Medically Fragile Children Work Group

July 19, 2012

Introductions ~ Members of Work Group

Organization	Member
Elizabeth Seton/Children's Rehabilitation Clinic	Ms. Pat Tursi
St. Margaret's Center	Mr. Alan Krafchin
Blythedale Children's Hospital	Mr. Lawrence Levine
St. Mary's Hospital for Children	Dr. Edwin F. Simpser
Terrence Cardinal Cooke	Mr. James G. Karkenny
Association for Technology Dependent Children – Angela's House	Mr. Robert Policastro
The Center for Discovery	Mr. Patrick Dollard
American Academy of Pediatrics	Ms. Elie Ward
Sick Kids Need Involved People (SKIP)	Ms. Margaret Mikol
Director of Project Delivery of Chronic Care	Ms. Maggie Hoffman
Coalition for Medically Fragile Children	Mr. Jim Lytle
People, Inc.	Ms. Rhonda Frederick
DOH ~ Office of Quality and Patient Safety	Dr. Lawrence Sturman

Overview

- Overview of Health Care Services for Medically Fragile Children(MFC)
  - Current Structure for Providing Health Care to MFC
  - MFC Medicaid Population, Spending, Providers
  - Timeline for Transitioning MFC Population to Managed Care
  - Care Management Models
- Discussion of Objectives of Medically Fragile Children (MFC) Work Group – October 1, 2012 Report
- Next Steps / Proposed Work Group Schedule

Current Health Care Delivery System for Medicaid's Medically Fragile Children

- Working definition of Medically Fragile Children
- Health care delivered through a variety of programs and reimbursement mechanisms
  - State Plan Services
  - Waiver Services
  - Combination of State Plan and Waiver Services
  - Fee-for-service and Managed Care
- MRT initiatives propose to transition long term care services, including those provided to MFC, to Managed Care
  - Provides fully integrated care management for all and shifts reimbursement model from fee-for-service (FFS) to Managed Care capitated PMPM

1915 (c) Waiver Programs that Serve MFC		
	Care at Home (I & II DOH)	**Care at Home (III, IV & VI OPWDD)**
Eligibility Criteria (Children of non-Medicaid eligible families quality)	CAH I – Skilled Nursing Facility (SNF) Level of Care CAH II – Hospital Level of Care	Under 18, Developmental Disability , ICF Level of Care and meet medical screening criteria
Waiver Authorization	Authorized through 11.30.13	Consolidate 3 Waivers into 1, Five year waiver effective 1.1.13 Pending CMS approval
Waiver Services in Addition to State Plan Services	Includes Respite Care (pending CMS approval), Home Adaptation/Vehicle Modification, Palliative Care	Includes Respite Care, Environmental modifications, assistive technologies
Case Management	Yes (Separate FFS Rate)	Yes (Separate FFS Rate)
Reimbursement (Patient s may be in Managed Care)	Fee-for-Service (FFS) – Total annual Cost Must be less than SNF	FFS – Total annual cost must be less than in ICF
Program Enrollment Limit	3,698	600
# MFC Children Served	896	559

1915 (c) Waiver Programs that Serve MFC

	LTHHCP	Home and Community Based Services (OPWDD Comprehensive Waiver)
Eligibility Criteria	Skilled Nursing Facility Level of Care	All children and adults with a developmental disability who meet ICF level of care criteria. A subset of enrollees can be described as medically frail.
Waiver Authorization	Authorized through August 2015	Authorized through 9.30.14
Waiver Services in Addition to State Plan Services	Includes Respite Care, Nutrition, Medical Social Services	Includes Community, Day, and Residential Habilitation , along with Respite Care, Environmental Modifications, Assistive Technologies, Family Education, Training, Community Habilitation, and other supports
Case Management	Yes – RN Monitors, Supervises and Coordinates Plan of Care (Cost incorporated in FFS)	Yes – Case Management is provided in a non-medical model through Medicaid Service Coordination (State Plan) or less intensive Plan of Care Support Services (Waiver Service)

1915 (c) Waiver Programs that Serve MFC

	LTHHCP	Home and Community Based Services (Comprehensive Waiver)
Reimbursement	FFS – Total cost of care must be less than 75% of SNF (Case by Case exceptions for 100% of SNF)	Currently FFS using agency specific budget/cost based rates or regional statewide fees depending on service
Program Enrollment Limit (not limited to Children)	No limit in the waiver, however slots are allocated by the county through the State CON process	CY 2013 - 76,486 recipients Ceiling increases annually for expected population growth
# Children Served 2011	710	458

