2017 Budgeting Considerations

These slides provide annual budgeting guidance for LeadingAge NY members, specifically on Medicare and Medicaid funding issues. Although in Power Point format, each issue is described in narrative detail with links to helpful resources. Please contact me with questions:

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Budgeting Considerations: Contents

The Landscape

The Landscape

2016 Election Results

- Significant uncertainty (new players include Tom Price, HHS; Seema Verma, CMS)

- Based on published agendas, Congress is likely to seek partial repeal of the Affordable Care Act. Those areas most likely to be targeted include:
    - Medicaid expansion and subsidies to states
    - Individual and Employer Mandate
    - Health Insurance Exchanges

- Even if not specifically targeted, ACA initiatives subject to annual appropriation (e.g., Center for Medicare and Medicaid Innovation) may be impacted

- Initiatives less likely to be impacted include value-based purchasing provisions, ACOs and bundled payments, and hospital readmission penalties

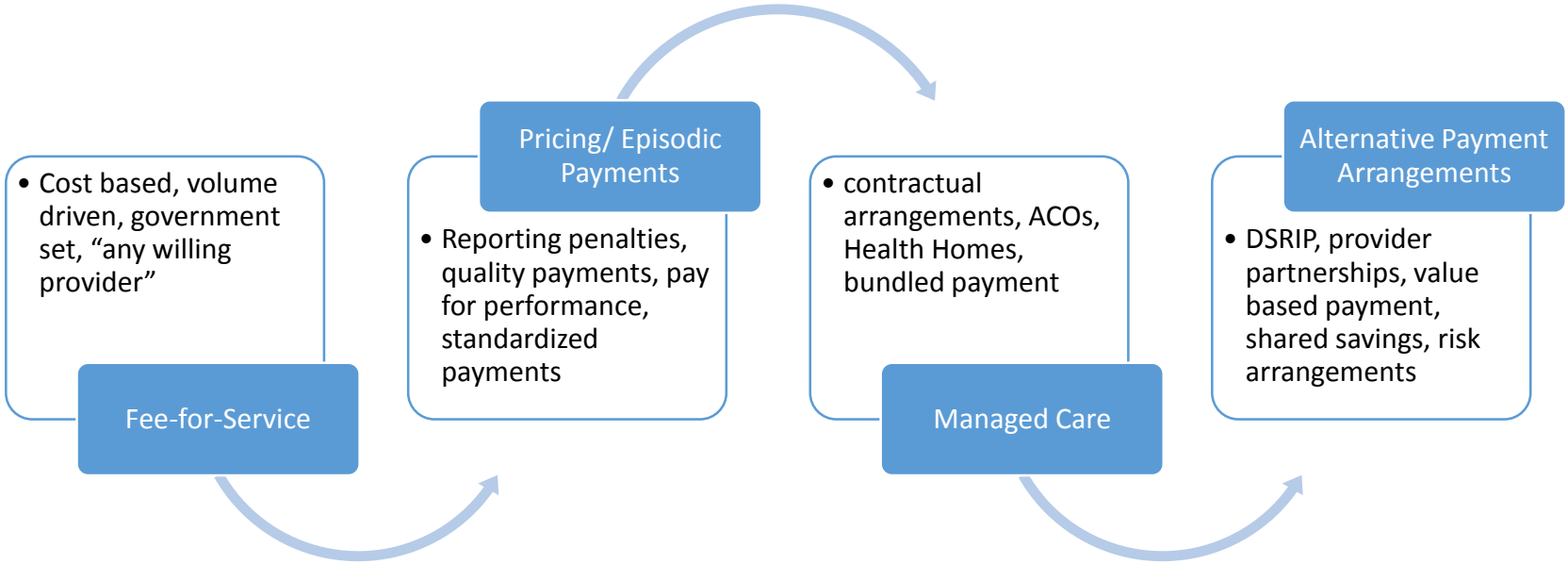
- Labor related regulations may be impacted

- Single party control of both Congress and the Presidency may facilitate quick change

A potential risk to New York is increased health costs if programs are retained while federal funding to the state decreases.

The Landscape

The trend from fee-for-service to value-based payments continues



Relationships	Payer Mix
Quality	FFS Rate
Data	Occupancy
Technology	CMI

The Landscape

Both NY State and CMS have explicit, ambitious VBP goals

NEW YORK STATE | Department of Health | Medicaid Redesign Team

A Path toward Value Based Payment: Annual Update

June 2016: Year 2

New York State Roadmap

for Medicaid Payment Reform

NY Medicaid VBP for MLTC/Long Term Care Population is the second phase, but its coming

…how the State will plan and implement its goal of 80-90% of managed care payments to providers using value based payment methodologies by end of demonstration year five (2019).

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm

CMS

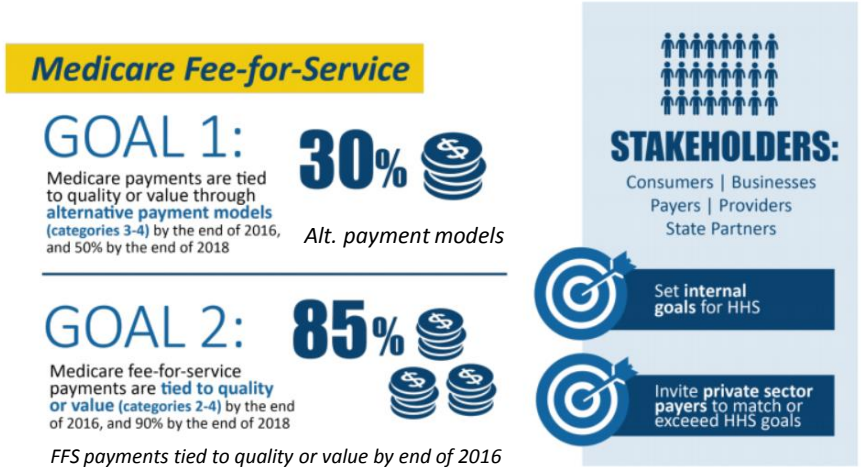
VBP- BPCI - CJR

Value-Based Purchasing

Bundled Payments for Care Improvement

Comprehensive Care for Joint Replacements

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **Alternative Payment Models in Medicare**



