Home Care Work Group

November 10, 2009

Agenda

- Principles of Reimbursement
- Discuss Updated Model for 2008 OASIS and Claims Data
- Review Components of Episodic Pricing Model
  - Regions for Wage Index Factor
- Data Sharing
- Next Steps

Principles of Medicaid Reimbursement Reform

Medicaid Rates should:

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 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
9) Be consistent with Budget Constraints

Updating Episodic Model for 2008 OASIS and 2008 Claims Data

- Effective January 1, 2008 CMS Updated OASIS B
- The updates impact how case mix (HIPPS codes) are determined
- The number of Clinical Groups reduced from 4 to 3
  - Groups now also impacted by Therapy Visits and Early/Late Episode Designation
    - Early Episode (1st or 2nd 60 Day Episode)
    - Late Episode (3rd or Subsequent 60 Day Episode)
- The number of Functional Groups reduced from 5 to 3
  - Groups now also impacted by Therapy Visits and Early/Late Episode Designation
    - Early Episode (1st or 2nd 60 Day Episode)
    - Late Episode (3rd or Subsequent 60 Day Episode)

Updating Episodic Model for 2008 OASIS and 2008 Claims Data Underway

- The timing of an episode (i.e., early or late) impacts how case mix / HIPPS is determined
- Claims data was used to determine if an OASIS assessment is related to an early or late episode
- OASIS assessments with their Early/Late designation were used to determine HIPPS code
- HIPPS codes were matched with claims to determine costs by case mix and episode
- When assigning claims to an episode it was assumed:
  - A 60-day period constitutes an episode.
  - 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 gap in service.
  - A change in CHHA providers in the course of CHHA services does not reset the counter.
  - A look-back to January 2007 claims was applied
- Dollars related to claims from patients under 18 were excluded from the analysis that calculates base price and weights

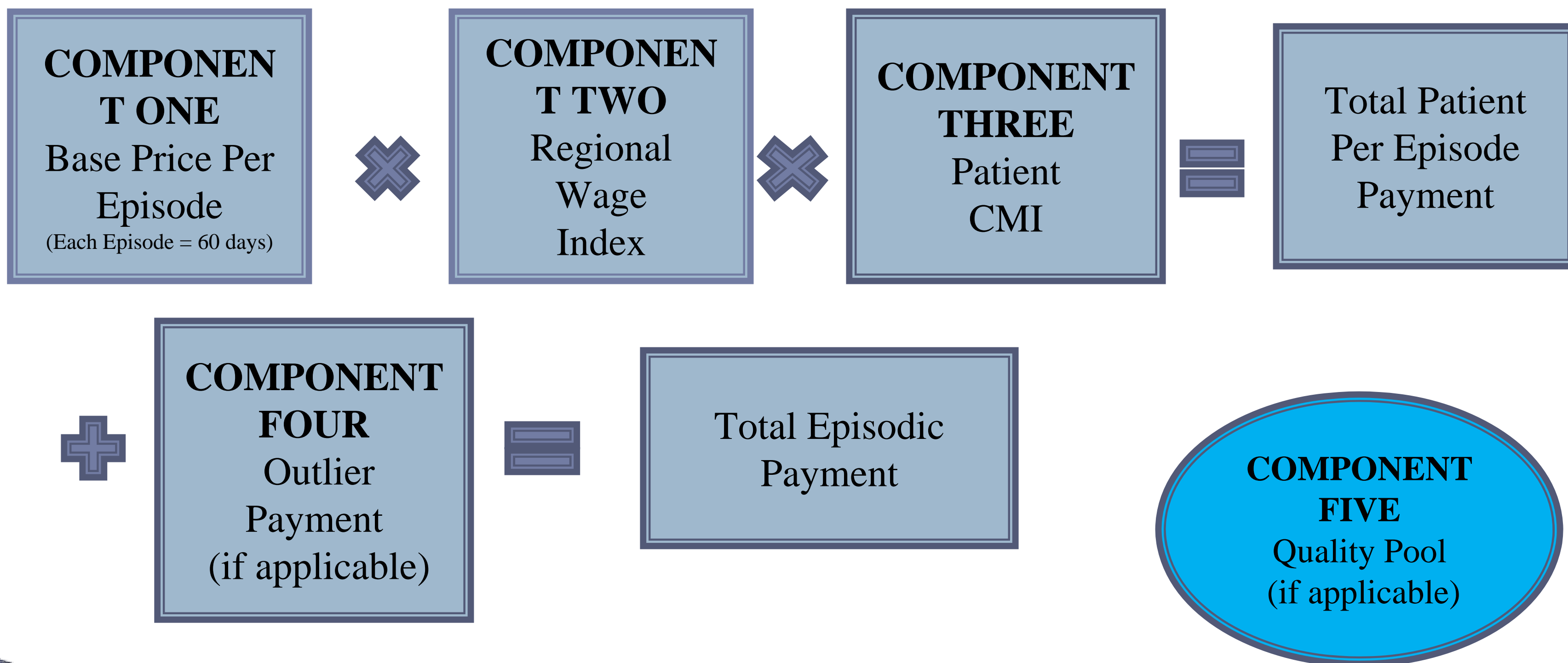
Statistical/Regression Analysis
Comparison of 2007 to 2008 OASIS Grouper

