July 9, 2008

William Streck, MD, Chairman
New York State Public Health Council
c/o
Ms. Colleen Frost, Executive Secretary
New York State Public Health Council
Corning Tower, Room 1441 - Empire State Plaza
Albany, New York122397

Dear Dr. Streck:

On behalf of the Home Care Association of New York State, I am writing in regard to the State Health Department's report to the Public Health Council on Bad Debt/Charity Care (BD/CC) provided by Certified Home Health Agencies (CHHAs), which is being presented at the July 11, 2008 Council meeting. We respectfully offer and appreciate this opportunity to share our comments and recommendations with the Council.

The Home Care Association (HCA) represents over 400 mission-driven home care providers, allied organizations and individuals involved in home care in New York State, including the vast majority of the state's CHHAs. Our members totally support state and provider-based initiatives to ensure that all patients in need of home care services can access and benefit from these services. Our agencies are committed to serving the people and communities of New York State and continuously advocate for the federal, state and other resources necessary to meet the need for care.

With respect to the issue of CHHA BD/CC brought before the Council, we fundamentally believe that the existing process for determining and reporting CHHA BD/CC expenses and need requires significant reform, as does the BD/CC regulation itself. This process is inappropriately structured and is not achieving the intended policy or public health goals. Rather than evolving in a constructive manner, the process has instead been retroactively changed and narrowed. We also assert that, in addition to the reporting process, the existing charity requirement itself – a twenty-two year old regulation – needs complete reexamination given the changes in the health system since its adoption and the particular manner in which this requirement is applied to home care.

We agree with the Department's stated intention to explore changes in the system, enrollment, accounting, referrals, operating costs, the fixed percentage approach of the regulations and other factors which in the Department's own terms raise questions about whether "the 1986 standards have become obsolete." We also agree with the Department's intention to seek input from the provider community in identifying the answers to these questions.

However, we disagree that providers not apparently in compliance with the regulations based on the current problematic reporting process be simultaneously asked to file plans of correction prior to the suggested

state/industry analysis of the system and a determination of the continued merit, functionality and appropriateness of the requirement itself.

In this letter, we will review further aspects of CHHA BD/CC issue that are not addressed in the Department's paper or that raise additional concerns requiring comment.

Historical Development/Intent of the Regulation is at Odds with the Current System and Circumstances

The history of the CHHA BD/CC provision is rooted in the regulations that followed the enactment of Chapter 959 of 1984, the law which first permitted the certification of proprietary agencies. Prior to this law, only public and nonprofit entities could be certified as home health agencies in New York State. One of the major issues debated during and after the enactment of that law was the necessity to require equitable practices among agencies in their services to patients and communities. Particular concerns centered on the impact of the law's introduction of a "profit incentive" within the existing mission-driven public and nonprofit certified home health care agency system. The fact that existing public and nonprofit agencies willingly accepted costly and difficult-to-serve cases at the risk of financial loss led the Department to consider a number of requirements that sough to ensure similar practices among any incoming agencies in order to spread adverse risk. Among the ideas generated and implemented by the Department was the institution of the 2 and 3.3 percent minimum charity care loss requirements for nonpublic and public CHHAs, respectively. The Department also implemented other measures to avoid unfair shifting of risk, and severely restricted the entrance of new proprietary agencies into the system.

As the system evolved, and with the institution of these other requirements, the idea for spreading adverse risk and charitable service through the BD/CC provision has inadvertently turned from a mechanism aimed at protecting patient access and providers stability into a regulatory mandate for 2 and 3.3 percent losses through uncompensated visits.

These 2 and 3.3 percent losses are not only mandated as a condition of eligibility for modest BD/CC pool distributions, but are also mandated as a basic standard of CHHA certification. This in itself is inequitable with respect to the treatment of other sectors; for example, by hospitals, which while federally required to accept charitable cases, are not mandated to affirmatively "case-find" for the purpose of actively incurring uncompensated services. And even then, hospitals receive in excess of a billion dollars in combined aid for their BD/CC losses. Additionally, the minimum BD/CC level for a hospital is 0.5 percent, compared to the 2 and 3.3 percent levels for nonpublic and public CHHAs.

Changes in Departmental Procedure

Chapter 884 of 1990 required that the State Hospital Review and Planning Council adopt rules and regulations to establish uniform reporting and accounting principles designed to enable CHHAs to fairly and accurately determine and report the costs of BD/CC. The SHRPC adopted regulations 86-1.47(f) which required CHHAs to report this information in a supplement to the cost report. CHHAs complied with the SHRPC regulation using supplement form 519 to report BD/CC costs. On December 19, 2007, the Department issued a letter (DAL: HCBC 07-13, Mark Kissinger to CHHA Administrators) changing the reporting process from the use of the supplement to the cost report. The change in reporting was also applied retroactively and affects measurement of provider BD/CC performance both retroactively and prospectively because the cost report does not capture CHHAs' charity care costs to the same extent as the supplement. HCA objected on the grounds that the reporting process pursuant to statute is the jurisdiction of SHRPC and that the change was

unilaterally instituted outside the SHRPC and regulatory processes. HCA also expressed concern that the cost report as currently structured would not be inclusive of CHHAs' actual BD/CC services. HCA offered to work with the Department in establishing a reporting mechanism and standard that would more accurately capture CHHAs' charitable services. The Department chose not proceed in this fashion.

