# Medically Fragile Children Work Group

September 20, 2012

# Agenda

- Review Possible Recommendations - Based upon feedback and discussions from the Work Group to date, DOH and OPWDD have developed possible recommendations for the Work Group members to consider for inclusion in the final report to the Governor and Legislature
  - Care Coordination
  - Transition to Managed Care
  - Medicaid FFS Rates for Pediatric Nursing Homes
  - Out-of-State MFC

- Follow up discussion on Definition of Medically Fragile Children (MFC)

- Next Steps – Schedule for Drafting and Submitting Final MFC Report

# Care Coordination

# Feedback from August 15th MFC Work Group on Health Homes for Children

- Managed care plans provide some care coordination but not a full range of individualized care planning across multiple sectors of the health care system and community
- MFC and their families need care coordination, but the types of services being coordinated may vary based upon the type of setting (community versus institution)
- Some MFC providers are providing care coordination but not receiving specific reimbursement for this type of service
- Care coordination currently provided under the Care at Home (CAH) waivers should remain in tact to continue serving MFC
- Some MFC providers may be interested in applying for the health home designation to provide care coordination to MFC not currently served in a waiver

  - Based upon this feedback the following recommendations reflect the conclusion that care coordination is essential for MFC and that CAH and Health Homes are effective options for providing care coordination to MFC

# Possible Recommendation #1:
# Care Coordination

**Possible Recommendation #1**: Allow CAH I/II children that are enrolled in Managed Care to retain their waiver services until such time as the waivers end and are transitioned to Managed Care. Beginning in 2016 the CAH I/II population would continue to receive care coordination as a waiver service, plus any services not covered in the MMC benefit package (e.g., respite, palliative care, and environmental and vehicle modifications). Include a contractual obligation for the Plan and Care Coordinator of waiver services to communicate and monitor care activities. All other services (e.g., Personal Care) would be covered by the MCO.

**Goals:**

- Ensures continuity of services that are essential to care coordination of MFC but are not part of the services required to be provided by Health Homes (e.g., respite, home adaptations, vehicle modifications, day habilitation, family education and training, personal emergency response systems, and home delivered meals)

# Possible Recommendation #2: Care Coordination

**Possible Recommendation #2** : Offer the Children's Health Home model now under development to provide care coordination for MFC not receiving care coordination under a waiver

**Goals:**

- Ensure MFC and their families are provided with critical care coordination benefits
  - Needed Benefits are consistent with those required by Health Homes
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care
  - Patient and family support
  - Referral to community and social supports
  - Use of health information technology to link services
- Utilize a care coordination model that has (and therefore recognizes) chronic condition criteria that coincides with MFC population
- Ensure the recommendations for Health Homes for Children are inclusive enough to include MFC and flexible enough to be expanded to include providers who serve MFC with frequent, special and complex needs

# Transition to Managed Care

# Possible Recommendation #3:
# Transition to Managed Care

**Possible Recommendation #3**: Establish an Advisory/Implementation Committee comprised of Plans to ensure smooth transition of MFC to Managed Care

**Goals:**

- Provide a forum to facilitate direct dialogue between providers, MFC/families, and the Plans to discuss:
  - Readiness – ensure comprehensive understanding of unique and complex care needs of MFC
  - Network capacity – network provides full range of services unique to MFC needs
  - Contract terms – tailored to reflect provisions specific to and appropriate for unique needs of MFC

# Possible Recommendation #4: Transition to Managed Care

**Possible Recommendation #4**: Establish Managed Care premiums that are all inclusive and provide sufficient resources to meet the complex needs of MFC

**Goals:**

- Managed Care benefits will be comprehensive and include a full range of services (hospital, clinic, nursing homes) to meet MFC needs
- Providers and Plans negotiate rates of payment, with DOH established rates as a guide
  - Plans will be accountable for ensuring adequate care network to meet needs of MFC
    - DOH will closely monitor network capacity
  - To preserve continuity of care, protections will be established for institutional patients
- Pay for quality