	Clinical Only + Dual Status	Functional Only + Dual Status	Full Model (Clinical +Functional +Dual Status)
2007 R-Square	.06	.14	.15
2008 R-Square	.04	.26	.26

- Analysis based on all episodes
- Regression model predicting total costs
- For 2008, the full model of clinical, functional and dual status explained 26% of the variation in total costs

Episodic Pricing Model Proposed in 2009-10 Budget

- A Statewide base price (for each 60-day episode of care) is multiplied by the provider regional Wage Index and the individual Patient CMI.
- This total episodic payment is adjusted by any applicable Outlier costs and provider Quality payments



COMPONENT ONE: Base Episodic Price

- 2008 Data Set:
  - Total 2008 Adjusted Claims: $1.13 billion
  - Total Patients: 71,659
  - Total Episodic Claims: 220,806
- Each episodic payment is for 60-day period
- Base price varies per episode based on 2008 claims excluding:
  - Outlier payments above threshold payments
  - Low utilization payments ($500 or less)
  - Claims from patients under 18 years of age

Episode	Base Price
1	$3,441
2	$5,045
3	$5,710
4	$6,135
5	$6,273
6+	$6,435

2008 base prices are higher compared to 2007 due primarily to a decrease in recipients and episodic claims per episode

COMPONENT TWO : Wage Index Factor

- Option 1 A – Uses Cost Report Data and same 3 Regions as current CHHA reimbursement ~ New York City, Other Downstate, Upstate
- Option 1 B – Uses Cost Report data and 8 NYPHRM Regions ~ NYC, Long Island, Northern Metropolitan, Northeastern, Western, Utica, Central, Rochester
- Methodology:
  - WIF based on average wages reported in 2007 certified CHHA cost reports ~ 85 % of costs affected by Wages
  - For each region, average wage was computed for two groups of employees: professional (nursing and therapy) and home health aides (HHA).
  - Regional average wage was divided by statewide average to arrive at regional index value
  - Weighted average wage was then computed for each region, based on proportion of professional and HHA employees in that region.

COMPONENT TWO:
WIF Using CBSA Regions and BLS Wage Data

- Uses 17 CBSA Regions ~ 4 Rural, 13 Urban
- 2008 Federal Bureau of Labor Statistics Occupational Employment Statistics Data for Wages that are Reported by the CBSA Regions and the Rural Regions from the following Occupational Categories:
  - Home Health Aide (HHA)
  - Registered Nurses (RN)
  - Occupational Therapists (OT)
  - Physical Therapists (PT)
  - Speech Therapists (ST)
- The occupational categories are weighted by Medicaid visits as reported in the 2008 cost report
  - HHA 77.28%
  - RN 20.30%
  - OT .47%
  - PT 1.75%
  - ST .20%

Pros and Cons of WIF Options

	Option 1A **2009-10 Proposed WIF - 3 Regions**	**Option 1 B** **NYPRHRM** **8 Regions**	**Option 2** **CBSA 17 Regions– BLS Data – Occupational Employment Survey**
PROS	Regions are used in current Fee For Service CHHA rates	Increases number of defined labor markets from 3 to 8	Increases number of defined labor markets from 8 to 17 Includes rural labor markets Uniform wage data Industry-wide Health Care Worker Data
CONS	Three regions may not accurately capture labor market variation Cost report FTE data may not be consistently reported	More labor markets but rural areas not specifically identified Cost report FTE data may not be consistently reported	Wages only, does not include cost of fringe benefits NYC WIF overstated due to inclusion of area outside NYC (i.e., NJ)

COMPONENT TWO: Base Price Episode 1 = $3,441 Adjusted for WIF (Labor = 85.35%)

CBSA Region	CBSA WIF	Episode 1 Base Price	NYPHRM Region	NYPHRM WIF	Episode 1 Base Price
Albany-Schenectady-Troy, NY	1.024727	$3,514	Northeastern	0.806147	$2,872
Glens Falls, NY	1.083210	$3,685			
Capital/No. NY Non Metro Area	1.000469	$3,442			
East Central NY Non Metro Area	1.006498	$3,460			
Binghamton, NY	1.082085	$3,682	Central	0.782360	$2,802
Elmira, NY	1.034501	$3,542			
Syracuse, NY	1.023131	$3,509			
Ithaca, NY	0.971704	$3,358			
Central NY Non Metro Rural Area	0.961371	$3,327			
Utica-Rome	1.146203	$3,870	Utica	0.808072	$2,877
Rochester	1.013840	$3,482	Rochester	0.798407	$2,849
Buffalo-Niagara Falls, NY	0.967799	$3,346	Western	0.859773	$3,029
Southwest NY Non-Metro (Rural)	0.994422	$3,425			
Poughkeepsie-Newburgh-Middletown	1.147664	$3,875	Northern Metro	0.975345	$3,369
Kingston, NY	0.953319	$3,304			
Nassau-Suffolk	1.046171	$3,577	Long Island	0.861598	$3,035
NYC – White Plains	0.992613	$3,419	NYC	1.037065	$3,550

*Boundaries for WIF Regions may not precisely align with boundaries for NYPHRM regions.