Furthermore, in 1995, the Department promulgated and posted to the Health Provider Network policy guidance in the form of Qs & As which described qualifying losses for BD/CC purposes, including qualifying losses resulting from shortfalls between provider costs and the Medicaid rates in existence for an agency. The guidance was used for over ten years. In another departure from appropriate procedure, the Department next abruptly rescinded this guidance in mid-2007, whereupon it applied different standards retroactively with respect to the measurement of CHHA BD/CC thresholds. HCA contended that such a retroactive shift in rules was inappropriate and led to a misrepresentation of agency BD/CC experience.

BD/CC Definition and Reporting Mechanism Does Not Reflect True Charitable Service

HCA contends that the definition of BD/CC care – uncompensated care provided to individuals not covered by Medicaid, Medicare or private insurance whose household income is less that 200 percent of the federal poverty level – is not an adequate measure of the true level of charitable services provided by CHHAs within their communities.

CHHAs provide extensive charitable outreach and services to the community which do not meet this definition but are nevertheless charitable in nature. Examples include: flu clinics, medications, transportation to medical appointments, needed home improvements such as bathroom railings and ramps, uncompensated support to the Nurse Family Partnership and Head Start programs, and others. CHHAs also absorb losses from services to growing proportions of managed care patients (which did not exist in the mid-80's when the BD/CC regulations were adopted) which are either wholly or partially denied coverage or reimbursement, and/or which are reimbursed substantially below cost. Providers statewide report significant losses in their managed care populations – none of which qualify under the state's current BD/CC definition nor would otherwise be captured under the current cost-reporting process for BD/CC losses. CHHAs also comply with Departmental regulations for the provision or continuation of services to significant numbers of Medicaid eligibles who, though excluded from the formal charity care definition, result in tremendous financial losses.

Changes in the Health System Over Time Necessitate that the BD/CC Requirement be Reexamined

This letter has already reviewed some of the changes in the system since the CHHA BD/CC requirements were developed and adopted twenty-two years ago, including the development and proliferation of managed care within the commercial and public coverage system.

Additional changes include the development of new forms of public coverage – Child Health Plus, Family Health Plus, Healthy New York and others – as well as an expansion of Medicaid to finance the care of individuals that twenty-two years ago would have been indigent care cases, and would likely have qualified under the BD/CC provision. In addition, private long term care coverage was essentially non-existent in 1986; even though market penetration has lagged behind public policy goals, people are covered today for home care who had no option for coverage when the regulations were adopted.

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Additional mechanisms for health coverage, such the Expanded In-Home Services for the Elderly Program for low-income non Medicaid-eligible patients, have also been created over the past twenty-two years, further affecting the referral of individuals who would meet the very narrow criteria of the existing regulations.

These represent further reasons why the BD/CC regulation should be revisited.

Concern Over Report Language

HCA is concerned over the report's use of the term "shortfall" in characterizing the difference between the minimum BD/CC percentiles and the actual agency losses as reported on the cost reports. The implication is that regardless of an agency's due diligence in its community service and charity care practices, fiscal losses that ultimately measure less than the mandatory amount are considered to constitute a "shortfall." This suggests a "case-finding" perspective that is also reflected in the report and that we contend was not contemplated in the initial establishment of the regulation. We also contend that this gives further evidence as to the need to reexamine the regulation itself.

Consider Senator Hannon's bill S.7809

In April, Senate Health Committee Kemp Hannon introduced legislation recommended by HCA to reform the BD/CC threshold and pool requirements for CHHAs. HCA believes that the ideas in this legislation would positively reform the system.

This legislation would update the requirements for charitable services by CHHAs consistent with those applicable to hospitals. Like hospitals, it would require CHHAs to develop and maintain community service plans, which would also be filed with the Health Department. (The community service plan requirement for hospitals, created pursuant to the 1990 amendments to the NYPHRM system, is more recent than the CHHA charity care regulations and reflects a broader approach to community service.) These CHHA community service plans would also incorporate public input and be periodically updated to reflect changing needs and priorities. These plans would not only be instituted as a basic CHHA requirement, but would also be a new requirement for CHHA in order to be eligible for BD/CC pool funding. CHHA BD/CC thresholds would also be set consistent with hospitals at 0.5 percent, rather than the current 2 or 3.3 percent levels. Thus, the current system which fails to encourage or recognize community service and outreach beyond a narrow definition, would be replaced by a broader community mission driven plan, a more effective state policy and a more equitable standard for minimum BD/CC losses.

HCA appreciates this opportunity to comment and would be pleased to answer further any questions or discuss our recommendations with the Council at any time. We respectfully ask the Council's consideration of our concerns and recommendations.

Thank you.

Sincerely,

Joanne Cunningham
President

cc: Members of the Public Health Council

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