https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

The Landscape

Medicaid Global Cap Constrains State Medicaid Spending

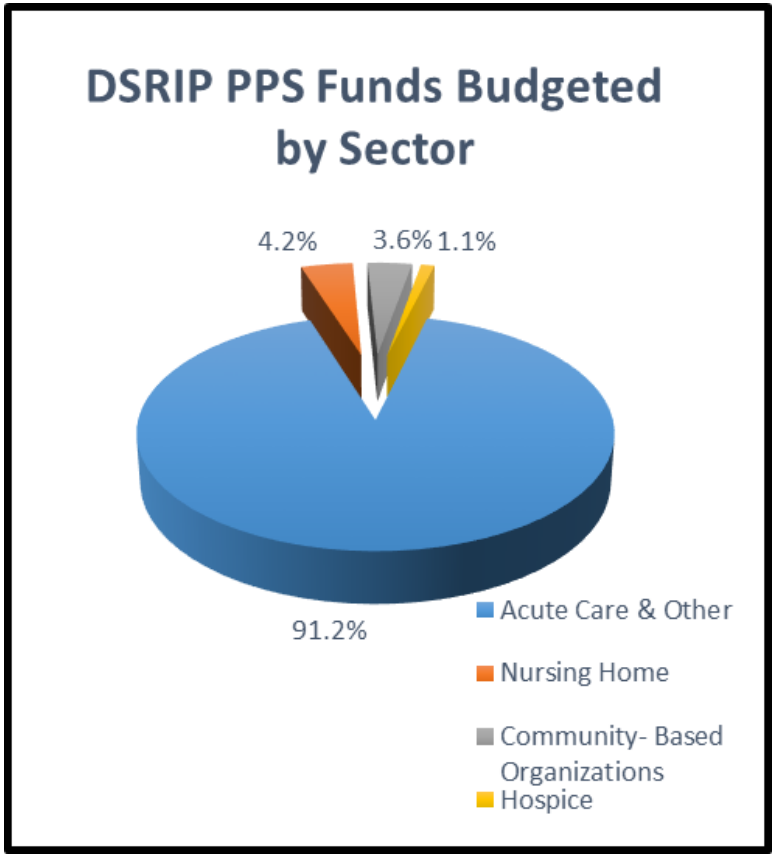
Medicaid Global Cap

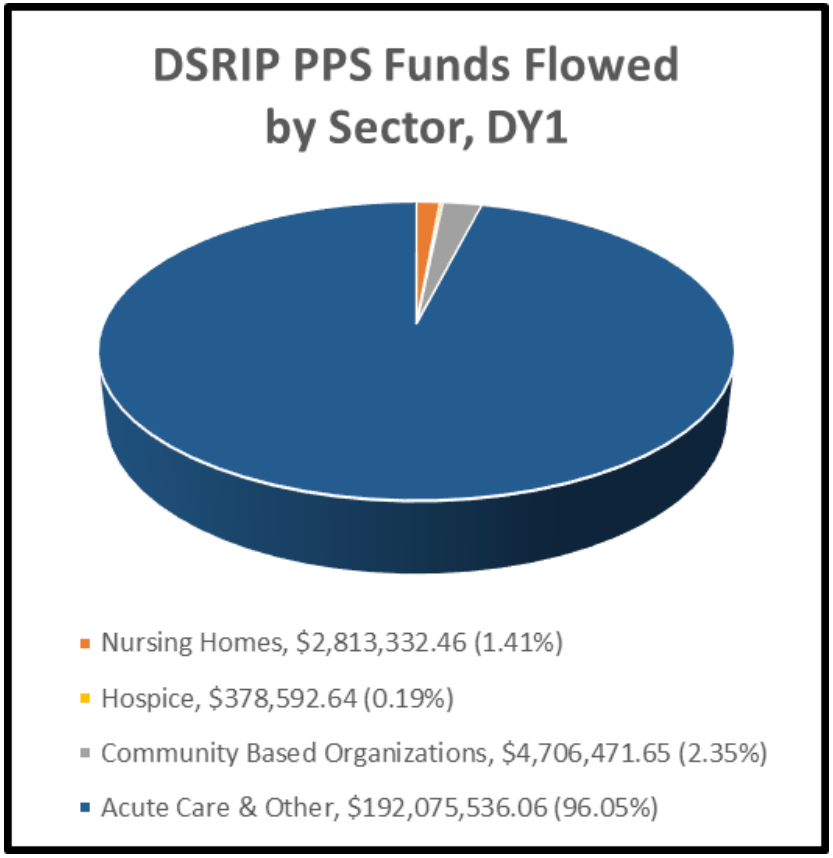
- Projects state Medicaid spending ($18.8 billion in SFY 2016-17)
- Monitors actual vs. projection monthly
- Grants "super-powers" to Commissioner of Health to reduce spending if Medicaid expenditures exceed projections
- Shared savings potential but not realized in any year yet

Medicaid Spending – FY 2016 (dollars in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$12,400**	**$12,466**	**$66**
Mainstream Managed Care	$8,760	$8,673	($87)
Long Term Managed Care	$3,640	$3,793	$153
Total Fee For Service	**$9,658**	**$9,689**	**$31**
Inpatient	$2,923	$3,014	$91
Outpatient/Emergency Room	$458	$491	$33
Clinic	$551	$570	$19
Nursing Homes	$3,469	$3,379	($90)
Other Long Term Care	$653	$676	$23
Non-Institutional	$1,604	$1,559	($45)
Medicaid Administration Costs	**$498**	**$504**	**$6**
OHIP Budget / State Operations	**$257**	**$271**	**$14**
Medicaid Audits	**($358)**	**($261)**	**$97**
All Other	**$2,502**	**$2,285**	**($217)**
Local Funding Offset	**($7,216)**	**($7,216)**	**$0**
TOTAL	$17,741	$17,738	($3)

The Landscape

DSRIP is providing very limited funding to LTC- not adequate for restructuring investments





Source: PPS First Quarter Report Budgets, Module 1.2; PPS Reports, DY1, Q4 Funds Flowed.

The Landscape

LTC Hot Topics

- **Quality and Value**
- **Managed Care, Alternative Payment Methods**
- **Higher Acuity**
- **Affiliations, Partnerships, Consolidation**
- **Risk (requires scale)**

- ***Scarce Resources***
- ***Early in the VBP Process for LTC***

Dates & Deadlines

- Medicare Cost Report (5 months after FY ends, <10% Medicare may apply for waiver)
- Medicaid Cost Report (July 15 in 2016, same likely going forward)
- Immunization Reports
- Executive Compensation Report (end of June or Medicaid Cost Report Due Date, whichever later)
- MDS Census Submission for CMI (April & October)
- Capital Component Review
- PBJ Submissions

Importance of Staffing, Contract Staff, Turnover schedules of Medicaid cost report!

Medicare Budgeting Considerations

Medicare Budgeting Considerations

SNF PPS Rule for FFY 2017

Part A Rate (Oct. 1, 2016-Sep. 30, 2017)

- 2.4 percent market basket increase
  - Reflects a .3 percentage point "productivity" adjustment
  - No forecasting error adjustment
  - 2015 projected was 0.2 percentage points higher than actual
  - $920 million higher than last year
- Wage Adjustment updates vary by region
- Link to LeadingAge NY memo with PPS rate lists
- Link to LeadingAge Template for Projecting Medicare Revenue

Note that resolution of Medicare Part B funding issues requires a one percent increase in Part A rates for FFY 2018 (i.e., Oct. 2017) for post-acute providers including long-term care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health and hospice providers in place of the market basket calculation.

Medicare Budgeting Considerations

Part B

- Medicare Physician Fee Schedule (MPFS) determines Medicare Part B rates paid to physicians and other practitioners, along with the ancillary rates paid to nursing homes and home care providers for ancillary services
- “Sustainable Growth Formula” repealed (no more “doc fix”)
- 0.5 percent annual increases through 2019
- “Merit-based Incentive Payment System” (MIPS) consolidates current practitioner quality programs (Physician Quality Reporting System (PQRS), Meaningful Use (MU), and Value Based Payment Modifier (VBM) programs)
- extended the current Medicare therapy caps exceptions process for another two years, through December 31, 2017

- Link to LeadingAge Medicare Part B Rate Calculator

Medicare Budgeting Considerations

2 percent sequestration cut continues on all Medicare payments

Medicare Budgeting Considerations

SNF Quality Reporting Program

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires implementation of a quality reporting program for SNFs (SNF-QRP)
- Starting FY 2018 (i.e. Oct. 2017), SNFs that do not satisfactorily report will have their market basket percentage updates reduced by two percentage points

Domain	Finalized Measures
Skin Integrity and Changes in Skin Integrity	Outcome Measure: Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678; Measure Steward: CMS)
Incidence of Major Falls	Outcome Measure: Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (NQF #0674; Measure Steward: CMS)
Functional Status, Cognitive Function, and Changes in Function and Cognitive Function	Process Measure: Percent of Patients or Residents With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF#2631) (Endorsed on July 23, 2015; Measure Steward: CMS)

Medicare Budgeting Considerations

Quality Reporting Program (QRP)

Four additional measures added in the 2017 SNF PPS Rule:

- Discharge to Community: This proposed measure assesses successful discharge to the community from a SNF setting, with successful discharge to the community including no unplanned re-hospitalizations and no death in the 31 days following discharge from the SNF. (2018)
- Medicare Spending per Beneficiary: The MSPB-PAC SNF measure holds SNF providers accountable for the Medicare payments within an "episode of care" (episode), which includes the period during which a patient is directly under the SNF's care, as well as a defined period after the end of the SNF treatment, which may be reflective of and influenced by the services furnished by the SNF. (2018)
- Potentially Preventable Readmission: The proposed measure assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries in the 30 days post-SNF discharge. (2018)
- Drug Regimen Review: This proposed measure assesses whether PAC providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified. (2020)

Medicare Budgeting Considerations

Quality Reporting Program (QRP)

- To establish the initial QRP measures, data will be collected for the October 1-December 31, 2016 timeframe and must be submitted by May 15, 2017. SNFs unable to provide QRP data to CMS can submit written requests for data submission exceptions or extensions within 90 days of "extraordinary circumstances" occurring that would prevent data submission. Beginning with FY 2018, SNFs that do not satisfactorily report required quality data to CMS under the SNF QRP will have their market basket percentage updates reduced by two percentage points.
- QRP background is available here.

