2018 Budgeting Tune Up

LeadingAge New York
Regional CFO Council Meetings
Fall 2017

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Director of Financial Policy & Analysis

2018 Budgeting Tune Up - VBP

Session Roadmap

- Value Based Contract Amendments
- Medicaid Funding Issues
- Medicare Funding Issues
- Other Considerations
- Tools

2018 Budgeting Tune Up - VBP

State-Federal agreement requires that by April 1, 2020, **80-90%** of all payments by MCOs to providers must be in VBP arrangements.

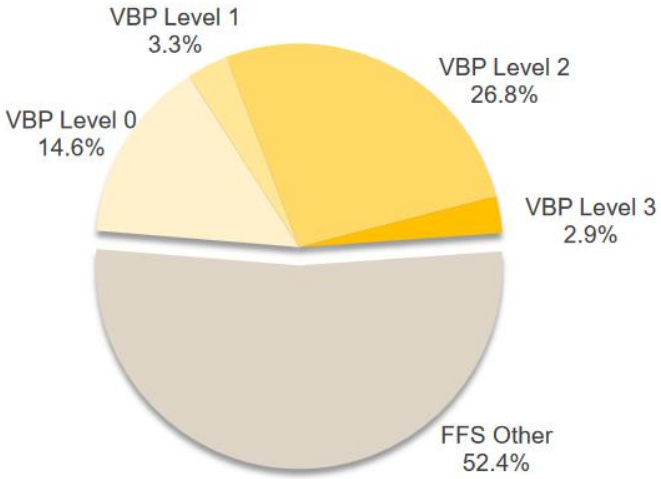
Old News

4 "Integrated Service Models:"

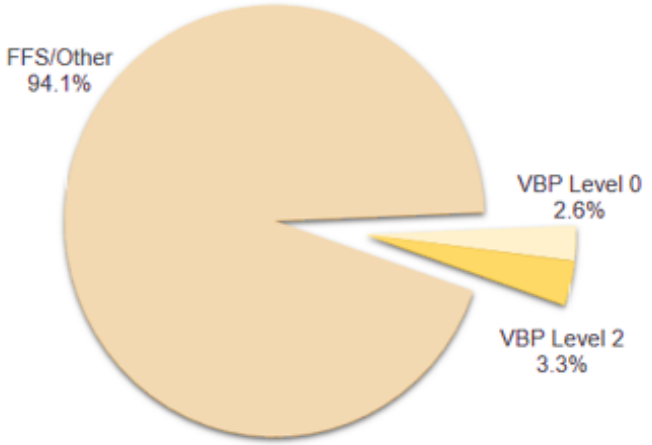
- Total Care for General (attributed) Population
- Integrated Primary Care Bundle
- Maternity Care Bundle
- Total Care for a Special Needs Subpopulation
    - HIV/AIDS
    - Behavioral health with comorbidities
    - People with multiple morbidities and disabilities
    - Frail elderly

2018 Budgeting Tune Up - VBP

MAINSTREAM MEDICAID MC



SINGLE CAPITATED MLTC



Source: NYS DOH, VBP Resource Library, July 2016

2018 Budgeting Tune Up - VBP

- MLTC partial capitation plans must implement MLTC Level 1 VBP arrangements **by December 31, 2017** using the Potentially Avoidable Hospitalization (PAH) measure.
- Provider contracts covered by the requirement are for covered services provided by Licensed Home Care Services Agencies (LHCSAs), Certified Home Health Agencies (CHHAs), and Skilled Nursing Facilities (SNFs).

2018 Budgeting Tune Up - VBP

What is an MLTC Level 1 VBP Arrangement for Partially Capitated MLTC Product Lines?

- A performance bonus (pay-for-performance, or P4P) agreement between an MLTC plan and a provider
- based on the provider meeting performance targets for a set of specific quality measures agreed to in a VBP contract between an MLTC Plan and a provider or group of providers (the "VBP Contractor")
- a cornerstone of MLTC Level 1 VBP arrangements is monitoring and reducing potentially avoidable hospital use.

