Per-Patient Spending Limits for Certified Home Health Agencies (CHHA)

Effective date: 10/5/11

Pursuant to the authority vested in the Commissioner of Health by section 3614(12) of the Public Health Law and section 111(a) of Part H of Chapter 59 of the Laws of 2011, Subpart 86-1 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended, to be effective on and after April 1, 2011, upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subpart 86-1 of title 10 of NYCRR is amended and a new section 86-1.13-a is added, to read as follows:

86-1.13-a. Certified home health care agency ceilings

(a) Effective for services provided on and after April 1, 2011 through March 31, 2012, Medicaid payments for certified home health care agencies (agencies), except for such services provided to children under eighteen years of age, shall reflect ceiling limitations determined in accordance with this section. Ceilings for each agency shall be based on a blend of:

(1) the agency's 2009 average per patient Medicaid claim, weighted at 51 percent, and

(2) the 2009 statewide average per patient Medicaid claim for all agencies, as adjusted by the regional wage index factor and by each agency's patient case mix index, and weighted at 49 percent.

(b) Effective for rate periods on and after April 1, 2011, the Department shall determine, based on 2009 claims data, each agency's projected average per patient Medicaid claim for the period

April 1, 2011 through March 31, 2012, as compared to the applicable ceiling computed pursuant to subdivision (a) of this section. To the extent that each agency's projected average claim is in excess of such ceiling, the Department shall reduce such agency's payments for periods on and after April 1, 2011 by an amount reflecting the degree that such agency's projected average claim is in excess of such ceiling.

(c) The regional wage index factor (WIF) will be computed in accordance with the following and applied to the portion of the statewide average per patient Medicaid claim attributable to labor costs:

(1) Average wages will be determined for agency service occupations for each of the 10 labor market regions as defined by the New York State Department of Labor.

(2) The average wages in each region will be assigned relative weights in proportion to the Medicaid utilization for each of the agency service categories as reported in the most recently available agency cost report submissions.

(3) Based on the average wages as determined pursuant to paragraph (1) of this subdivision, as weighted pursuant to paragraph (2) of this subdivision, an index will be determined for each region, based on a comparison of the weighted average regional wages to the statewide average wages.

(4) The Department may adjust the regional WIFs proportionately, if necessary, to assure that the application of the WIFs is revenue-neutral on a statewide basis.

(d) Agency specific case mix indexes (CMIs) will be calculated for each agency and applied to the statewide average CMI. Computation of such CMIs shall utilize the episodic payment system grouper and shall reflect:

(1) 2009 adjusted agency Medicaid claims as grouped into 60 day episodes of patient care;

(2) data for each agency patient as derived from the federal Outcome Assessment Information Set (OASIS) and as reflecting the assignment of such patients to OASIS resource groups;

(3) the assignment of a relative weight to each OASIS resource group;

(4) the assignment of each agency's CMI index based on the sum of the weights for all of its grouped episodes of care divided by the number of episodes.

(e) Ceiling limitations determined pursuant to this section shall be subject to retroactive adjustment and reconciliation. In determining payment adjustments based on such reconciliation, adjusted agency ceilings shall be established. Such adjusted ceilings shall be based on a blend of: (i) an agency's 2009 average per patient Medicaid claim adjusted by the percentage of increase or decrease in such agency's patient case mix from the 2009 calendar year to the annual period April 1, 2011 through March 31, 2012, weighted at 51 percent, and; (ii), the 2009 statewide average per patient Medicaid claim adjusted by a regional wage index factor and the agency's patient case mix index for the annual period April 1, 2011 through March 31, 2012, weighted at 49 percent. Such adjusted agency ceiling shall be compared to actual Medicaid paid claims for the period April 1, 2011 through March 31, 2012. In those instances when an agency's actual average per patient Medicaid claim is determined to exceed the agency's adjusted ceiling, the amount of such excess shall be due from each such agency to the state and may be recouped by the Department in a lump sum amount or through reductions in the Medicaid payments due to the agency. In those instances where an interim payment or rate of payment adjustment was applied to an agency in accordance with paragraph (a) and such agency's actual average per

patient Medicaid claim is determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling shall be remitted to each such agency by the Department in a lump sum amount or through an increase in the Medicaid payments due to the agency.