Medicare Budgeting Considerations

Medicare SNF Value-Based Purchasing Program (SNF VBP)

Section 215 of the Protecting Access to Medicare Act of 2014 established a SNF Value-Based Purchasing (VBP) program beginning in FY 2019 (which starts 10/1/18). Under VBP, a two percent withhold will be made to SNF Part A payments that can be partially earned back based on a SNF's re-hospitalization rate and level of improvement.

- Two percent withhold of SNF Part A payments
- Partially earned back based on a SNF's re-hospitalization rate and level of improvement (50-70%)

Medicare Budgeting Considerations

SNF VBP Measures

- The 2016 final rule adopted the SNF 30-Day *All-Cause Readmission Measure*, (SNFRM) for use in the SNF VBP Program
- risk-standardized rate of all-cause, unplanned, hospital readmissions for SNF Medicare beneficiaries within 30 days of their prior proximal short-stay acute hospital discharge

- Legislation requires CMS to specify a more refined hospitalization measure as soon as practicable
- In the 2017 final rule CMS specifies a SNF 30-day *Potentially Preventable Readmission Measure* (SNFPPRM) as the refined measure

Medicare Budgeting Considerations

SNF Value-Based Purchasing Program (SNF VBP)

- The primary difference between the two measures is that the former focuses on all-cause unplanned readmissions, the proposed one focuses on readmissions that are potentially preventable. For readmissions during a SNF stay, "preventable" is defined as "avoidable with sufficient medical monitoring and appropriate treatment."
- Calculated using a full year's worth of data
- Claims-based so no additional reporting
- Risk adjusted
- Considers performance and improvement
- In the 2017 rule CMS details the scoring methodology:
  - 2015 claims as the baseline period for calculating performance standards for FFY 2019 SNF VBP
  - CY 2017 would be the measured performance period for FFY 2019 SNF VBP

Medicare Budgeting Considerations

Bundled Payments for Care Improvement Initiative (BPCI)

- Multiple phases and models
- LTC providers mostly in Models 2 and 3
- Participants by provider type:
  - Acute Care Hospitals (423)
  - Physician Group Practices (441)
  - Home Health Agencies (101)
  - Inpatient Rehabilitation Facilities (9)
  - Long-Term Care Hospitals (1)
  - Skilled Nursing Facilities (1071)
- Medicare continues to make fee-for-service (FFS) payments to providers and suppliers furnishing services to beneficiaries
- Actual expenditures are reconciled against a target price for an episode of care
- At the time of reconciliation, the total expenditures for all related services during a beneficiary's episode are compared against a bundled payment amount (the target price)
- If the total expenditures are below the bundled payment amount, then CMS shares those savings with the Awardee; if the total expenditures are above the bundled payment amount, then the Awardee pays a recoupment amount to CMS

Medicare Budgeting Considerations

Comprehensive Care for Joint Replacement (CJR)

This initiative requires nearly all hospitals in selected regions to accept Medicare bundled payments for hip and knee replacement surgeries (DRGs 469 and 470) beginning in April 2016.

In New York State, hospitals in Erie, Niagara, Dutchess, Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, and Westchester Counties are subject to the requirement.

Under the program, hospitals are responsible for the quality and costs of care for the entire episode – including almost all Part A and Part B services from the time of the surgery through 90 days after discharge. Hospitals, physicians, and post-acute care providers bill Medicare on a fee-for-services basis. Depending on the quality and total cost during the episode, the hospital would receive an additional payment or be required to repay Medicare for a portion of the episode costs. To succeed under this payment model, hospitals must collaborate with nursing homes, home health agencies, and other post-acute partners.

The nursing home 3 day stay requirement may be waived and hospital may share savings (or risk) with providers.

Complete information: https://innovation.cms.gov/initiatives/CJR

Medicare Budgeting Considerations

Payroll Based Journal (PBJ)

- CMS collecting nursing home staffing data through the new Payroll-Based Journal (PBJ) reporting system
- Nursing homes started collecting data in specified ways in July 2016
- Quarterly data due to CMS 45 days after end of quarter
- Provides CMS with refined staffing data for additional quality measures (staffing levels, turnover, tenure)
- CMS has indicated that they are not likely to use PBJ submitted data in 5-star ratings for at least a year

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html

Medicare Budgeting Considerations

Revised Nursing Home Conditions of Participation

- Published Oct. 4
- Phased in over several years
- Significant staff training may be needed to implement the new requirements successfully
- Care planning and discharge planning requirements
- Annual facility assessment
- Additional quality program requirements

Access the LeadingAge summary here:

www.leadingageny.org/providers/nursing-homes/survey-clinical-and-quality/leadingage-ny-counsel-issues-summary-of-nursing-home-regulations/

Medicare Budgeting Considerations

Medicare Premiums

70 percent of Medicare Part B covered individuals will see no increase in their Part B premium and will continue to pay an average of $109 per month in 2017. This is due to a hold harmless provision that is intended to prevent Part B premium hikes when Social Security benefits do not increase above a set threshold.

Beneficiaries not protected by the hold harmless provision will see their Part B premiums increase from $121.80 to $134.00 per month. Those facing the increase include beneficiaries who do not receive Social Security benefits, those who enroll in Part B for the first time in 2017, those who are directly billed for their Part B premium, those who are dually eligible for Medicaid and have their premium paid by state Medicaid agencies, and those who pay an income-related premium. Note that Part B premiums for individuals with annual incomes above $85,000 per year are higher than those listed above.

Medicare Budgeting Considerations

Medicare Deductibles and Coinsurance

- The Part B deductible for 2017 will be $183, up from $166 in 2016.
- Part A daily SNF coinsurance for days 21 through 100 will be $164.50, up from $161 in 2016.
- Part A hospital inpatient deductible will be $1,316, up from $1,288 in 2016.
- Daily hospital coinsurance for days 61 through 90 will increase by $7 to $329.

Additional information is available here.

Medicare Budgeting Considerations

MEDICARE TAKEWAYS

- SNF Medicare Part A rates up by 2.4 percent (Oct. 2016)
- Medicare Part B rates increased by .5 percent (Jan. 2017)
- Sequestration (i.e., 2 percent reduction of Medicare payment) scheduled to continue for next five years
- Be familiar with and ready for SNF QRP reporting to avoid penalties
- Be familiar with SNF VBP hospitalization measure (effective Oct. 2018 but measurement period in 2017)
- SNF Medicare Part A rates effective Oct. 2017 will have a 1 percent adjustment in lieu of the market basket adjustment

Medicaid Budgeting Considerations

Medicaid Budgeting Considerations

Projecting Your Medicaid Operating Rate

- 2016 represented the fifth year of the phase-in of the pricing methodology for nursing homes and the final year of constraint on gains and losses resulting from the new methodology. Impact of 2016 rates was limited to a ten percent increase or decrease when compared to a home's July 2011 rate with the CMI held constant. In 2017 the stop-loss/stop-gain provision will no longer apply.
- The operating component will increase by roughly $0.75 over 2016 due to the rate phase-in. No trend factor is expected.
- The largest potential driver of change to the operating rate is the case mix adjustment and the special population add-ons. The January 2017 rate will eventually be updated to reflect the case mix calculated based on the July 2016 MDS census roster.
- The LeadingAge NY Rate Template that can be downloaded from the LeadingAge NY Data page by clicking here allows you to project your home's rate by entering the Case Mix Index (CMI) you want to model along with the counts of residents that meet the special population add-on criteria.
- Operating rates for discrete specialty units are frozen at 2009 rates and remain unchanged