2018 Budgeting Tune Up - VBP

4 Types of Payment with Different Levels of Risk

- **MLTC Level 1 (MMC Level 0)**: FFS with a pay-for-performance element tied to avoidable hospital use and other quality metrics*****
- **MMC Level 1**: FFS with upside-only shared savings (when outcome scores are sufficient)
- **Level 2**: FFS with 2-sided risk sharing (upside available when outcome scores sufficient; downside reduced when outcome scores high)
- **Level 3**: PMPM capitated payment for total care for subpopulation (with outcome-based component)

***** The State has agreed to count these types of arrangements between MLTC plans and providers as Level 1.

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What are MLTC Category 1 and 2 quality measures for VBP?

- Category 1 and 2 quality measures have been recommended for use for VBP
- The MLTC VBP Category 1 and 2 quality measure set for measurement years 2017 and 2018 are largely drawn from the MLTC Quality Incentive and **Nursing Home Quality Initiative measure sets**, including potentially avoidable hospitalization (PAH) measures.
- Contracts for LHCSAs and CHHAs must include the Managed Long Term Care Incentive PAH measure as a P4P measure from Category 1.
- SNF's Level 1 contracts must include the Nursing Home Quality Initiative PAH measure as a P4P measure from Category 2. Other measures from Categories 1 and 2 may be included as deemed appropriate by the contracting parties.
- Measures for use with LHCSAs and CHHAs are selected from Category 1 and for SNFs from Category 2
- *www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/2017-06-02_mltc.htm*

2018 Budgeting Tune Up - VBP

Where is the MLTC quality measure data for VBP?

- For LHCSAs and CHHAs – All Category 1 quality measures including PAH will be calculated by the Department of Health (DOH) for plan–provider combinations for **attributed member groups** submitted to DOH
- For SNFs – The Category 2 PAH will be calculated by DOH at the **facility level** and are posted in the NHQI Database on Health Data NY

Considerations:

- Contract must include VBP with PAH measure; can include more measures
- Level 1 is no risk to provider but may also be no benefit given anemic funding
- Providers doing well on PAH measure less likely to benefit if performance defined as year-over-year improvement
- Open questions remain, especially on baseline/measurement years
- DOH intends to present Webinar

2018 Budgeting Tune Up - VBP

VBP Managed Long Term Care (MLTC)

Managed Long Term Care

The Managed Long Term Care, or MLTC, VBP Resources page houses content specifically related to the implementation of VBP i implementation for MLTC plans and providers, use of quality measures specific to MLTC, and contracting materials developed for on the MLTC VBP Resources page.

- Value Based Payment For Managed Long Term Care Plans: Level 1 Contracting – July 2017

MLTC Clinical Advisory Group (CAG) Report for 2017

DOH is pleased to announce the release of the final Managed Long Term Care Clinical Advisory Group Report for 2017.

- Managed Long Term Care CAG Report – Value Based Payment Recommendations – September 2017

VBP Template Provider Amendments

- Amendment to the Participating Provider Agreement between MLTC Plans and LHCSAs
  - DOH Response to Comments to the Template LHCSA Amendment
- Amendment to the Participating Provider Agreement between MLTC Plans and SNF
  - DOH Response to Comments to the Template SNF Amendment

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

2018 Budgeting Tune Up - Medicaid

Projecting Nursing Home Medicaid Operating Rate

- 2016 was the last year of the 5-year phase-in of the pricing methodology for nursing homes. In 2017 no stop-loss/stop-gain provisions apply.
- The largest potential driver of change to the operating rate is the case mix adjustment and the special population add-ons.
- Operating rates for discrete specialty units are frozen at 2009 rates and remain unchanged.
- Base year costs from 2007 (no trend factor since 2007)
- Wage adjustments based on 2009 data
- Possibility of eventual base year update
- Benchmark rate for extended until the end of 2020

2018 Budgeting Tune Up - Medicaid

2018 Medicaid Rate-Setting Timetable

- DOH is seeking to move rate setting process forward to ensure rates are ready close to effective date
- Jan 2018 rates will have July 2017 MDS CMI (!)
- Capital attestations for all ($30M appeals cap)
- Homes that miss rate-setting sensitive deadlines (i.e, capital attestation, CMI roster submission, minimum wage surveys) may face rate update delays (including benchmark list updates)
- Uncertainty whether OMIG will continue doing MDS audits (but still doing 2015 MDS audits)

