	$ 504.12	$ 3,441.10
Episode 2	$ 4,306.10	$ 739.13	$ 5,045.23
Episode 3	$ 4,873.69	$ 836.55	$ 5,710.24
Episode 4	$ 5,236.42	$ 898.81	$ 6,135.23
Episode 5	$ 5,354.19	$ 919.03	$ 6,273.21
Episode 6+	$ 5,492.05	$ 942.69	$ 6,434.74

NEW YORK STATE DEPARTMENT OF HEALTH
APPENDIX C

Certified Home Health Agencies
Proposed Episodic Payment System

Outlier Thresholds (80th percentile level for episodic claims over $500)
(Based on 2008 claims data - patients under age 18 excluded)

Clinical	Functional	Dual Eligible?	Episodes: 1	2	3	4	5	6+
A	**F**	**N**	$ 3,401.69	$ 4,924.27	$ 5,652.43	$ 5,343.30	$ 6,017.31	$ 6,566.04
A	**F**	**Y**	$ 4,258.92	$ 5,850.50	$ 6,142.84	$ 6,500.84	$ 6,535.73	$ 5,875.02
A	**G**	**N**	$ 6,175.46	$ 7,823.55	$ 10,322.96	$ 10,421.57	$ 9,992.37	$ 9,703.44
A	**G**	**Y**	$ 8,174.96	$ 10,980.99	$ 12,017.62	$ 12,701.87	$ 12,892.23	$ 13,354.37
A	**H**	**N**	$ 8,587.30	$ 11,279.84	$ 13,615.63	$ 14,154.70	$ 13,131.79	$ 13,017.03
A	**H**	**Y**	$ 12,608.24	$ 14,217.48	$ 22,609.64	$ 23,653.48	$ 24,174.69	$ 25,255.11
B	**F**	**N**	$ 3,216.90	$ 4,399.62	$ 4,746.09	$ 5,991.18	$ 5,984.92	$ 5,572.26
B	**F**	**Y**	$ 3,952.83	$ 5,229.88	$ 5,674.50	$ 6,265.91	$ 5,514.40	$ 5,933.36
B	**G**	**N**	$ 6,315.59	$ 9,065.07	$ 9,861.53	$ 9,573.28	$ 11,436.09	$ 10,032.58
B	**G**	**Y**	$ 8,216.28	$ 10,632.75	$ 12,171.28	$ 12,607.25	$ 12,620.97	$ 12,912.36
B	**H**	**N**	$ 9,575.96	$ 14,566.64	$ 14,063.61	$ 12,658.74	$ 12,988.62	$ 14,458.88
B	**H**	**Y**	$ 13,490.78	$ 19,790.68	$ 22,570.38	$ 23,749.68	$ 24,450.80	$ 24,791.55
C	**F**	**N**	$ 3,490.73	$ 4,446.84	$ 5,044.40	$ 5,434.01	$ 5,526.30	$ 6,622.98
C	**F**	**Y**	$ 4,164.25	$ 5,537.02	$ 5,277.30	$ 5,899.74	$ 6,256.80	$ 6,704.14
C	**G**	**N**	$ 5,772.49	$ 7,892.23	$ 8,767.23	$ 8,745.43	$ 10,191.48	$ 11,008.11
C	**G**	**Y**	$ 7,557.68	$ 9,857.61	$ 11,415.70	$ 12,434.40	$ 13,302.65	$ 12,846.87
C	**H**	**N**	$ 10,871.76	$ 10,566.35	$ 11,281.24	$ 12,665.82	$ 14,323.11	$ 14,804.59
C	**H**	**Y**	$ 13,930.68	$ 20,574.84	$ 19,080.00	$ 21,025.44	$ 21,846.42	$ 23,267.68
M *	**M ***	**N**	$ 2,384.48	$ 4,621.32	$ 6,126.72	$ 4,471.35	$ 5,639.09	$ 8,707.80
M *	**M ***	**Y**	$ 5,244.96	$ 8,910.88	$ 11,266.76	$ 9,726.48	$ 9,045.10	$ 13,494.50