Medicaid Budgeting Considerations

NH Medicaid Rate Dynamics

- 2016 was year 5 of pricing phase-in (provided a 10% stop-loss/gain)
- 2017 rates => no more stop-loss/gain
- Direct price change from 2016 to 2017: +$0.51 (FS) / +$0.56 (HB and 300+)
- Indirect price 2016 to 2017: +$0.26 (FS) / +$0.29 (HB and 300+)
- 3 year MLTC NH benchmark rate clock started:
  - Feb. 2015 (NYC)
  - April 2015 (Nassau, Suffolk, Westchester)
  - July 2015 (ROS)
- Carve out of transportation cost from Medicaid rate is pending (retro to 4/1/16)
- *DOH now posts outstanding rate adjustment schedule here:*

www.health.ny.gov/facilities/medicaid_rate_inventory/

Medicaid Budgeting Considerations

Medicaid FFS Rates (and Benchmark Rates) are Predictable

STATEWIDE PRICES 2016 & 2017	300+ and HB		FS Under 300	
	YEAR 5 (2016)	YEAR 6 (2017)	YEAR 5 (2016)	YEAR 6 (2017)
	Medicaid Rate for Part B Eligible Patients	Medicaid Rate for Part B Eligible Patients	Medicaid Rate for Part B Eligible Patients	Medicaid Rate for Part B Eligible Patients
Statewide Direct Price	$123.35	$123.91	$113.25	$113.76
Statewide Indirect Price	$64.23	$64.52	$56.92	$57.18
Transition Adjustment	10% stop gain/loss	no stop gain/loss	10% stop gain/loss	no stop gain/loss

2017 Medicaid rate calculation for free-standing home with fewer than 300 beds

		2017	
		Medicaid Rate (Part B Ineligible)	Medicaid Rate for Part B Eligible Patients
1	Statewide Direct Price	115.37	113.76
2	WEF Adjustment	0.8098	0.8098
3	Facility Case Mix Adjustment	1.0358	1.0358
4	**WEF and Case Mix Adjusted Price**	**96.77**	**95.43**
5	Statewide Indirect Price	57.18	57.18
6	WEF Adjustment	0.9096	0.9096
7	**WEF Adjusted Indirect Price**	**52.01**	**52.01**
8	**Facility Specific Non Comp Price**	**10.00**	**10.00**
9	**Total Operating Component**	**161.70**	**160.36**
10	Dementia, Bariatric, and TBI per diem add-ons	2.56	2.56
11	Transition Adjustment	na	na
12	Quality Adjustment	pending	pending
13	Bed-hold Related Cut	-0.50	-0.50
	5% Case Mix Change Constraint (if applic.)	0	0
14	Capital Per Diem	30.00	30.00
15	**TOTAL RATE**	**188.28**	**186.93**

Benchmark rate= all this plus cash receipts assessment reimbursement amount

Link for Medicaid rate template to model CMI changes:
www.leadingageny.org/topics/data/templates/

Link for benchmark rate list:
www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/

Medicaid Issues Update

CMI Considerations

- Although DOH has not announced the census rosters dates that will be used in 2017 for CMI calculation purposes, we anticipate that it will be the last Wednesday in January and the last Wednesday in July.
- Homes whose Medicaid CMI changes by more than 5 percent when compared with their CMI six months prior, will have their CMI change capped at 5 percent when their rate is calculated. When OMIG completes MDS audits and DOH processes rate changes from any audit findings for that census roster submission cycle the cap will be removed.
- Homes should file an MDS with CMS for any resident that may be listed on their case mix census roster, even if not required by regulations. If DOH is unable to match a resident listed on the roster with an MDS in the CMS database, ANY resident on the roster without an MDS match is presumed to be Medicaid and defaults to the lowest RUG category.
- DOH clarified that all managed long term care residents, including those that integrate Medicaid and Medicare such as PACE, FIDA and MAP, are counted in the Medicaid CMI calculation

Medicaid Issues Update

Medicaid Rates: Add-on Criteria

The roster submission system should automatically identify residents who qualify based on their MDS data for BMI ($17), Dementia ($10) or TBI ($36) add-ons but it is worthwhile to validate that this is in fact occurring. Note that the add-ons are based on the criteria below.

BMI:

$17.00 per day trended from 2006 to the applicable rate year for each resident whose Body Mass Index (BMI), using the relevant MDS data, is greater than thirty-five (35).

(PHL §2808(2-b)(b)(ix). Residents with a BMI greater than 35 have been identified using the weight and height data from the relevant MDS data. The Department has

employed the formula used by the National Institute of Health to calculate a resident's BMI of (Weight-lbs/ (Height-inches {squared}))*703

Dementia:

•Qualifies under both the RUG-III impaired cognition and the behavioral problems categories

OR

•Has been diagnosed with Alzheimer's disease or dementia, and is classified in the

RUG-III reduced physical functions A, B, or C categories,

OR

•Is classified in the RUG-III behavioral problems A or B categories and has an

activities of daily living index score of ten or less. (PHL §2808(2-b)(b)(viii))

Medicaid Budgeting Considerations

Retroactive Adjustments Due

- Five areas of outstanding rate adjustments include:
  - 2013 through 2015 Nursing Home Quality Initiative payments
  - A one percent increase in the operating rate retroactive to 4/1/14 to reflect reinvestment of the .08 percent assessment that is scheduled to continue
  - July 2016 rate updated in November to reflect Jan 2016 CMI
  - The release of the CMI constraint on homes whose CMI changed by more than five percent
  - Reissuance of rates reflecting OMIG MDS audit findings for homes that had MDS audits

The tables on the following slides show the timing and status of CMI adjustments as well as older outstanding rate adjustments by rate period (through 2015).

Medicaid Issues Update

Pre-2016 Outstanding Rate Issues

Rate Effective Date	Outstanding Issue #1	Outstanding Issue #2	Outstanding Issue #3	Outstanding Issue #4	Outstanding Issue #5
1/1/2012					
7/1/2012		Reissuance of rates reflecting OMIG MDS audit findings*	Release of 5% CMI constraint for any period a home experienced an MDS audit**		
1/1/2013	2013 Quality Pool Adjustment				
4/1/2013				Release of 5% CMI Constraint	
7/1/2013					
1/1/2014	2014 Quality Pool Adjustment				1% rate increase (Re-investment of .8% assessment) Calc retroactive to 4/1/14; rate adjustment will appear in April 2015 rates and forward.
7/1/2014				Release of 5% CMI constraint for home not experiencing MDS audit	
1/1/2015	2015 Quality Pool Adjustment				
7/1/2015					

**** For homes that have OMIG MDS audit with findings for a given time period***

***** For homes that had an MDS audit related to the constrained time period, regardless of findings***

****** For homes with 5% constraint that did/do not have MDS audit for constrained period***

Medicaid Budgeting Considerations

2017 Medicaid Rate Timetable

- July 1, 2016 Medicaid rates reflecting a Case Mix Index (CMI) based on the January 2016 picture date have been approved, and associated rate adjustments retroactive to July 1st are scheduled to be made in Medicaid payment cycle 2047, which has a check date of Nov. 14th with a Nov. 30th release date. The associated rate sheets are not yet posted on the Health Commerce System (HCS), but DOH is working on doing so.
- DOH posted draft preliminary 2017 Nursing Home and ADHC rates on the Health Commerce Network in early November. This posting includes full 2017 Medicaid rate sheets and follows the posting of capital rate sheets in early October.
- The state is targeting to publish the final 2017 rates, which will include minimum wage adjustments and reflect capital based on attested capital calculations for those homes that submit corrections, in mid-January. DOH will not process a separate capital correction schedule as it has done in the past and will not accept any capital attestations after Dec. 2, 2016. We urge members that have identified errors to file the attestation as early as possible and ensure that it meets the criteria outlined in the DOH guidance.