Services Provided Under State Plan		
	# of MFC Providers	**Reimbursement Methodology**
Children's Hospitals	1 – Blythedale	Specialty per diem based on 2007 Base Year Costs, Adjusted for Case Mix (Services to children in Health Plans billed separately as FFS)
Clinics	2 – Children's Rehabilitation Clinic, Blythedale	Specialty per visit rates based upon historical costs (Services to children in Health Plans billed separately as FFS)
Pediatric Nursing Homes	9 – E Seton, Avalon Sunshine, St. Mary's, St. Margaret's, Incarnation, Pathways, Rutland, Highpoint at Michigan	Operating Rate: 1.1.09 Rate - Cost Based Methodology – No Ceilings, No Case Mix Adjustments (added staff appeals) Base years costs and rates vary significantly across pediatric nursing homes , rates include capital
CHHAs	2 – Extraordinary Home Care , VNA of Western New York	Children Under 18 and, services provided to medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by DOH (Extraordinary HC) FFS pending CMS approval– All other under EPS Pricing System – effective May 1, 2012)
Private Duty Nursing	74	An enhanced rate of 30% is added for children under 21 where the nurse providing the services is trained to care for the medically fragile children in the community

What types of case management services are employed by these providers?

Total 2011 Medicaid Spending for MFC

Program	# Providers	# Recipients	2011 Total Medicaid Spending
Care at Home (I & II DOH)	15	896	$70,612,462
Care at Home (III, IV, &VI, OPWDD)	19	559	$28,493,516
HCBS – OPWDD Comprehensive Waiver	27	458	$40,986,758
Pediatric NHs	9	519	$143,460,773
Children's Hospital	1	173	$39,027,587
Specialty Hospital	1	23	$8,065,744
Intermediate Care Facilities	18	61	$14,225,874
Children's Clinics	2	514	$21,163,124
LTHHCP	12	710	$35,989,819
CHHAs	116	869	$155,293,453
Private Duty Nursing	74	47	$7,752,803
Total	---	4,829	$565,071,913

See Appendix: Data Definitions and Notes for Information on How Data Was Compiled

MFC Spending by Program and Recipient County of Residence

Program ($ in millions)	New York City Medicaid Spending	Rest of State Medicaid Spending	2011 Total Medicaid Spending
Care at Home (I & II DOH)	$23.5	$47.1	$70.6
Care at Home (III, IV, &VI, OPWDD)	$3.9	$24.6	$28.5
HCBS – OPWDD Comprehensive Waiver	$11.6	$29.4	$41.0
Pediatric NHs	$104.4	$39.0	$143.5
Children's Hospital	$29.9	$9.1	$39.0
Specialty Hospital	$7.9	$0.2	$8.1
Intermediate Care Facilities	$7.6	$6.6	$14.2
Clinics	$6.5	$14.6	$21.2
LTHHCP	$32.2	$3.8	$36.0
CHHAs	$105.6	$49.7	$155.3
Private Duty Nursing	$2.5	$5.2	$7.8
Total	$335.8	$229.3	$565.1

See Appendix: Data Definitions and Notes for Information on How Data Was Compiled

Per Person Per Year by County of Residence

Program PPPY – Per Person Per Year	NYC Recipient	New York City Medicaid Spending	ROS Recipients	Rest of State Medicaid Spending	2011 Total Medicaid Spending
Care at Home (I & II DOH)	242	$97,087	654	$72,045	$78,809
Care at Home (III, IV, &VI, OPWDD)	62	$63,600	497	$49,397	$50,972
HCBS – OPWDD Comprehensive Waiver	101	$114,518	357	$82,410	$89,491
Pediatric NHs	353	$295,880	166	$235,031	$276,418
Children's Hospital	123	$243,163	50	$182,370	$225,593
Specialty Hospital	22	$359,391	1	$159,141	$350,685
Intermediate Care Facilities	29	$263,576	32	$205,692	$233,211
Clinics	129	$50,533	385	$38,037	$41,173
LTHHCP	611	$52,652	99	$38,580	$50,690
CHHAs	585	$180,580	284	$174,839	$178,704
Private Duty Nursing	15	$167,786	32	$163,626	$164,953
Total	2,272	$147,779	2,557	$89,682	$117,016