(f) Projected payment adjustments computed pursuant to subdivision (b) of this section shall be based on Medicaid paid claims, as determined by the Department, for services provided by agencies in the base year 2009. Amounts due or owed from reconciling projected payment adjustments pursuant to subdivision (e) of this section shall be based on Medicaid paid claims, as determined by the Department, for services provided by agencies in 2009 and Medicaid paid claims, as determined by the Department, for services provided by agencies in the reconciliation period April 1, 2011 through March 31, 2012.

(g) The Department may require agencies to collect and submit any data deemed by the Department to be required to implement the provisions of this section.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The authorization for per-patient spending limits for Certified Home Health Agencies (CHHAs) pursuant to regulations is set forth in section 3614(12) of the Public Health Law.

Legislative Objectives:

The Legislature chose to address the issue of over-utilization of CHHA services as a result of the recommendations submitted by the Medicaid Redesign Team and endorsed by the Governor. Pursuant to statute, provider-specific limits on average spending per patient, for a period of one year, were chosen as the vehicle to address this issue.

Needs and Benefits:

The proposed amendment appropriately implements the provisions of Public Health Law Section 3614(12), which establishes average per-patient spending limits for providers. According to data provided by the New York State Department of Health Datamart (Office of Health Insurance Programs), total paid Medicaid claims for CHHAs in New York State increased from $760 million in 2003 to $1.349 billion in 2009. At the same time, total CHHA recipients decreased from 92,553 to 86,641. The result was an increase of 89.5% in spending per recipient, from $8,215 in 2003 to $15,570 in 2009.

This amendment will discourage over-utilization of CHHA services by providers with average per-patient spending that is significantly above the state average and will serve as a transition to the implementation of the Episodic Pricing System on April 1, 2012. The episodic

system is similar to Medicare's Prospective Payment System and bases reimbursement on 60-day episodes of care, adjusted for patient acuity.

Costs:

There are no additional administrative costs to the regulated parties for the implementation of and continuing compliance with this amendment.

There are no additional costs to the Department of Health, state government, or local governments for the implementation of and continuing compliance with this amendment.

Local Government Mandates:

The proposed amendment does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

There is no additional paperwork required of providers as a result of this amendment.

Duplication:

These regulations do not duplicate existing state or federal regulations.

Alternatives:

No significant alternatives are available. The Department is required by the Public Health Law section 3614(12) to promulgate implementing regulations.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

Section 86-1.13-a requires the Department of Health to adjust payments for CHHAs which had base year average per-patient claims in excess of the calculated limits for 2011-12. No action is required by the providers to achieve compliance with the rule.

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REGULATORY FLEXIBILITY ANALYSIS
FOR
SMALL BUSINESSES AND LOCAL GOVERNMENTS

Effect of Rule:

The proposed rule will apply to 139 Certified Home Health Agencies (CHHAs). Of this total, 69 have fewer than 100 full-time equivalent employees. Public CHHAs (operated by county health departments) account for 42 of the 69 small providers.

Compliance Requirements:

There are no reporting, recordkeeping or other affirmative acts that small businesses or local governments will need to undertake to comply with the proposed rule. A small business regulation guide is not required.

Professional Services:

No new or additional professional services are required in order to comply with the proposed amendment.

Compliance Costs:

There are no initial capital costs required to comply with the proposed rule, and there are no annual costs for continuing compliance.

Economic and Technological Feasibility:

As the proposed rule affects only the amounts reimbursed for existing services, compliance by small businesses and local governments is not expected to have any economic or

technological implications.

Minimizing Adverse Impact:

The proposed amendment reflects statutory intent and requirements.

Small Business and Local Government Participation:

The proposed rule resulted from the recommendations of the Governor's Medicaid Redesign Team. The recommendations process allowed for input from Medicaid industry stakeholders, including large and small providers, and the general public, through statewide hearings and website outreach.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Numbers of Rural Areas:

The proposed rule will apply to 139 Certified Home Health Agencies (CHHAs), of which 51 are located in counties with populations of less than 200,000. CHHAs are located in 40 of the 43 rural counties in the state. There are no agencies in townships which have population densities of 150 persons or fewer per square mile and are within counties with population above 200,000.

Reporting, Recordkeeping and Other Compliance Requirements; and Professional Services:

No new reporting, recordkeeping, or other compliance requirements are being imposed as a result of this proposal. No additional professional services will be required for compliance.

Costs:

There are no initial capital costs or additional annual costs which are required to comply with this proposal.

Minimizing Adverse Impact:

The proposed amendment reflects statutory intent and requirements.