Medicaid Budgeting Considerations

- **Case Mix Adjustment & Audits**
- Case mix related MDS audits performed by the Office of the Medicaid Inspector General (OMIG) for 2012 and 2013 rate periods have been finalized, and rate adjustments for homes with audit findings as well as the release of remaining CMI constraints for these time periods are being processed. We will publicize the Medicaid payment cycle that will contain these adjustments as soon as they are known.
- Work on 2014 audits continues, but DOH is exploring other options for CMI audits beginning with 2015 data and has scheduled a dedicated meeting to discuss potential options. We continue to stress to DOH that the lengthy delays in lifting CMI constraints result in large retroactive rate adjustments that have cash flow implications, cause administrative headaches for both homes and managed care plans, and put reimbursement at risk in those cases where plans are not making retroactive rate updates.
- DOH expressed concern that a number of homes did not upload their July census rosters during the October upload period and that homes have residents listed on submitted picture date census rosters who fail to match with an MDS in the CMS database. Historically, staff has reached out to homes in these situations to resolve problems and avoid defaulting residents to the lowest RUG category. However, this time, intensive process can cause delays in CMI calculations and rate updates. DOH is discussing strategies to alleviate this, which may include some type of penalty for failure to submit accurate and timely information.

Medicaid Budgeting Considerations

Other CMI Considerations

- Next census roster date ("picture date") is Wednesday, Jan. 25, 2017
- Five percent cap on CMI change continues
- **Homes should file an MDS with CMS for any resident that may be listed on their case mix census roster, even if not required by regulations**
- Managed long term care residents, including those in plans that integrate Medicaid and Medicare such as PACE, FIDA and MAP, are counted in the Medicaid CMI calculation
- Recent DOH suggestion to examine an alternative approach

Medicaid Budgeting Considerations

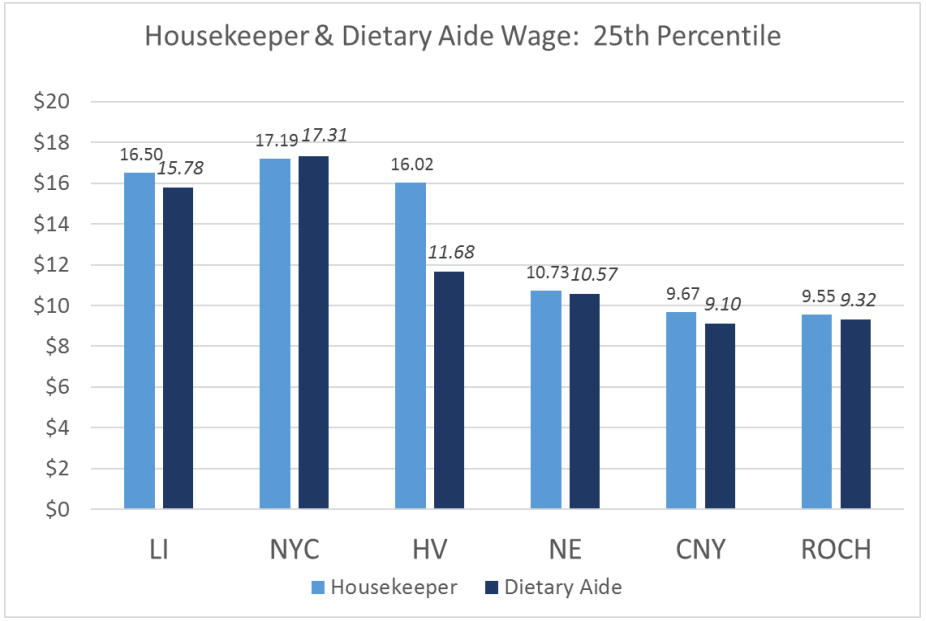
Minimum Wage Increase

- Phases in $15 minimum wage
- Roll-out varies by region
- Safety valve provision starting 2019
- The agreement includes funds intended to cover some of the costs of the increase for health care providers
- Allows DOH to adjust the Medicaid Global Cap to account for the impact of the minimum wage increases
- DOH working with associations to develop impact estimates
- Impact largest on home/personal care
- DOH will require additional cost reporting which will be basis of reimbursement adjustments For minimum wage

- Dec. 31, 2016:
  - $9.70 Upstate (then +$0.70 each yr.)
  - $10 LI/Westchester (then + $1 each yr.)
  - $11 NYC (then up $2 each yr.)

(fast food workers now $10.50 NYC / $9.75 ROS;

$12 / $10.75 on Dec 31, 2016)



Medicaid Budgeting Considerations

Universal Settlement

- Up to $850 million over a five-year period
- Roughly $350 million derived from the 0.8 percent cash receipts assessment
- Homes agree to drop nearly all pending lawsuits and rate appeals for rates in effect prior to Jan. 1, 2012
- State transfers money to trustees, trustees issue payments:
  - Distributions related to specific litigation sent to attorney of record for distribution to home
  - Other distributions sent directly to home
  - Disputed moneys held in escrow
- Outstanding Medicaid liabilities offsets:
  - Up to 70 percent of first distribution
  - Up to 100 percent of subsequent distributions
  - DOH will refund through the trustees any offsets for liabilities that have been paid
- Payment Schedule:
  - First payment (SFY 2015-16) made in March 2016
  - Second payment (SFY 2016-17) made in July 2016
  - Third payment (SFY 2017-18) to trustees by March 31, 2018
  - Fourth payment (SFY 2018-19) to trustees by March 31, 2019
  - Final payment (SFY 2019-20) to trustees by March 31, 2020

Medicaid Budgeting Considerations

Update to Federal Regulations Defining Executive/Admin/Professional Workers Exempt from Overtime

FEDERAL RULE UNDER INJUNCTION-

ON HOLD AS OF NOW

- ~~The effective date of the Final Rule is December 1, 2016~~
- ~~The initial increases to the standard salary level from $455 to $913 per week ($913 per week is equivalent to $47,476 per year for a full-year worker)~~
- ~~Future automatic updates to those thresholds will occur every three years, beginning on January 1, 2020~~

HOWEVER Note that New York State has pending regulations that will update the state exemption levels effective Jan 1, 2017. If the federal rule is implemented, the state regulations have no impact. If the federal rule is not implemented and the state regulations are adopted, the following weekly salary levels will define individuals exempt from overtime in New York:

New York City: $825

Long Island & Westchester County: $750

Rest of State: $727.50

Medicaid Budgeting Considerations

Two-percent Cut Restoration

- **The cash receipts assessment continues at 6.8 percent (6 percent reimbursable 0.8 percent not reimbursable)**
- **DOH intends to supplement Medicaid rates by one percent retroactive to 4/1/14 to reinvest funds collected by the 0.8 percent assessment**

In 2011, the State enacted a 0.8 percent increase in the cash receipts assessment on nursing homes in lieu of the two percent across-the-board cut imposed on most other Medicaid providers. While the two percent cut has expired, the 0.8 percent nursing home assessment continues. DOH has indicated that proceeds of the .8 percent assessment will be reinvested in nursing home care: a portion will help fund the Universal Settlement with the rest slated to fund an increase in the Medicaid operating rate.

In Sep. 2015 the State filed a placeholder Medicaid State Plan Amendment (SPA) with the Centers for Medicare and Medicaid Services (CMS) to make the reinvestment. When approved, the provision will fund an increase in nursing home Medicaid operating rates by approximately one percent retroactive to the time that the cut was repealed on April 1, 2014. Expected to be paid as a retro add-on to April 2015 rates and forward.