See Appendix: Data Definitions and Notes for Information on How Data Was Compiled

Pediatric Nursing Homes Rates Vary Significantly Across Providers

Pediatric Nursing Home	Beds	Medicaid Occupancy (2010)	Total Non Capital Component	2012 Capital	Total Pediatric NH Rate
Pediatric NH 1	44	89%	$1,003.13	$31.40	$1,034.53
Pediatric NH 2	136	97	907.86	102.75	1,010.61
Pediatric NH 3	21	99	787.03	29.42	816.45
Pediatric NH 4	95	94	723.44	48.69	772.13
Pediatric NH 5	36	32	659.21	24.57	683.78
Pediatric NH 6	21	97	487.58	56.42	544.0
Pediatric NH 7	36	99	519.43	8.57	528.0
Pediatric NH 8	56	66	$490.36	34.50	524.86

Base Year Costs (trended to 2012) Vary from 1983 to 2010, Rates Included Added Staff

Time Line for Transition to Managed Care

Population/Benefit	Date
CDPAP Benefit (non-duals and duals)	10/1/12
LTHHCP Population (non-duals)	1/1/13
Nursing Home Population (non-duals)	10/1/13
Nursing Home Population (duals)	1/1/15
HCBS CAH I and II Waiver (non-duals)	1/1/16
HCBS CAH III, IV and VI Note: The transition to managed care will occur after the 3 CAH waivers are consolidated into one regular waiver and the larger comprehensive HCBS waiver has fully transitioned to Managed Care which will not occur for several years. Pending CMS approval, the first Plans under the People First waiver are expected to begin operation November 2013 (initial phase will be voluntary enrollment). A larger statewide roll-out of mandatory managed care plans is planned to begin November 2015, and thereafter will proceed to expand to new regions based on provider capacity.	See Note

Care Management Models: State is Working to Develop Health Homes (HH) for Children with Chronic Conditions

- **What is a <u>Health Home</u>?**
  - A model of service delivery for Medicaid beneficiaries with chronic conditions
  - Goal is to expand upon the traditional and existing medical home models to build linkages to community and social supports, and to enhance coordination of medical, behavioral, and long-term care
  - States may elect to implement the HH model under their Medicaid State Plan

Developing HH for Children with Chronic Conditions

- **Eligibility Criteria:**
  - Child has two or more chronic conditions (i.e. asthma, diabetes, obesity), or
  - Child has one chronic condition and high risk of developing another, or
  - Child has at least one serious and persistent mental health condition

Developing HH for Children with Chronic Conditions

- **Health Home Services per Federal Legislation:**
  - Comprehensive case management
  - Care coordination and health promotion
  - Comprehensive transitional care from inpatient to other settings
  - Patient and family support
  - Referral to community and social support services
  - Use of health information technology to link services

Developing HH for Children with Chronic Conditions

- **Progress on HH Development**
  - A DOH interagency workgroup (involving OCFS, OMH, OASA) is developing recommendations
  - An OMH interagency group is looking at care coordination models for children in foster care and those receiving behavioral/ substance abuse services
  - The goal is to ensure alignment of recommendations for HH for Children with Chronic Conditions
  - Medically Fragile Children are not currently the focus of this work, but HH could be a care management tool that could be developed for this population

Objectives and Recommendations of MFC Work Group

- Work Group legislatively established with 2012-13 Enacted Budget to make recommendations on :
  - Adequacy and Viability of Medicaid Rates
  - Transition of Pediatric Nursing Home to Managed Care
    - Ensure rates are equitable and sufficient to meet needs of MFC
    - DOH will consult with Mercer and Stakeholders to ensure development of actuarially sound rates
    - What Resources and policy issues need to be addressed to ensure smooth transition to Managed Care?
    - MRT Waiver - Managed Long Term Care Preparation Program under the MRT Waiver will address transition to Managed Care and NH Capital Rates
  - Approaches for Care Coordination Models

Objectives and Recommendations of MFC Work Group

- Legislation also authorized Commissioners of DOH and OPWDD to take steps to assist pediatric rehabilitation clinics during the time in which the Work Group is deliberating