Rural Area Participation:

The proposed rule resulted from the recommendations of the Governor's Medicaid Redesign Team. The recommendation process allowed for input from Medicaid stakeholders

from all areas of the state, including rural areas, through regional hearings and website outreach.

JOB IMPACT STATEMENT

Nature of Impact:

The proposed rule is required to implement the recommendations of the Governor's Medicaid Redesign Team for controlling rapid increases in Certified Home Health Agency (CHHA) utilization. Between 2003 and 2009, average annual Medicaid claims per recipient increased from $8,215 to $15,570 (89.5%).

By limiting per-patient spending for each provider, the proposal will incentivize CHHAs to increase operational efficiency and control excess utilization. To the extent that total hours of service are reduced, the limits could result in some staffing reductions. However, providers will have the opportunity to reduce non-labor costs in order to minimize any impact on staffing levels. By focusing on average spending per patient, the proposal also will allow CHHAs to meet targeted spending levels by balancing resources devoted to high-needs patients with resources allocated to lower-acuity clients.

In addition, a related Medicaid Redesign Team project will require the movement of significant numbers of fee-for-service CHHA patients into the Managed Long Term Care (MLTC) program. Consequently, potential staffing reductions by CHHAs may be counterbalanced by increases in the MLTC patient population.

Categories and Numbers Affected:

There are five categories of direct care workers at CHHAs: home health aides, nurses, physical therapists, occupational therapists and speech pathologists. Statewide, 84% of CHHA claims dollars are for home health aide services. In New York City, where this proposal's greatest impact is expected (see below), home health aides account for 89% of all CHHA claims

dollars.

Regions of Adverse Impact:

New York City providers are expected to account for approximately 96% of the total Medicaid cost savings achieved by this proposal.

Minimizing Adverse Impact:

As noted above, any staffing reductions which might occur at CHHAs may be offset by increases in MLTC or other types of providers. In addition, CHHAs will continue to receive funding through the Worker Recruitment and Retention program and the Recruitment, Training and Retention program, which allocated a combined total of approximately $72 million to CHHAs in calendar year 2010.

Self-Employment Opportunities:

Not applicable.

Assessment of Public Comment

Public comments were submitted to the NYS Department of Health (DOH) in response to this regulation. These comments and DOH's responses are summarized below.

1. COMMENT: Comments were received from the NYS Association of Health Care Providers, which argued that the Commissioner of Health should exercise the discretion available in the enabling statute to revise the proposed regulation to exempt "special needs" patients, in addition to the statutorily mandated exemption for children.

   RESPONSE: Since the aggregate savings amount is mandated in the statute any further discretionary exemption of discrete groups will increase the reductions imposed on those groups remaining subject to the ceilings. The Department has therefore concluded that it would not be appropriate to exempt additional groups of patients from these ceilings. In addition, the Department's analysis of Medicaid CHHA claims data does not support the conclusion that non-children special needs patients are more resource intensive than non-children CHHA patients generally.

2. COMMENT: Comments were received from St Mary's Healthcare System for Children, which argued that the commissioner of Health should exercise the discretion available in the enabling statute to revise the proposed regulation to exempt all patients of CHHAs who primarily serve children, including those patients of the CHHA who have "aged out" and are 18 years old or older.

RESPONSE: The statute does not permit DOH to exempt categories of CHHAs, only discrete categories of patients and such an exemption would have to apply to all such patients, regardless of the nature of the CHHA caring for them. As indicated in DOH's response to comment #1, the DOH believes that it is best to share the burden of these ceilings as widely as possible and limit exemptions to the statutorily mandated exemption for children under age 18.

3. COMMENT: Objections were raised concerning the use of 2009 base year data in computing the utilization ceilings.

RESPONSE: Use of 2009 base year data to compute these ceilings is required by the enabling statute.

4. COMMENT: Objections were raised concerning the "entire reconciliation process" and a suggestion was made to delay any implementation of this process.

RESPONSE: The reconciliation process is required by the enabling statute and the Department is legally obliged to implement it as written.

5. COMMENT: Objections were raised concerning the use of the federal "outcome and assessment information set" ("OASIS") in computing the CMI adjustments to the utilization ceilings for each agency. An assertion was made that OASIS does not accurately take into account patients with developmental disabilities.

RESPONSE: In applying risk adjustment to a population it is important to use the same measurement set for all individuals in the analysis. The OASIS data set is being employed because its use is mandated for all CHHAs by the federal government and it is thus the best available data that covers all patients across all CHHAs.