The math (in rough numbers):

- State collects @$70M through .8 percent assessment
- Reinvests $35M into Universal Settlement (matched by federal funds)
- Reinvests $35M into NH rates (matched by federal funds)

Medicaid Budgeting Considerations

Nursing Home Quality Initiative (NHQI)

- Rate adjustments on hold (2013, 2014 & 2015) pending resolution of legal challenge
- DOH issued 2016 NHQI methodology
  - Replaces CMS 5-star staffing hours measure with annualized staffing hours measure based on Medicaid cost report data
- Detailed 2013 and 2014 and 2015 scores are available to the public
- 2013 and 2014 amounts shown on the benchmark rate listings on the DOH Medicaid rate web page:
  - the 2014 NHQI adjustment amounts are listed on the "January 2015 Nursing Home and Specialty Rates" document
  - 2013 NHQI adjustment amounts appear on the July 2014 benchmark rate lists accessible by clicking on Historical Benchmark Rates
- DOH published an NHQI Honor Roll (in top quintile all three years)

http://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/

2016 Nursing Home Quality Initiative Scoring Quick Reference

QUALITY COMPONENT (Total Possible 70 Points)	Data Source and Measurement Period	Scoring
Percent of contract / agency staff used	2015 Medicaid Cost Report	If rate is below 10%= 5 points If rate is above 10%= 0 points
Rate of Staffing Hours per Day	2015 Cost Report and 2015 calendar year MDS 3.0 data	Quintile 1= 5 points Quintile 2= 3 points Quintile 3= 1 point Quintiles 4 & 5= 0 points
Percent of employees vaccinated for Influenza	Employee vaccination data submitted through HERDS for the 2015-2016 Influenza season	If rate is 85% or greater= 5 points If rate is lower than 85%= 0 points
Percent of long stay high risk residents with pressure ulcers	2015 calendar year MDS 3.0 data	Quintile 1= 5 points Quintile 2= 3 points (+1 point if higher quintile than previous year) Quintile 3= 1 point (+1 point if higher quintile than previous year) Quintile 4= 0 points (+1 point if higher quintile than previous year) Quinitle 5= 0 points
Percent of long stay residents who received the pneumococcal vaccine*		
Percent of long stay residents who received the seasonal influenza vaccine*		
Percent of long stay residents experiencing one or more falls with major injury		
Percent of long stay residents who have depressive symptoms		
Percent of long stay low risk residents who lose control of their bowel or bladder		
Percent of long stay residents who lose too much weight		
Antipsychotic use in persons with dementia		
Percent of long stay residents who self-report moderate to severe pain		
Percent of long stay residents whose need for help with daily activities has increased		
Percent of long stay residents with a urinary tract infection		
COMPLIANCE COMPONENT (Total Possible 20 Points)	**Data Source and Measurement Period**	**Scoring**
CMS Five-Star Quality Rating for Health Inspections (regionally adjusted)	CMS health inspection survey scores as of April 1, 2016	5 stars= 10 points 4 stars= 7 points 3 stars= 4 points 2 stars= 2 points 1 star= 0 points
Timely submission of employee Influenza vaccination data	Employee influenza vaccination data submitted through HERDS for the 2015-2016 Influenza season	If submitted by due date= 5 points If not= 0 points
Timely submission of certified and complete nursing home cost reports	2015 Medicaid Cost Report	If submitted by due date= 5 points If not= 0 points
EFFICIENCY COMPONENT (Total Possible 10 Points)	**Data Source and Measurement Period**	**Scoring**
Potentially Avoidable Hospitalizations	2015 calendar year MDS 3.0 and SPARCS	Quintile 1= 10 points Quintile 2= 8 points Quintile 3= 6 points Quintile 4= 2 points Quintile 5= 0 points
If a home receives a J/K/L level deficiency between July 1 of the measurement year (2015) and June 30 of the payment year (2016) it is ineligible for NHQI ranking.		

Note: Measures and scoring varies slightly from year to year. Information based on 2016 payment year (2015 measurement year) scoring.

For complete scoring details and categorical exclusions see www.health.ny.gov/health_care/medicaid/redesign/nursing_home_quality_initiative.htm

Medicaid Budgeting Considerations

Cash Receipts Assessment

- 6.8 percent assessment on all non-Medicare revenue continues
- DOH processing 2015 assessment reconciliation; hope to include it in a January Medicaid payment cycle
- Assessment reimbursement amount used in 2016 was updated from a 2010-based figure to a 2014-based figure in August 2016
- State intends to use the 2014-based assessment reimbursement figure throughout 2017

Assessable Receipts:

Yes

- Universal Settlement payments
- Advanced Training Initiative funding
- Medicaid Managed Long Term Care revenue

Unclear

- DSRIP-related funding

No

- Medicare and Medicare Managed Care revenue

Medicaid Budgeting Considerations

Advanced Training Initiative

- $46 million for SFY 2016-17
- Teach direct caregivers to detect changes in a resident's status that could lead to health declines and/or hospitalization
- Awardees partner with designated training partners to implement selected program
- Eligibility criteria: retention rate above statewide median (excluding hospital-based homes and VAP recipients)
- Qualified applicants should receive year two funds in January 2017

Medicaid Budgeting Considerations

NH and Medicaid Managed Care

- Crucial for providers to be familiar with each plan's billing manual and procedures
- Definitive guidance in Benchmark Letter
- Wealth of info in Frequently Asked Questions (FAQs)
- Don't assume plan or provider knows
- Plans seeking VBP arrangement proposals

- 2015 MLTC Report
  - Enrollee characteristics by plan
  - Quality indicators
  - Satisfaction survey data

- Critical for providers to have accurate billing and managed care revenue management systems in place

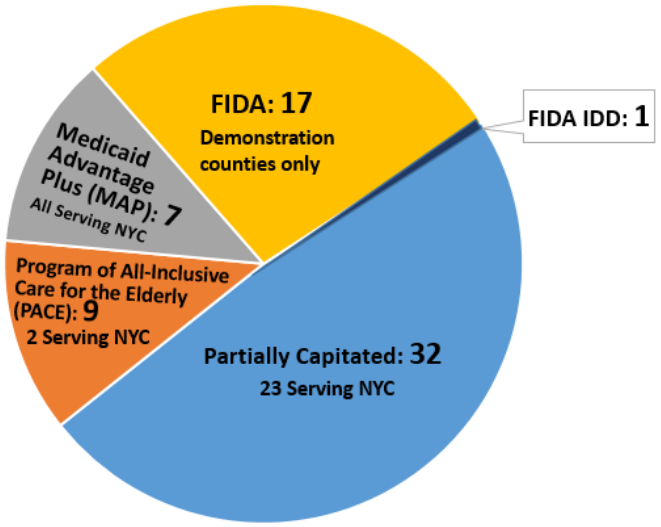
http://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/benchmark/docs/jun2015_benchmark_letter.pdf

The Landscape

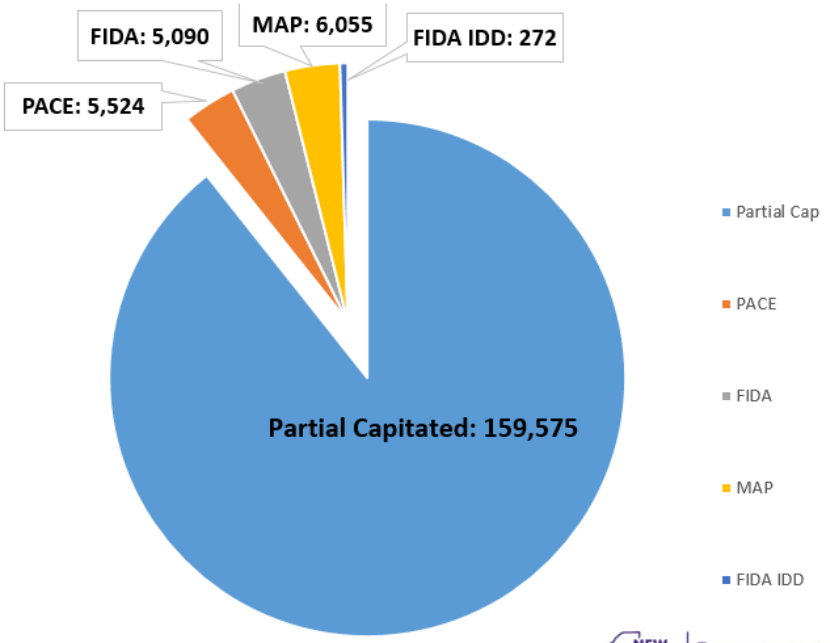
MLTC enrollment is spread across a large number of plans

