Medically Fragile Children Work Group

Statutory Scope of
Medically Fragile Children (MFC) Work Group

- Goals for Today:
  - Identify Issues , goals for which recommendations will be made
  - Work Group definition of MFC

- Work Group charged with making recommendations on MFC:
  - Adequacy and Viability of Medicaid Rates
    - Current NH rates, Case Mix
    - Out of State MFC in NHs
    - Educational Payments for MFC
  - Transition of Pediatric Nursing Home to Managed Care
    - Refined Timeline
    - What Resources and policy issues need to be addressed to ensure smooth transition to Managed Care?
  - Approaches for Care Coordination Models
    - Exploring Health Homes for MFC

Working Definitions of MFC Population

- Preliminary "Data" Definition (July 19 discussion)
  - Non-Duals Medicaid FFS enrollment data from DOH and OPWDD
  - Recipients less than 21 years of age as of 12.31.2011
  - CHHA PDN MFC if PMPM spending greater than $10,000

- Proposed definition (care coordination focus) relies upon existing definitions for children receiving certain services by or under:
  - Private duty nursing
  - Pediatric Nursing Homes
  - CAH and LTHHCP Waivers
  - Children's served by exempt acute care Children's hospitals
  - Other – children in a hospital or nursing home identified by physician who will need more than 60 days of additional services in above categories

- Can either or both definitions be refined with clinical /claims information
  - Diagnoses
  - Procedure Descriptions
  - CRGs
  - Combination?

Working Definitions of MFC Population

- With refined definition of MFC we can look at other data to help inform recommendations, including:
  - Refined Spending Trends by Program, Provider
  - MFC now in Managed care
  - Duals (only .02% of **all** children are duals)
  - Length of stay data
  - Data on third party insurance (41% of Data Definition have third party insurance)
  - Medicaid in Education/School Supportive Health Services Program (SSHSP) and Early Intervention (EI) Services for MFC
    - Issue: Medicaid Managed Care denying children rehabilitation services outside of educational setting if provided through Individualized Education Program (IEP)
    - MFC receive $6.2 million EI (2.6% total) $1.9 million SSHSP (4.5%)

Data Definition of MFC:
Historical Spending Trends Per Recipient, Per Year by Program

Calendar Year (by Service Date)	# Recip.	Spending Per Recip. 2009	# Recip.	Spending Per Recip. 2010	# Recip.	Spending Per Recip. 2011
Care at Home (I & II DOH) Waiver Svcs Only	554	$ 4,080	716	$ 4,097	835	$4,208
Care at Home (III, IV, &VI, OPWDD) Waiver Svcs Only	551	4,667	556	4,818	553	4,760
HCBS – OPWDD Comprehensive Waiver	458	28,086	511	25,545	497	23,092
Pediatric NHs	582	161,647	571	167,597	539	213,733
Children's Hospital	119	196,393	121	143,306	164	124,043
Specialty Hospital	32	305,212	31	357,874	25	328,653
Intermediate Care Facilities	95	164,511	110	155,499	80	175,549
Clinics	292	10,899	706	8,350	667	8,789
LTHHCP	1,303	21,697	1,185	23,196	976	21,307
CHHAs	2,374	4,410	2,425	4,188	2,448	5,150
Private Duty Nursing	1,056	90,144	1,144	94,429	1,184	95,201
Total	4,686	63,520	4,990	62,419	4,829	67,801

Time Line for Transition of Medically Fragile Children to Managed Care

Population/Benefit (see notes)	**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	no earlier than Nov 2015

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.

Note 1: As the Medicaid Managed Care (MMC) program is presently constructed, only non-dual children can move into MMC and they will be moving into mainstream MMC, not MLTC.

Note 2: CHHA services are already an “in-plan” benefit for MMC enrollees. It is covered FFS for all other persons (including waiver enrollees that have not voluntarily enrolled in a managed care plan).