2018 Budgeting Tune Up - Medicaid

Pending Retroactive Adjustments

Areas of outstanding nursing home rate adjustments include:

- 2013 through 2016 Nursing Home Quality Initiative adjustments (up & dow
- 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 (litigation exposure concern)
- The release of the CMI constraint on homes whose CMI changed by more than five percent (July 2015 rates forward)
- Carve-out of transportation costs from nursing home Medicaid rate
- Cash Receipts Assessment reconciliation for 2016 payments (2 US payments in 2016) (note FFS assessment reimbursement per-diem based on 2014 reconciliation, benchmark assessment reimbursement on 2015)
- Hospitalization bedhold elimination: enacted, implementation pending promulgation of regulations, potential “buy back”
- Public home IGT for 2017-18 being made in 2 payments: Nov. 2017 and March 2018

2018 Budgeting Tune Up - Medicaid

CMI Considerations

- CMI picture dates last Wednesday in January and the last Wednesday in July
- Submission window: 3 weeks starting Sep. 11, 2017
- 5 percent CMI growth constraint (pending audit) 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**
- 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
- Complete MDS accurately to capture special populations eligible for add-on (Dementia and Bariatric)

2018 Budgeting Tune Up - Medicaid

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
- Outstanding Medicaid liabilities offsets:
  - Up to 100 percent of distributions
- 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) made in Oct. 2017
  - Fourth payment (SFY 2018-19) to trustees by March 31, 2019
  - Final payment (SFY 2019-20) to trustees by March 31, 2020

2018 Budgeting Tune Up - Medicaid

Minimum Wage

- State Budget includes funds intended to cover some of the costs of the increase for health care providers
- Funding included in provider Medicaid rates as of Jan 1, 2017 and will be updated annually
- DOH may adjust the Medicaid Global Cap to account for the impact of the minimum wage increases
- Impact largest on home/personal care
- **DOH to require additional cost reporting which will be basis of reconciliation and future rate adjustments**
- **State expects use of funds to be documented and those not used for minimum wage to be returned**

Starting Dec. 31, 2017:

- $10.40 Upstate (+$0.70 each yr.)
- $11 LI/Westchester (+ $1 each yr. to $15)
- $13 NYC (+ $2 each yr. to $15)

Fast food workers:

- $12.00 NYC / $10.75 Rest of State in 2017
- Increasing to $13.50 / $11.75 on Dec 31, 2017

2018 Budgeting Tune Up - Medicaid

Nursing Home Quality Initiative (NHQI)

- Rate adjustments on hold (2013, 2014, 2015 & 2016) pending resolution of legal challenge
- DOH recently issued 2018 NHQI methodology (same as 2017)
- Detailed 2013 through 2016 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
- 2017 payment year (2016 measurement year) scores to be published soon, PAH posted