# Adequacy and Viability of Medicaid Payment Rates to Providers

# Pediatric NH Rates Are Not Consistent with Costs or Acuity

- Effective January 1, 2012, Pediatric NHs are paid their January 1, 2009 operating rate – this rate is based on a 1983 cost based methodology:
  - Methodology is not transparent
  - Rates vary significantly among providers
  - Rates are not informed by or adjusted for patient acuity
  - Costs vary significantly among providers
  - The base years used to calculate rates vary among providers and do not reflect current costs
  - The absence of a meaningful case mix tool makes it difficult to evaluate costs and ensure every pediatric patient is receiving consistent, cost effective, quality care
  - Budgeted rates and added staff appeals further complicate methodology
  - Rate methodology is not linked to quality

# Pediatric NHs with Largest Concentration of Higher Acuity Patients Have Higher Case Mix Proxy

| Percentage of Children that Fall within MDS RUGS Classifications in 2011 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Pediatric Nursing Home** | **Beds** | **Rehab w/ Extensive Services** | **Rehab w/ High Services** | **Rehab Medium or Low** | **Special Care** | **Clinically Complex** | **Impaired Function or Behav.** | **Physical** | **2011 Relative Case Mix Proxy (1)** |
| Elizabeth Seton | 136 | 54.84% | 5.30% | 34.37% | 3.11% | 2.38% | 0.00% | 0.00% | 1.59 |
| St. Mary's | 95 | 16.98 | 1.16 | 24.42 | 36.98 | 16.51 | 0.23 | 3.72 | 1.28 |
| St. Margaret's | 72* | 21.99 | 4.56 | 0.83 | 65.56 | 1.66 | 0.00 | 5.39 | 1.36 |
| Sunshine | 46** | 32.07 | 9.78 | 40.22 | 10.33 | 5.98 | 0.54 | 1.09 | 1.44 |
| Northwoods | 36 | 19.29 | 1.43 | 3.57 | 62.86 | 7.14 | 2.14 | 3.57 | 1.34 |
| Avalon Gardens | 36 | 25.88 | 1.76 | 26.47 | 34.12 | 5.88 | 0.00 | 5.88 | 1.27 |
| Rutland | 32 | 10.00 | 3.64 | 15.45 | 47.27 | 9.09 | 0.00 | 14.55 | 1.14 |
| Incarnation | 21 | 0.00 | 0.00 | 0.00 | 7.53 | 18.28 | 0.00 | 74.19 | 0.58 |
| Highpointe | 21 | 1.92 | 0.00 | 0.00 | 87.50 | 6.73 | 3.85 | 0.00 | 1.27 |

(1) Reflects 2011 MDS data and counts and geriatric SNF weights from 1993-1997 Federal Time Study

*St Margaret's bed size has been adjusted from 56 to 72 for the beds added 10/1/2010.
**Sunshine's bed size was to reflect the addition of beds in 2011

# 2011 Total Allowable Costs Per Bed Vary Significantly and Do Not Reflect Case Mix Proxy

| Pediatric Nursing Home (2011 Cost Report Data)*** | Beds | 2011 Allowable Direct Total Per Bed | 2011 Allowable Indirect Total Per Bed | 2011 Allowable Non-Comparable Per Bed | 2011 Total Allowable Cost Per Bed | 2011 Case Mix Proxy |
|---|---|---|---|---|---|---|
| Elizabeth Seton | 136 | $179,721 | $56,340 | $25,852 | **$261,913** | 1.59 |
| St. Mary's (2011 Cost Report) | 95 | 203,671 | 72,981 | 31,536 | **308,188** | 1.28 |
| (2012 Proposed Budget) | 95 | 293,402 | 144,775 | 39,838 | **478,015** | NA |
| St. Margaret's | 72* | 114,146 | 5,254 | 4,333 | **123,733** | 1.36 |
| Sunshine | 46** | 201,725 | 66,857 | 13,730 | **282,312** | 1.44 |
| Northwoods | 36 | 80,647 | 22,259 | 18,960 | **121,865** | 1.34 |
| Avalon Gardens | 36 | 109,684 | 47,939 | 15,753 | **173,376** | 1.27 |
| Rutland | 32 | 144,150 | 38,943 | 20,694 | **203,787** | 1.14 |
| Incarnation | 21 | 169,604 | 81,453 | 16,631 | **267,688** | 0.58 |