- October 1, 2012 Report of Recommendations
  - Commissioners of DOH and OPWDD are required to prepare a report presenting findings and recommendations of DOH, OPWDD and the Work Group to the Governor, and Chairs of Fiscal and Health Legislative Committees by October 1, 2012

Proposed Work Group Schedule

Action	Date
First Work Group Meeting Review of Existing Programs, Data and Mission of Work Group	July 19, 2012
Second Work Group Meeting Further Discussion on Policy Issues	August 2, 2012
Third Work Group Meeting Discuss Initial Recommendations	August 16, 2012
Fourth Work Group Meeting Finalize Recommendations	August 30, 2012
Circulate First Draft Report to Work Group	September 6, 2012
Finalize Draft Report to Work Group	September 13, 2012
Circulate Final Draft Report to Outside Stakeholders	September 17, 2012
Receive Comments on Draft Report	September 24, 2012
Finalize Report and Submit Report to Governor and the Legislative Fiscal and Health Committees	October 1, 2012

Appendix

- Data Definitions and Notes
- Medically Fragile Children Work Group Statute

Data Definitions and Notes

- Definition of MFC Population:
  - Recipients had FFS billings only (does not include Managed Care or Medicare) in CY 2011
  - Based on DOH and OPWDD eMedNY Medicaid enrollment data from DOH and OPWDD
  - Recipients < 21 years of age as of 12/1/2011
  - CHHA and PDN MFC recipients were selected if PMPM spending > $10,000
  - OPWDD Comprehensive Waiver recipients based on Development Disabilities Profile Scores suggest medical frailty

- 2011 Spending Summary Tables (based upon recipient's classification):
  - Recipients were classified based on type of service/waiver status and all categories and spending is mutually exclusive by recipient ID and ordered according to the hierarchy shown. For example, recipient and corresponding spending in CAH Waiver I will not be counted in the PDN category
  - Medicaid spending for each category reflects all reimbursement paid for all Medicaid services provided to recipients during the calendar year
  - Recipient regions: NYC (5 boroughs) vs. ROS based on county of Medicaid fiscal responsibility.
  - Early Intervention (EI) spending was excluded from all categories.

MFC Work Group Statute
Chapter 56 Laws of 2012, Part D §34-b

34-b. Workgroup on medicaid payment for services for medically fragile children.

1. The commissioner of health and the commissioner of the office for people with developmental disabilities shall convene and co-chair, directly or through a designee or designees, a workgroup on Medicaid payment for services for medically fragile children (referred to in this section as the "workgroup") to make recommendations on the adequacy and viability of Medicaid payment rates to certain pediatric providers who provide critical services for medically fragile children including recommendations on appropriate models for care coordination and the transition of the pediatric nursing home population and benefit into Medicaid managed care, including home care agencies affiliated with pediatric nursing homes and diagnostic and treatment centers which primarily serve medically fragile children.

2. The workgroup shall be comprised of stakeholders of medically fragile children, including providers or representatives of pediatric nursing homes, home care agencies affiliated with such pediatric nursing homes and diagnostic and treatment centers which primarily serve medically fragile children (including pediatric rehabilitation diagnostic and treatment centers), representatives of families of medically fragile children, and other experts on Medicaid payment for services for medically fragile children.

MFC Work Group Statute
Chapter 56 Laws of 2012, Part D §34-b

34-b. Workgroup on medicaid payment for services for medically fragile children.

Members (other than representatives of families of medically fragile children) shall have demonstrated knowledge and experience in providing care to medically fragile children in pediatric nursing homes and diagnostic and treatment centers, including providers who provide care primarily to the Medicaid population, or expertise in Medicaid payment for such services. Members shall be permitted to participate in workgroup meetings by telephone or videoconference, and reasonable efforts shall be made to enhance opportunities for in-person participation in meetings by members who are representatives of families of medically fragile children.

3. The commissioners shall present the findings and recommendations of the department of health, the office for people with developmental disabilities and the workgroup to the governor, the chair of the senate finance committee, the chair of the assembly ways and means committee, the chair of the senate health committee and the chair of the assembly health committee by October 1, 2012 at which time the workgroup shall terminate its work and be relieved of all responsibilities and duties hereunder. During the timeframe in which the workgroup is deliberating, the commissioner of health shall take steps to assist pediatric rehabilitation clinics.