* M = Claims for which there was no OASIS match

NEW YORK STATE DEPARTMENT OF HEALTH
APPENDIX C

Certified Home Health Agencies
Proposed Episodic Payment System

Case Mix: weights for clinical and functional groups
(Based on 2008 claims data - patients under age 18 excluded)

Clinical	Functional	Dual Eligible?	Episodes: 1	2	3	4	5	6+
A	**F**	**N**	0.55	0.53	0.54	0.49	0.52	0.51
A	**F**	**Y**	0.67	0.61	0.55	0.53	0.51	0.43
A	**G**	**N**	0.94	0.87	0.98	0.97	0.89	0.83
A	**G**	**Y**	1.27	1.21	1.16	1.16	1.13	1.13
A	**H**	**N**	1.18	1.14	1.26	1.27	1.18	1.03
A	**H**	**Y**	1.80	1.50	2.01	1.94	1.99	2.11
B	**F**	**N**	0.52	0.45	0.43	0.47	0.46	0.43
B	**F**	**Y**	0.63	0.54	0.51	0.50	0.45	0.45
B	**G**	**N**	0.98	0.96	0.96	0.88	1.02	0.85
B	**G**	**Y**	1.27	1.15	1.14	1.11	1.11	1.09
B	**H**	**N**	1.34	1.45	1.19	1.13	1.11	1.13
B	**H**	**Y**	2.03	1.96	1.95	1.98	2.09	2.08
C	**F**	**N**	0.56	0.47	0.48	0.46	0.46	0.55
C	**F**	**Y**	0.65	0.57	0.49	0.50	0.52	0.54
C	**G**	**N**	0.88	0.83	0.82	0.84	0.92	0.91
C	**G**	**Y**	1.16	1.05	1.04	1.09	1.14	1.09
C	**H**	**N**	1.50	1.06	0.96	0.96	1.12	1.12
C	**H**	**Y**	2.02	1.95	1.60	1.67	1.65	1.79
M *	**M ***	**N**	0.39	0.43	0.49	0.35	0.38	0.63
M *	**M ***	**Y**	0.77	0.88	0.98	0.86	0.79	0.99

* M = Claims for which there was no OASIS match

Appendix D

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

Certified Home Health Agency	Subcontractor	CHHA HHA Rate	Contract Hourly Rate to LHCSA	Wage Rate
A	1	$23.89	$15.00	$8.06
A	2	$23.89	$14.20	$8.50
B	1	$19.59	$12.75	$8.75
B	2	$19.59	$13.00	$8.00
B	3	$19.59	$12.50	$8.00
B	4	$19.59	$12.50	$9.50
C	1	$15.64	$13.00	$8.00
C	2	$15.64	$13.00	$8.00
C	3	$15.64	$13.00	$8.00
C	4	$15.64	$13.00	$7.50
D	1	$20.19	$12.80	$8.75
D	2	$20.19	$12.50	$7.15
D	3	$20.19	$12.50	$8.00
D	4	$20.19	$12.90	$7.15
D	5	$20.19	$12.00	$7.30
E	1	$40.39	$23.00	$9.00
F	1	$19.16	$13.35	$7.15
F	2	$19.16	$13.25	$8.50
F	3	$19.16	$13.50	$8.00
F	4	$19.16	$13.35	$9.00
F	5	$19.16	$13.55	$8.00
G	1	$30.68	$23.40	$9.19
G	2	$30.68	$16.50	$8.50
G	3	$30.68	$16.25	$9.00
G	4	$30.68	$16.45	$9.00
H	1	$29.60	$14.60	$8.75
H	2	$29.60	$14.60	$8.25
H	3	$29.60	$14.72	$7.15
H	4	$29.60	$17.00	$8.25
I	1	$29.08	$15.25	$7.15
I	2	$29.08	$13.89	$7.75
I	3	$29.08	$13.18	$8.10
I	4	$29.08	$13.40	$7.50
J	1	$20.45	$13.82	$7.75
J	2	$20.45	$14.39	$7.15

Notes: 2007 CHHA rates include Worker Recruitment and Retention (WRR), Recruitment Training and Retention (RTR) and Productivity, Quality and Efficiency Payment (AQE), contracted rates reported to DOH, wage rates are lowest starting rates, does not include differentials, fringe or other benefits, each letter represents an individual CHHA. All regions of the state are represented.