*St Margaret's bed size has been adjusted from 56 to 72 for the beds added 10/1/2010.
**Sunshine's bed size was to reflect the addition of beds in 2011
*** Complete cost report data for Highpointe under new ownership, effective 12/3/11 is not available

# Pediatric NH Rates and Costs Vary Significantly

| | | Rate | | Costs | | |
|---|---|---|---|---|---|---|
| **Pediatric Nursing Home** | **Beds** | **Base Year Used to Calculate Rate** | **1/1/09 Rate Effective 1/1/12** | **2011 Adjusted Allowable Costs Per Day** | **2011 Case Mix Proxy** | **Rate Vs. Adjusted Costs Per Day** |
| Elizabeth Seton (1) | 136 | 2005 | $908 | $827 | 1.59 | $81 |
| St. Mary's (2011 Cost Report) | 95 | 1983 | 748 | 836 | 1.28 | (61) |
| (2012 Proposed Budget) | 95 | 1983 | 748 | 1,296 | NA | (548) |
| St. Margaret's (2) | 72 | 2000 | 490 | 572 | 1.36 | (82) |
| Sunshine (3) | 46 | 2010 | 1,003 | 778 | 1.44 | 225 |
| Northwoods (4) | 36 | 1989 | 659 | 353 | 1.34 | 306 |
| Avalon Gardens | 36 | 2008 | 519 | 501 | 1.27 | 18 |
| Rutland (5) | 32 | 2004 | 490 | 620 | 1.14 | (130) |
| Incarnation | 21 | 1983 | 787 | 735 | 0.58 | 52 |
| Highpointe (6) | 21 | 1985 | 488 | - | 1.27 | - |

(1) Allowable Costs adjusted to reflect added staff included in the 1/1/12 rate

(2) Allowable Costs have been adjusted to reflect staff included in the 1/1/12 rate, days have been adjusted to reflect 90% occupancy, and bed size adjusted from 56 to 72 beds (10/01/10)

(3) Bed Size has been adjusted to reflect the addition of beds in June and November of 2011

(4) 1/1/12 Rate reflects budgeted rate – rate will be adjusted to reflect 2011 allowable costs

(5) 1/1/12 Rate reflects pediatric rate this is blended with SNF rate, days have been adjusted to reflect 90% occupancy

(6) 1/1/12 Rate reflects prior owner rate until such time as DOH receives a budget to establish a rate

# Possible Recommendation #5:
# Adequacy and Viability of Medicaid Rates

**Possible Recommendation #5**: Work with pediatric Nursing Homes to develop a pricing methodology that will provide a rational benchmark rate for the Transition to Managed Care

Goals:

- Provide a transparent, rational benchmark to transition to Managed Care by developing a pricing methodology for the operating component of pediatric nursing home rates
  - Initially move all providers to a rate that is based upon 2011 costs with DOH/provider review of costs
  - Establish a patient acuity tool and wage equalization factor to adjust the price
  - Incorporate quality payments into pricing methodology
  - Include multi-year transition to the price (reallocate resources from trend adjustment to smooth transition – global cap neutral )

NOTE: MRT Waiver protects legacy capital and significant investments in pediatric nursing homes by proposing to CMS the capital component of the rate be carved out of Managed Care Premiums