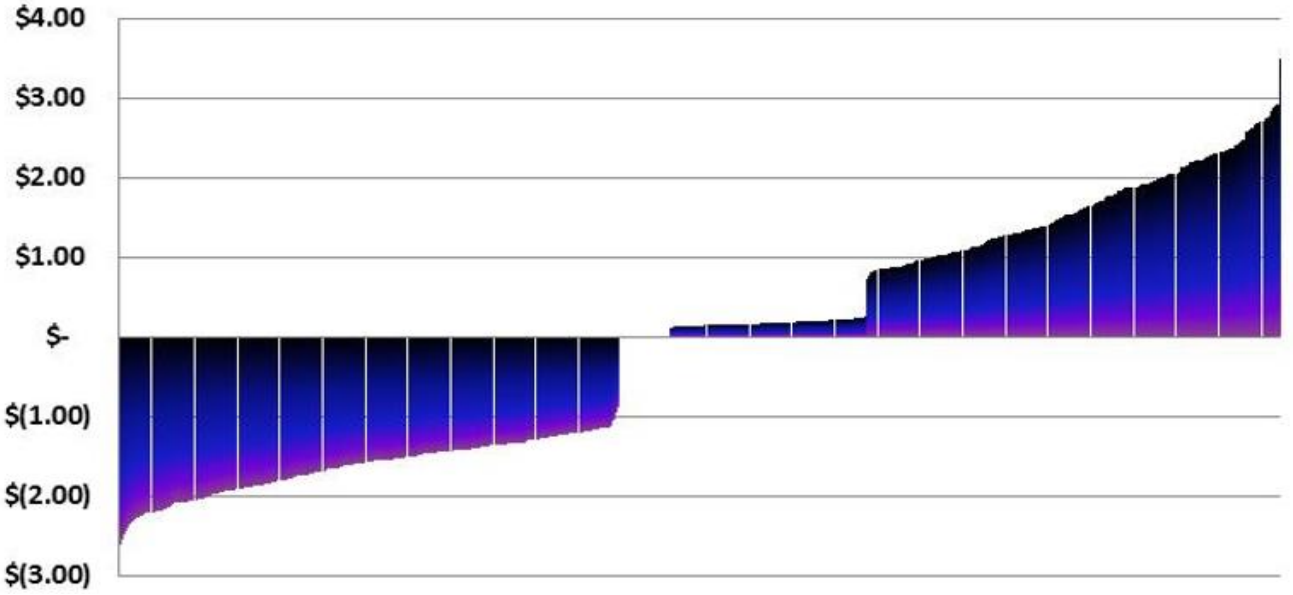
http://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/

2018 Budgeting Tune Up - Medicaid

Estimating your 2015 & 2016 NHQI adjustment amount (ROUGH ESTIMATE ONLY)

Quintile	Average Percent of Operating Rate	High	Low
1	1.20%	1.50%	1.05%
2	0.67%	0.80%	0.57%
3	0.15%	0.19%	0.12%
4	-0.90%	-0.75%	-1.00%
5	-0.90%	-0.75%	-1.00%

NHQI Adjustment Depends on Quintile & Home's Medicaid Rate



2018 Budgeting Tune Up - Medicaid

Adult Day Health Care

- Capital is only FFS rate component that changes
- Off-site program lease reimbursement
- Unbundled services option

Medicaid Assisted Living Program (ALP)

- Transition to managed care scheduled to begin in 2018
- DOH transition workgroup
- Some discussion of rate update but no $ to do so
- 2018 SSI COLA for ACF Residents (click here)

Home Care

- workforce mandates and related funding concerns (FLSA, minimum wage, 13 hour rule, call-in pay)
- Consumer Directed Personal Assistance Programs (CDPAP) now require authorization; workers now included under wage parity requirements downstate

2018 Budgeting Tune Up - Medicaid

Medicaid Managed Care

- Rate adequacy/clarity concerns
- Risk adjustment issues
- Rate cells
- NH Benchmark rate
- Marketing ban (MLTC)
- Geographic narrowing
- Uniform billing codes

- Discussion on the future of integrated (Medicaid/Medicare) models

December 8th in New York City

FutureofIntegratedCare@health.ny.gov

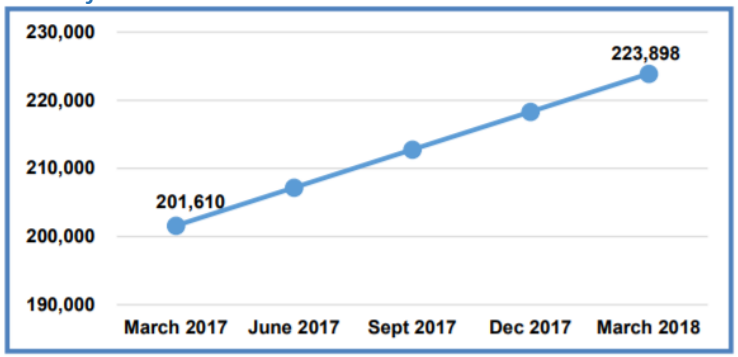
Medicaid Spending ($ in millions)			
Category of Service	**Estimated**	**Actual**	**Variance Over / (Under)**
Medicaid Managed Care	**$6,525**	**$6,576**	**$51**
Mainstream Managed Care	$4,272	$4,288	$16
Long Term Managed Care	$2,253	$2,288	$35
Total Fee For Service	**$3,946**	**$4,003**	**$57**
Inpatient	$1,305	$1,313	$8
Outpatient/Emergency Room	$151	$150	($1)
Clinic	$213	$221	$8
Nursing Homes	$1,173	$1,180	$7
Other Long Term Care	$257	$276	$19
Non-Institutional	$847	$863	$16
Medicaid Administration Costs	**$176**	**$170**	**($6)**
OHIP Budget / State Operations	**$189**	**$187**	**($2)**
Medicaid Audits	**($198)**	**($242)**	**($44)**
All Other	**$1,372**	**$1,341**	**($31)**
Local Funding Offset	**($3,025)**	**($3,025)**	**$0**
TOTAL	$8,985	$9,010	$25