COMPONENT THREE:
Episode 1 Base Price Adjusted for Case Mix (Non-Duals)

Clinical Group	Functional Group	Case Mix	Adjusted Base Price
A	F	0.5451	$1,876
A	G	0.9416	$3,240
A	H	1.1797	$4,059
B	**F**	**0.5204**	**$1,791**
B	G	0.9826	$3,381
B	H	1.3405	$4,613
C	F	0.5648	$1,943
C	**G**	**0.8844**	**$3,043**
C	H	1.5026	$5,170

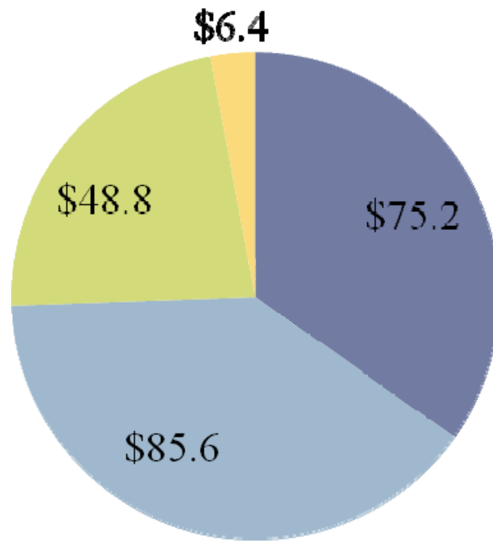
COMPONENT FOUR:
Outlier Payments ~ All Episodes

Outliers by Case Mix / Resource Group

Group	# Claims	$M Above Threshold
AF	4,547	$21.2
AG	6,282	$47.3
AH	1,492	$6.7
BF	5,189	$22.9
BG	6,815	$51.4
BH	2,347	$11.3
CF	2,761	$10.3
CG	3,290	$21.9
CH	2,842	$16.6
N/A *	1,214	$6.4
TOTAL:	36,779	$216.0

*Claims for which there is no matching OASIS data

COMPONENT FOUR:
Outlier Cases By Clinical Status



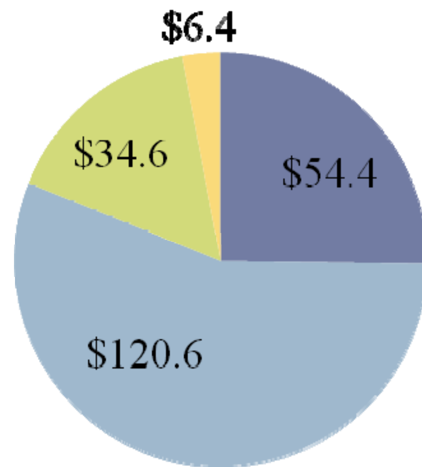
# of Claims

- A: 12,321
- B: 14,351
- C: 8,893
- NA: 1,214

Most outlier $/Cases are on the low to moderate end of the Clinical scale

COMPONENT FOUR:
Outlier Cases By Functional Status

Claims $M by Functional Status



Of Claims

- F: 12,497
- G: 16,387
- H: 6,681
- NA: 1,214

Most outlier $/Cases are on the low to moderate end of the Functional scale

COMPONENT FIVE: QUALITY

- Quality Performance Measures were selected based on:
  - Importance to patient well-being and efficient delivery of care
  - Validity and reliability
  - Information that is publically reported
  - Endorsement by IPRO and OASIS technical expert panel
  - Readily available and familiar to agencies' quality assurance programs
  - Ability to affect results within the agencies
  - Ability to assure comparisons to address like populations for two distinct provider types:
    - CHHA-Only
    - CHHA with a LTHHCP

- Quality Measures are nationally standardized risk-adjusted measures:
  - Improvement in medication management
  - Less pain
  - Improvement in transferring
  - Improvement in bathing
  - Remain in community after episode
  - Improvement in breathing

- Discussion on different measures dependent on "long stays" vs. "short stays"

Summary of Findings

- Updated 2008 model is robust ~ R Square is high
- Consider exploring potential refinements to case mix definition by using other elements of the OASIS data set to improve the fit of the model
  - Diagnoses
  - Living Arrangements
  - Incontinence
  - Neuro/Emotional status
  - Medication usage

Subcontracting/Transparency

- Consensus on Need for Increased Transparency
- Need for Additional Information?

Next Steps

- Make final decisions on regional groupings for WIF
- Explore other OASIS elements to refine case mix grouper
- Subcontracting/Transparency
- Report Due December 1, 2009
- Additional Meetings?