## Possible Recommendation #6: Adequacy and Viability of Medicaid Rates

**Possible Recommendation #6**: Work with Nursing Homes to establish new vent bed capacity aimed at repatriating MFC patients from out-of-state

**Goals:**

- Improve access to critical services to avoid out-of-state placements of MFC
  - Create the opportunity to bring MFC closer to their families
- Improve clinical relationships between New York State nursing home and the MFC's primary care physician
- Create job and business opportunities for New York State nursing home operators

# Defining the Medically Fragile Child Population

# Follow Up Discussion
# Definition of A Medically Fragile Child

**Based upon Feedback from the Work Group  the Definition of a MFC should:**

- Comprehensively define MFC by condition (diagnoses) as well as type of service received (e.g., pediatric nursing home, CAH, Children's Clinic or Children's Hospital)
- Be able to be applied to the Medicaid Claims database to help monitor adequacy of  care and costs

Proposed Definition:

A Medically Fragile Child is a child who is under 21 years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and is:

- technologically-dependent for life or health-sustaining functions, and/or
- requires a complex medication regimen or medical interventions to maintain or to improve their health status, and/or
- is 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.

NOTE: Chronic debilitating medical conditions include, but are not limited to: bronchopulmonary dysplasia, cerebral palsy, congenital heart disease, cystic fibrosis, microcephaly, muscular dystrophy, and multiple congenital

# Applying Proposed MFC Definition to FFS Claims Data

- Data includes non-dual MFC FFS Children
- 12 FFS Groups (Programs/Providers) – MFC Children and their total spending in all categories are counted once based on hierarchy presented in following table
- All CAH children are included in MFC definition
- All other MFC Children must have one of 96 Diagnoses
  - Children in the CHHA, PDN or other Children FFS have one of the 96 Diagnoses AND their Per Member Per Month (PMPM) is $10,000 or higher

# 55% of MFC Children are Already Enrolled in Managed Care

| (As of 12/31/11) | # Medicaid Children Under 21 | % Share All Children Under 21 | # Children that Meet MFC Proposed Definition | % Share of MFC Children | 2011 Medicaid Spending MFC Children (millions $) |
|---|---|---|---|---|---|
| Fee-for-Service | 334,749 | 15% | **5,855** | 45% | $777 |
| Managed Care | 1,900,618 | 85% | **7,013** | 55% | $131 |
| Total | 2,235,367 | 100% | **12,868** | 100% | $908 |

0.6% of All Children Meet the Proposed MFC Definition

# MFC Receive Care through A Variety of Programs
## FFS Children and Non Duals

| Total 2011 MFC FFS Spending Applying Proposed MFC Definition | | | |
|---|---|---|---|
| **Programs** | **Number of Providers[1)]** | **Number of MFC Children[2)]** | **Total Medicaid Spending for MFC (in millions)** |
| Care at Home (I & II DOH) | 15 | 899 | $73.9 |
| Care at Home (III, IV & VI, OPWDD) | 19 | 559 | $28.8 |
| Home and Community Based Services (MFC) | 27 | 406 | $39.5 |
| Pediatric Nursing Homes | 9 | 507 | $142.3 |
| Pediatric Hospital | 1 | 182 | $44.4 |
| Specialty Hospital | 1 | 21 | $7.3 |
| Intermediate Care Facilities | 18 | 57 | $13.4 |
| Children Clinics | 2 | 395 | $20.0 |
| LTHHCP (MFC) | 10 | 582 | $32.7 |
| CHHAs[3)] (MFC) | 100 | 851 | $155.7 |
| Private Duty Nursing[3)] (MFC) | 70 | 44 | $7.4 |
| Other MFC[3)] Children | **N/A** | 1,352 | $211 |
| **Total** | **N/A** | **5,855** | **$776.5** |

1) Number of providers who served the MFC children in CY 2011.
2) Children are counted mutually exclusively based on the hierarchy.
3) Children with MFC DX and $10,000 PMPM or higher.

