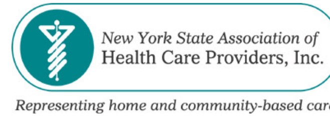


July 15, 2009

Hon. Richard F. Daines, MD
Commissioner of Health
NYS Department of Health
Corning Tower, 14th Floor
Empire State Plaza
Albany, New York 12237

Dear Commissioner Daines:

We are writing on behalf of the Home Care Association of New York State (HCA), the Healthcare Association of New York State, the New York State Association of Health Care Providers and the New York Association of Homes and Services for the Aging, collectively representing Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Licensed Home Care Services Agencies (LHCSAs), AIDS Home Care Programs (AHCPs), Managed Long Term Care Programs (MLTCPs), Hospices, Hospitals, Nursing Facilities and other health care services throughout the state.

As the Department begins to convene the Home Health Care Reimbursement Workgroup, we write to express our interest in collaboratively working with the Department and the Legislature to improve the state's home health care reimbursement methodology. Working together, on the right timetable and with openness to the essential issues (as subsequently enumerated in this letter), we are confident that progress and improvements can be made to the benefit of all New Yorkers, and we are committed to such a cooperative effort.

In fact, for the past several years, as associations, we have individually and/or collectively supported different pieces of legislation to improve the home care reimbursement methodology. We are pleased to have had the Legislature's support in the introduction of legislation that we have developed, advanced and/or advocated to address these issues.

At the same time, we continue to be very concerned with and will continue to oppose the imposition of a payment reform methodology which is not the result of thorough analysis, statistical modeling, piloting, transitioning and full vetting with providers, consumers and other stakeholders, and that fails to be responsive to certain basic goals, most importantly the stability of the home care agency safety net in providing accessible, high quality home care services. Our Associations are also committed to advocating the improvement of direct care staff compensation. We support reimbursement improvements toward this goal, and will continue to oppose categorical prohibitions or limitations on contracting such as the Department proposed during the budget process.

More broadly, any major changes to the home care payment methodology and/or the contracting arrangements underlying the delivery of home health aide services must be carefully considered not only for the direct effects they would have on home care itself, but also in the context of other state health policy initiatives. Major changes in the Medicaid reimbursement systems for acute care and nursing home care are in process, and assisted living program reimbursement is under discussion. Updates to the nursing home and CHHA need methodologies are under consideration, with a plan under development to take 6,000 nursing home beds out of service. Work is underway on a uniform assessment tool and assessment centers for long term care services. Individually or in combination, these initiatives could have a major effect on the delivery of home care services, and need to be considered along with impending federal changes in the development of home care payment and contracting policies.

The following further summarizes some of our threshold ideas and concerns relating to the workgroup's issues.

With respect to CHHA, LTHHCP and AHCP contracts with LHCSAs:

- We commend the Department's interests in supporting wages and benefits for contracted direct care personnel; we agree with this critical goal but not the Department's means. We oppose categorical prohibitions or percentage limitations on contracting which would cause irreparable upheaval in access, continuity of care, the workforce, the economy and agency operations and would offer no further efficiency and lead to increase costs. In addition, efforts to micromanage by regulation or statue the proportion of an agency's revenue allocated to direct care versus other cost centers, as was advanced by the Department, is similarly dysfunctional and unworkable. The Department should instead utilize the revised payment methodology to assist agencies to improve staff support. The payment methodology should properly accommodate real work force costs (including all direct and indirect expenses for recruiting, training, maintaining and appropriately compensating the home care workforce) and produce payment levels that adequately reimburse such costs and in turn allow for the necessary compensation of staff. We offer to work with you collaboratively to reach this goal.

With respect to payment reform:

- We commend the Department for attempting to improve the home care payment system, but believe that the discussion should not be limited to the Department's episodic rate proposal, and should examine other options and needs relating to improved payment. We are committed to working with you to advance meaningful payment reform that strengthens the home care system.

- We believe that payment reform should be centered on goals which relate to the support and improved functioning of the underlying system, and ultimately to the care of the patient. We urge the DOH workgroup to examine payment reforms that will result in improved: adequacy of payment; patient access; quality of care and performance incentives; recruitment and retention of personnel; provider financial stability; working capital for home care clinical and information technology infrastructure; cost-effectiveness; and other such elements essential to the operation and delivery of home care services in the state. The study should also determine the feasibility, methods and impact of providing for weighted reimbursement levels according to severity and complexity of patient needs and provider costs.

- We also believe that the workgroup should study whether the revised payment methodology should be limited in applicability to discrete populations or circumstances (e.g., post-acute, short-term cases), or provide for exclusions based on patient needs (e.g., infants and children, special needs

populations, or all patients with chronic illness/disability), agency characteristics (e.g., very small agencies, rural agencies, sole community providers) and/or other factors (e.g., high cost/high utilization outliers).