Pediatric Nursing Home Costs and Rates Vary Significantly Across Providers

Pediatric Nursing Home	Beds	Base Year	Ped Unit w/in NH or Ped Facility	Current Operating Rate (1/1/12)	2010 Allowable Costs (Trended to 2012)	Rate Per Day Vs Costs Per Day
Sunshine	44	2010	Facility	$1,003.10	$988.19	14.91
Elizabeth Seton*	136	2005	Facility	907.86	927.59	(19.73)
Incarnation	21	1983	Facility	787.03	778.50	8.53
St Mary's Hospital****	95	1983	Facility	748.05	854.81	(106.76)
Northwoods **	36	1989	Unit	659.21	446.89	212.32
Highpointe	21	1985	Unit	487.58	497.04	(9.46)
Avalon Gardens	36	2008	Unit	519.43	549.92	(30.49)
St Margarets *	56	2000	Facility	490.36	522.17	(31.81)
Rutland***	32	2004	Unit	$489.83	$493.11	(3.28)

* Costs adjusted to include staff added after the base year and included in rate
** Rate reflects budgeted rate, not consistent current costs or utilization
*** Pediatric Rate is a proxy based on per diem add on applied to all residents
**** Pending Added Staff Appeals before the Department

Staffing Levels at Pediatric Nursing Homes

Pediatric Nursing Home	Beds	Stand Alone Unit or Additional NF Unit	Pediatric FTE's RN, LPN, and Aide	FTE per Bed
Sunshine	44	Stand Alone	59.41	1.3502
Elizabeth Seton	136	Stand Alone	184.19	1.3543
Incarnation	21	Stand Alone	30.49	1.4519
St Mary's Hospital	95	Stand Alone	187.41	1.9727
Northwoods	36	Not Stand Alone	30.77	.8547
Highpointe	21	Not Stand Alone	18.45	.8787
Avalon Gardens	36	Not Stand Alone	37.34	1.0372
St Margarets	56	Stand Alone	42.14	.7525
Rutland	32	Not Stand Alone	30.33	.9478

Measuring Case Mix, Patient Acuity for NH and Pediatric Patients

- Analyzing data on variation in Pediatric costs is difficult without a tool to measure case mix differences across providers

- Current reimbursement methodology for non-specialty nursing homes rely upon MDS 53 RUG Group Data to adjust prices for case mix

- While MDS are completed for all patients (including specialty and pediatric nursing home patients) specialty nursing home rates are not currently subject to case mix adjustments (effective 1.1.12)

- Historically pediatric rates have not been subject to case mix adjustments (added staff has been the vehicle to adjust rates for changes in case mix)
  - NYS weights to calculate case mix were created using a "non-specialty" geriatric population that is arguably not applicable to pediatric/specialty population
  - Portions of assessment process, such as Section B relating to hearing, speech and vision may not "make sense" or are difficult to appropriately apply to a pediatric patient
    - Applying MDS case mix to pediatric population may result in artificially low case mix
    - See attached data historical data - distribution of pediatric patients across RUGs

Other Approaches to Measuring Case Mix for Pediatric NH Population

- Clinical Risk Groups (CRGs) are a categorical Clinical Model which assigns each member of a population to a single Mutually exclusive Risk Category. Each CRG can be used as a basis for the prediction of health care cost and utilization.
  - Core data elements in the CRG: Demographic, Diagnosis Codes, Procedure Codes and Pharmacy Billings.

- Using CRG's on the current Pediatric SNF population is complicated by the changes in reimbursement for prescription drugs
  - Up until 7.7.11 Pharmacy (prescription drugs) was reimbursed through the NH per diem reimbursement rates
  - Effective 7.7.11 Prescription Drugs carved out of Rate and Price (1.1.12)

- CRG data from final claims submitted post 7.7.11 may prove to be an accurate means of predicting cost and measuring case mix

- Diagnoses and Procedures Data

Transitioning Pediatric NH Patients to Managed Care

- NH MFC population will transition to Managed Care
- How will patient acuity / case mix be reflected in managed care premium?
- How will capital costs, including "legacy" capital be reimbursed under managed care?
- Other Issues?
  - Department will begin discussions with Mercer and provide Work Group feed back

Out of State NH Serving Children Ages 0 through 20

- From July 2011 thru June 2012 two New Jersey nursing homes provided $15.9 million in services to 75 children
  - One provider in PA provided less than $1,500 of services to one child

- Services are predominately for severe neurological or behavioral impairment
  - High intensity service are required
  - Majority are ventilator patients

- Repatriation activities for children are progressing slowly due to:
  - Impairment is such that many caregivers cannot or will not care for children in the home despite CAH or other programs
  - Capacity issues : Currently there are 477 pediatric beds statewide, 79 are identified as Pediatric Ventilator Beds, 1 is currently available