# Total FFS Medicaid Spending by MFC Group

| 2011 MFC Spending by Group and County of Residence Applying Proposed MFC Definition | | | |
|---|---|---|---|
| **Programs** | **NYC Total Medicaid Spending for MFC** | **Rest of State Total Medicaid Spending for MFC** | **Statewide Total Medicaid Spending for MFC** |
| Care at Home (I & II DOH) | $25.0 | $48.9 | $73.9 |
| Care at Home (III, IV & VI, OPWDD) | $3.9 | $24.9 | $28.8 |
| Home and Community Based Services (MFC) | $11.2 | $28.3 | $39.5 |
| Pediatric Nursing Homes | $104.5 | $37.8 | $142.3 |
| Pediatric Hospital | $33.0 | $11.5 | $44.4 |
| Specialty Hospital | $7.1 | $0.2 | $7.3 |
| Intermediate Care Facilities | $7.4 | $6.0 | $13.4 |
| Children Clinics | $6.3 | $13.7 | $20.0 |
| LTHHCP (MFC) | $29.7 | $3.0 | $32.7 |
| CHHAs[1)] (MFC) | $103.8 | $51.9 | $155.7 |
| Private Duty Nursing[1)] (MFC) | $2.5 | $4.9 | $7.4 |
| Other MFC[1)] Children | $122 | $89 | $211 |
| **Total** | **$456.2** | **$320.3** | **$776.5** |

1) Children with MFC DX and $10,000 PMPM or higher.

# MFC Receive Care through A Variety of Programs
# Calendar Year 2011

| Per Person Per Year (PPPY) by County of Residence Applying MFC Definition | | | | | |
|---|---|---|---|---|---|
| **Programs** | **NYC MFC** | **NYC Medicaid Spending for MFC PPPY** | **Rest of State MFC** | **Rest of State Medicaid Spending for MFC PPPY** | **Statewide Medicaid Spending for MFC PPPY** |
| Care at Home (I & II DOH) | 242 | $103,334 | 657 | $74,391 | $82,182 |
| Care at Home (III, IV & VI, OPWDD) | 62 | $63,579 | 497 | $50,109 | $51,603 |
| Home and Community Based Services (MFC) | 83 | $134,630 | 323 | $87,683 | $97,281 |
| Pediatric Nursing Homes | 346 | $302,066 | 161 | $234,679 | $280,667 |
| Pediatric Hospital | 127 | $259,726 | 55 | $208,305 | $244,187 |
| Specialty Hospital | 20 | $356,431 | 1 | $159,141 | $347,037 |
| Intermediate Care Facilities | 28 | $263,797 | 29 | $206,347 | $234,568 |
| Children Clinics | 110 | $57,422 | 285 | $48,028 | $50,644 |
| LTHHCP (MFC) | 510 | $58,156 | 72 | $41,807 | $56,133 |
| CHHAs[1)] (MFC) | 561 | $185,037 | 290 | $178,900 | $182,946 |
| Private Duty Nursing[1)] (MFC) | 15 | $168,086 | 29 | $169,373 | $168,934 |
| Other MFC[1)] Children | 784 | $155,344 | 568 | $157,192 | $156,121 |
| **Total** | **2,888** | **$157,975** | **2,967** | **$107,941** | **$132,620** |

1) Children with MFC DX and $10,000 PMPM or higher.

# Schedule of Next Steps

| Task | Due Date |
|---|---|
| Work Group members provide feedback on possible recommendations for Report | September 27 |
| DOH/OPWDD distribute draft report to Work Group Members for Review | October 4 |
| Work Group Members submit comments to DOH/OPWDD | October 9 |
| DOH/OPWDD distribute revised draft report to Work Group Members for Review | October 12 |
| Final Report Delivered to Governor and Legislative Chairs of Health and Fiscal Committees | October 15 |