- Our Associations have had a long-standing policy position that assessment reform must come first, and that any broad-based payment reform would *follow* and be based on assessment reform (as in the implementation of a common assessment tool and data collected based on this tool). As the Department and the Legislature have already devoted significant state resources toward the development of a new assessment system, it is unclear how the assessment tool initiative would work in conjunction with a payment system constructed on an entirely different assessment tool. We believe that proposed payment reforms must be modeled based on the most appropriate assessment tool. The Department's existing reform proposal is modeled using the federal Medicare assessment tool called "OASIS," which is scheduled to change next year to OASIS-C. Our members are very concerned that neither OASIS nor its successor captures the needs of the Medicaid home care population. This is another reason why assessment reform should take place first.

- We also believe strongly that payment reform must start with and be predicated upon the most recently submitted cost data, not claims/expenditure data as the Department has proposed. This data also must consist of current base year costs (not reduced to ceiling or A&G caps), appropriate trend factors, workforce funding adjustments and other necessary price considerations (e.g., new regulatory and corporate compliance costs), with appropriate base year updates that include failsafe provisions if the Department does not update the base year.

- Payments must be sensitive to regional wage differences. A wage index or other adjustment factor should be modeled using more than the three regions (upstate, NYC and downstate metropolitan) and should contain an adjustment factor for rural/travel/productivity/ patient density or other appropriate adjustment to account for these factors.

- Payment reform must not unfairly or inequitably treat different categories of agencies. In addition to regional wage differences, various factors appropriately influence cost differences among providers delivering services. Careful analysis must be undertaken to identify and understand the appropriate cost differences based on geography, hospital and nursing home based agencies, and public agencies. Moreover, further review is needed of the impact on home health care from public policies affecting the acute care and nursing home systems.

- We are very concerned about the unintended consequences that may result from a payment system that creates financial disincentives to treat the highest cost outlier cases, as would be the result under the Department's budget proposal. The Department has acknowledged that a large portion of the out-year savings in the proposed payment system is due to the large savings attributed to the under-funding of home care provided to the most needy, high cost patients. This would be a highly regressive action to our state's policy, the Medicaid program itself, the quality of health and life of our citizens and the state's compliance with the US Supreme Court's *Olmstead* decision, as it would shift patients from home care toward institutionalization.

- Any reforms to the Medicaid home care payment methodology must consider the relationship between Medicaid and Medicare for dually eligible individuals. Currently for dual eligibles, Medicaid is necessary to meet patients' needs that are beyond Medicare coverage, and this role must be preserved. Additionally, the logistics of patient movement and associated billing between payors must be appropriately navigable.

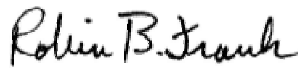
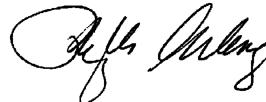
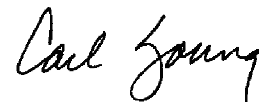
- With respect to implementation, payment reform should not be forced into an artificial or premature time frame; the system should be implemented *only* after it has been tested, the results and implications understood and aligned with the desired goals, and confirmed to be ready for operation at both the state and provider levels (including billing procedures, software, MMIS readiness, etc). Any change from the current system should include appropriate mechanisms for transition, including mechanisms which: mitigate rate shock/service dislocation; provide for payment system blending or phase-in as necessary; and consider other transition concepts (e.g., phase-in by region, provider size or group, or other).

- Payment reform must consider its effects on provider behavior, along with the potential for patient dislocation, and institute consequent changes to the wider system. Reform should seek to prevent or minimize such dislocation, and also institute parallel changes to ensure that appropriate options are accessible and viable – e.g., through the Long Term Home Health Care Program (through streamlined increases in agency capacity, reform of the patient expenditure cap and other access measures), Managed Long Term Care plans (through appropriate risk adjustment), and other means.

We support improvement of the payment system but believe it must be accomplished thoughtfully, carefully and methodically. We support change that provides for the stability of New York's home care providers and ensures their ability to deliver accessible, quality, consumer-oriented care. We very much look forward to working with you toward such progressive change.

We would be pleased to meet with you to further discuss our perspectives and to answer any questions you may have regarding the ideas and concerns conveyed in this letter.

Sincerely,

Joanne Cunningham, President, HCA	Robin Frank Vice President of Governmental Affairs and Continuing Care, HANYS	Phyllis Wang, President, HCP	Carl Young President, NYAHSA

cc: Honorable David A. Paterson, Governor
Members of the New York State Legislature
Members of the Home Care Reimbursement Workgroup
Mark Kissinger, Deputy Commissioner, Office of Long Term Care
Deborah Bachrach, Deputy Commissioner, Office of Health Insurance Programs