Developing Health Homes (HH) for Children with Chronic Conditions

- Provides another avenue for Care Coordination
- Fiscal support through the Affordable Care Act (ACA) with 90 percent FMAP rate for the 8 fiscal quarters that a HH SPA in effect
- Primary goal : Comprehensively address the complex needs of Medicaid beneficiaries who qualify for Health Home services including:
  - Physical (primary care physicians & specialists)
  - Behavioral (mental illness & chemical dependency)
  - Social (such as housing & entitlement programs)
- Beneficiary criteria –
  - at least two chronic conditions
  - one chronic condition and at risk for another (HIV/AIDS)
  - one serious and persistent mental health condition

Developing HH for Children with Chronic Conditions

Health Home Services per Federal Legislation and required for payment:

- 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, OASAS) has been developing preliminary recommendations
- An OMH interagency group is looking at care coordination models for children in foster care and those receiving behavioral/ substance abuse services
- A SPA is planned to support the developing recommendations.
- Medically Fragile Children are not excluded in the categories of children with chronic conditions.
- Validated risk assessment tools and evidence based quality metrics are being reviewed for this program.

Developing HH for Children with Chronic Conditions

- Health Effectiveness Data and Information Set (HEDIS) Metrics used by Health Plans to Measure Performance:
  - HEDIS Use of Services: Acute care and emergency room, Mental health services (inpatient and outpatient)
  - HEDIS/NYS: Follow-up after hospitalization for MH or SA
  - HEDIS/NYS: Medication adherence
  - HEDIS/NYS: Management of chronic disease (DM)
  - HEDIS/NYS: Preventive care

MFC and Children's Health Homes

How do Medically Fragile Children fit into Children's Health Homes?

- The MFC population fits the clinical parameters of this model and could be a small segment within the model.
- MFC are already receiving care coordination services. Modeling for a CHH would have to consider integration of this care into the HH Care Coordination Model including who would provide Health Home services.
- Modeling would have to address whether current care coordination would transition to provide Health Home services or a separate care provider would coordinate overall care.
- HIT requirements would likely be a significant issue for care providers not traditionally linked with EHRs and HIE.

Next Steps for Work Group

- Finalize list of issues / goals for which to make recommendations
- Identify additional analysis, data needs to help refine issues to be addressed and goals
- Identify initial recommendations or approaches to consider, including issues to be addressed goals to be achieve
- Date for next meeting (see Work Group schedule on following slide)

Current 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 ??, 2012
Fourth Work Group Meeting Finalize Recommendations	August ??, 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

- Proposed Care Coordination Definition of MFC
- Medically Fragile Children Work Group Statute

Propose Definition of MFC ~ Care Coordination

(1) A child who is at risk of hospitalization or institutionalization, including but not limited to children who are technologically-dependent for life or health-sustaining functions, require complex medication regimen or medical interventions to maintain or to improve their health status or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk, but who are capable of being cared for at home if provided with appropriate home care services, including but not limited to case management services and continuous nursing services.

(Note-this is the home care provision from PHL §3614 (3-a))

(2) Children served at specialty nursing home facilities which provide extensive nursing, medical, psychological and counseling support services to children with diverse and complex medical, emotional and social problems.

(Note -this is the nursing home provision from 10 NYCRR 210)

(3) Children served at facilities designated as exempt acute care children's hospitals.

(Note-this is the definition from PHL §2807-c (4) (e-2) (iv))

Proposed Definition of MFC ~ Care Coordination

(4) Children covered by §1915 (c) care at home waivers or LTHHCP waivers.

(Note- does not include waiver for home and community based services (OPWDD comprehensive waiver). It was assumed those patients were waived by virtue of their developmental disability rather than their unusual medical needs.)

(5) Children currently hospitalized or in a nursing home and, in a physician's judgment, who in sixty days thereafter will likely either remain hospitalized, in nursing home, or will be receiving home care pursuant to (1) above.

(Note-this is a "catch-all" definition to include miscellaneous other situations.

In part, this seemed necessary to assure that patients can be classified as medically fragile before they are sent to specialized providers. The definitions in paragraphs 1, 2, 3 and 4 make it clear that the patient is considered medically fragile after they get to the specialized provider. However, since part of the anticipated ultimate purpose of the definition is to construct new rules for care coordination, it seems the definition should also include those types of patients even before a decision has been made whether to send the patient to a specialized provider. This definition would include children who are treated at conventional hospitals

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.