MLTC Statewide Enrollment*

Number of Plans Statewide Actively Enrolling: **66**



Total Enrollees Statewide: **176,516**



**Based on the August 2016 Partial/MAP/PACE enrollment reports and the September 2016 FIDA enrollment report.*

NEW YORK STATE | Department of Health

"Mainstream" Medicaid Managed Care Enrollment:
4,437,000 (including 321,000 SSI-eligible individuals) = Medicaid state spend of $8.8 B
177,000 MLTC individuals = Medicaid state spend of $3.7 B

Medicaid Budgeting Considerations

Value-Based Payment (VBP) Arrangements

- DOH convened a series of subcommittees to work out the operational details of implementing VBP in contracts between providers and Medicaid managed care plans
- Link to Updated Medicaid Value Based Payment Roadmap
- By the end of year five, 80-90 percent of payments to providers by Medicaid managed care plans must be made through a value based methodology other than fee-for-service
- Challenge of developing purely Medicaid VBP in long term care
- DOH seeking VBP pilots
- LeadingAge NY VBP resources on dedicated VBP Web page

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/1st_annual_update_nystate_roadmap.pdf

http://www.leadingageny.org/topics/medicaid-redesign1/

Medicaid Budgeting Considerations

Latest installment in NYS Value Based Payment video series called, "VBP For Providers“ is now available. The video highlights how VBP will reshape the healthcare system and the important role providers play within VBP. More information on VBP can be found on the DOH website, http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm

The video is here: https://www.youtube.com/watch?v=_mvfd5GXvvs

Medicaid Budgeting Considerations

MEDICAID BUDETING TAKEWAYS

- 2012-2014 OMIG Audit results and lifting of associated 5% CMI constraint likely early in the year
- Important to know NHQI adjustment amounts (2013, 2014 and 2015 listed in benchmark rate lists)
- Transportation carve out from rate likely in 2017
- 1 percent increase to rate (.8 assessment reinvestment) likely in 2017
- Good managed care billing/revenue management systems are crucial

Contact: Darius Kirstein, dkirstein@leadingageny.org, 518-867-8841

Other Landscape Considerations

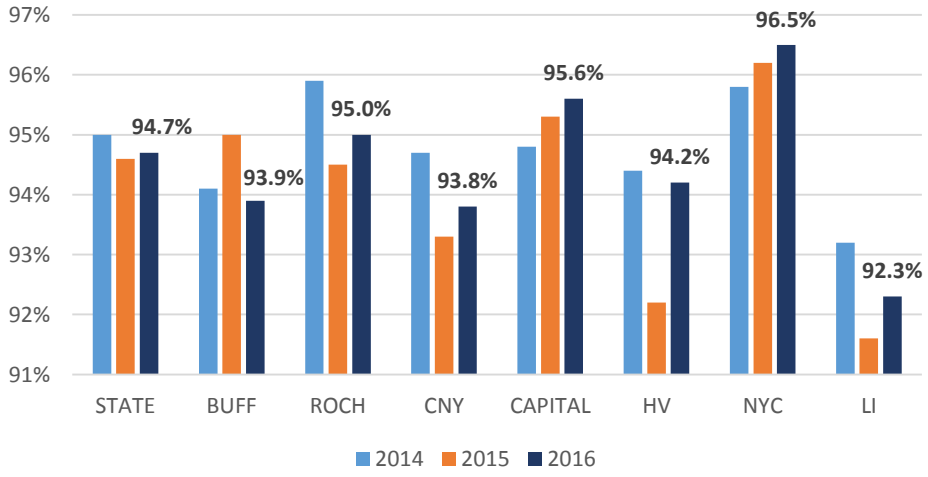
The Landscape

Nursing home occupancy is decreasing but still high in many homes

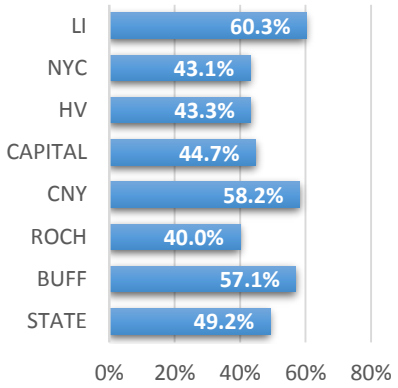
NH Occupancy

- Analysis of weekly bed availability reports
- Based on matched set of regularly reporting homes

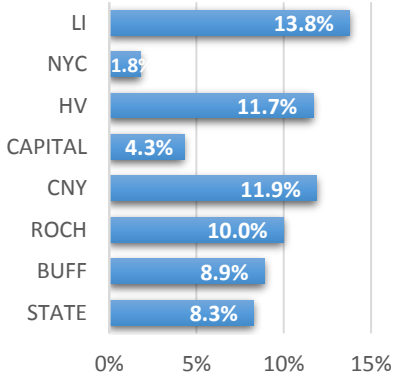
Median Occupancy: April 2014, 2015, 2016



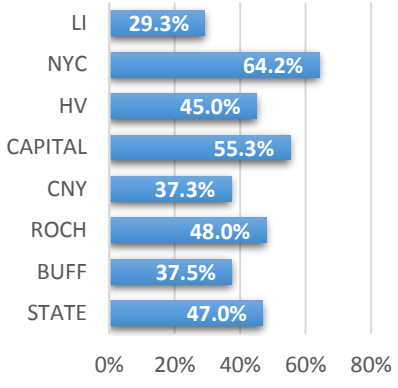
1. Percent of Homes with Apr. 2016 Occupancy Lower than 2015



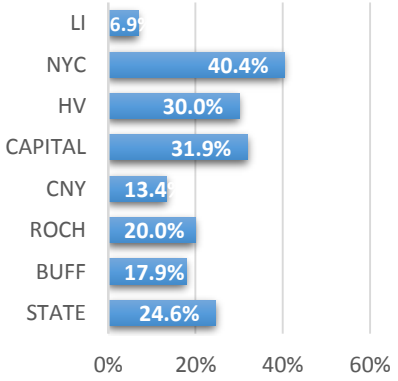
2. Percent of Homes with Apr. 2016 Occupancy Lower than 85%



3. Percent of Homes with Apr. 2016 Occupancy 95%+

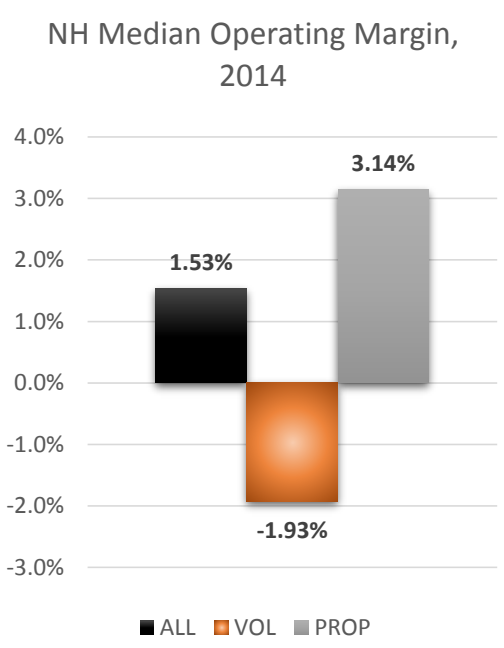


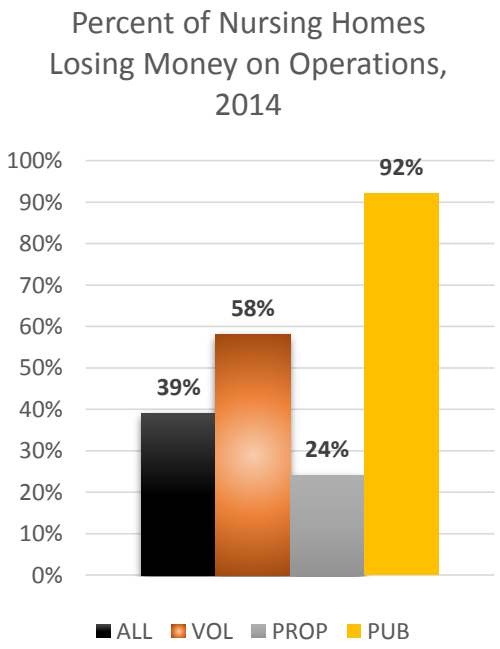
4. Percent of Homes with Apr. 2016 Occupancy 97%+

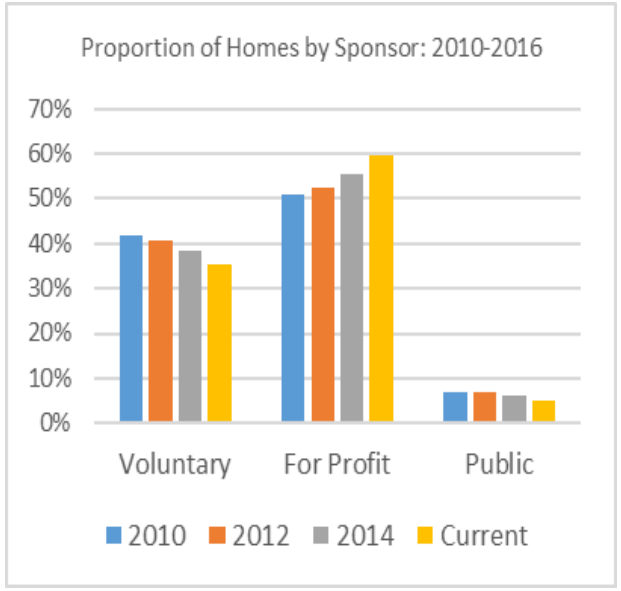


The Landscape

Provider finances vary by sponsorship type





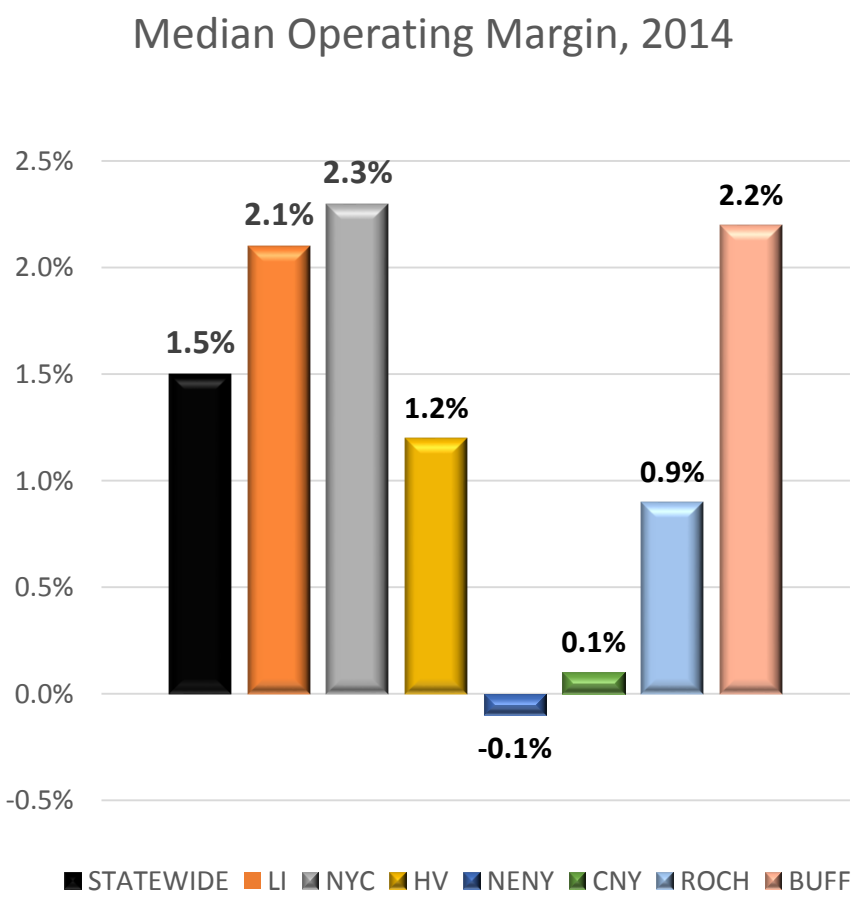


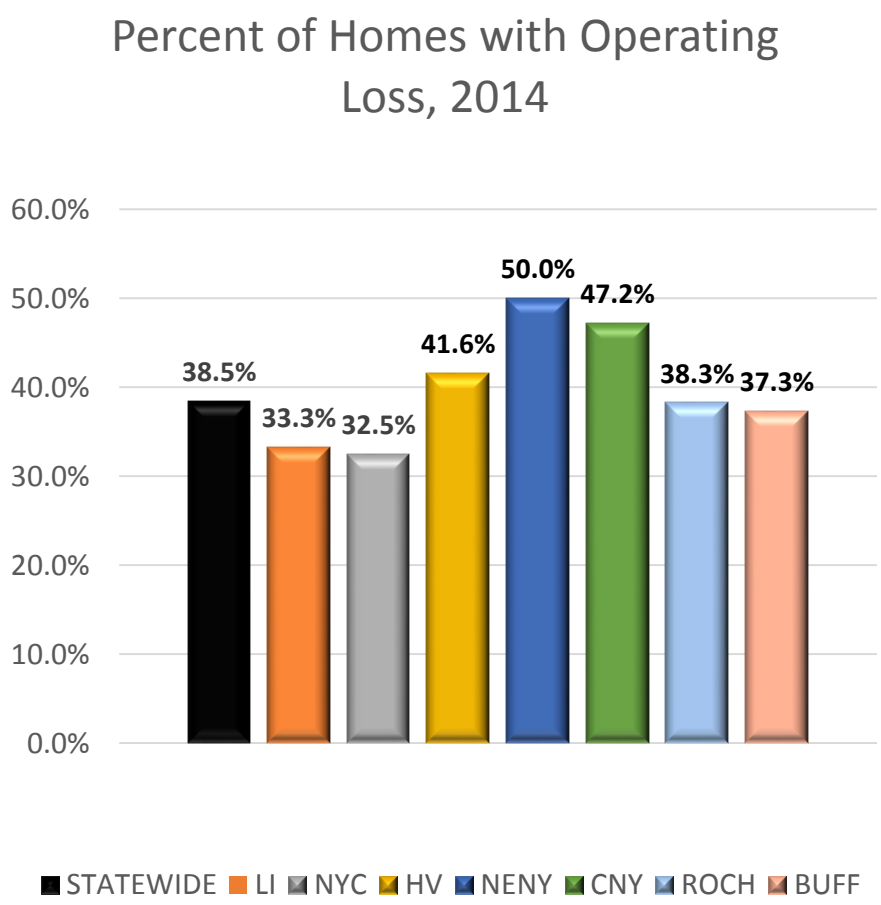
New York Nursing Homes Sponsorship Distribution			
	Voluntary	For Profit	Public
2010	42.0%	51.1%	7.0%
2012	40.8%	52.4%	6.8%
2014	38.3%	55.6%	6.1%
Current	35.4%	59.7%	4.9%
Current Beds	34.4%	58.7%	6.9%

Source: LeadingAge NY analysis of 2014 RHCF-4 cost report data

The Landscape

Provider finances vary by region





Source: LeadingAge NY analysis of 2014 RHCF-4 cost report data

The Landscape

Key Considerations

- Invest in data and analytics and health information exchange
  - Make sure staff can use the data generated and the clinical information transmitted
- Monitor and benchmark performance on key indicators
  - Hospitalization rates
  - Quality/outcome measures
  - Consumer satisfaction
  - Unit cost of services
  - Total cost of care per episode
- Evaluate tolerance for risk/shared savings arrangements
  - Assuming partial risk from a managed care plan
  - Joint venturing to share risk (e.g., ACO, bundled payments)

The Landscape

Key Considerations (cont'd)

- Clinically integrate with other service lines/other organizations
- Educate key stakeholders on your organization's performance and strengths
  - Payers (e.g., managed care plans)
  - Referral sources (e.g., hospitals, physicians, ACOs)
  - Other potential network partners (e.g., CBOs)
  - Consumers (e.g., clients, families)
- Be open to new collaborations, lines of business and risk sharing opportunities
  - Networks may have more bargaining power