Medicaid Managed Care

Medicaid spending in major Managed Care categories was $51 million over projections.

- Long Term Managed Care was $35 million above projections due to slightly higher than expected enrollment. Through August there were 2,925 more recipients than anticipated.

Projected MLTC Growth



2018 Budgeting Tune Up - Medicare

Medicare Rates

Part A Rate (Oct. 1, 2017-Sep. 30, 2018)

- Increased by 1 percent over the previous year
- Wage Index update will cause some regions to see an increase slightly higher than 1%, others slightly lower
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), established a special rule for FY 2018 that requires the market basket percentage, after application of the productivity adjustment, to be 1.0%.
- Without MACRA it would have been a 2.3 percent market basket increase

Note: CMS re-published Part A rates and wage indexes on Oct 4, 2017 to correct errors

Part B Rates (2018 Calendar Year)

- 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
- **0.5 percent annual increases through 2019**

2 percent sequestration cut continues on all Medicare payments

2018 Budgeting Tune Up - Medicare

Home Health PPS Final Rule 2018

- reduces nationwide payments by $80 million
- delays adoption of Home Health Groupings Model (HHGM) that would have slashed rates by an estimated $950 million in 2019
- rate will see a net decrease of 0.4 percent:
  - a 1 percent home health market basket (inflation) update ($190 million increase);
  - a 0.97 percent decrease to the national, standardized 60-day episode payment rate to account for case-mix growth ($170 million decrease); and
  - a 0.5 percent cut that eliminates the rural add-on provision ($100 million decrease).

2018 Budgeting Tune Up - Medicare

Quality Reporting Program (SNF QRP)

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) mandated a quality reporting program for SNF
- Goal: comparable measures and reporting across settings
- **Beginning with FY 2018 (which starts Oct. 2017), SNFs that fail to comply will have their market basket percentage updates reduced by two percentage points**
- Initial QRP measure scores will be based on October 1-December 31, 2016 assessments
- From existing MDS (including 2016 changes) and Medicare claims
- 80% of assessments must have data items required to calculate MDS-based measures

2018 Budgeting Tune Up - Medicare

This Year's Additions to Quality Reporting Program (QRP)

For QRP affecting FFY 2020 payment year, CMS plans:

- to replace the current pressure ulcer measure with an updated version
- to adopt four new outcome-based measures that address functional status and align with Inpatient Rehabilitation Facility (IRF) QRP:
  - Change in Self-Care Score for Medical Rehabilitation Patients
  - Change in Mobility Score for Medical Rehabilitation Patients
  - Discharge Self-Care Score for Medical Rehabilitation Patients
  - Discharge Mobility Score for Medical Rehabilitation Patients

WILL REQUIRE SIGNIFICANT MDS MODIFICATIONS

2018 Budgeting Tune Up - Medicare

Medicare SNF Value-Based Purchasing Program (SNF VBP)

The Protecting Access to Medicare Act of 2014 (PAMA) requires that VBP apply to SNF payments beginning in October 2018 (i.e., FFY 2019)

- Two percent withhold of SNF Part A payments
- Partially earned back based on a SNF's re-hospitalization rate and level of improvement (60%)
- CMS tasked with:
  - specifying a risk adjusted re-hospitalization measure
  - calculating a score for each SNF
  - providing the measure and score reports to SNFs for review and make it available to the public

2018 Budgeting Tune Up - Medicare

SNF VBP Earn-Back Methodology

1. Estimate Medicare spending on SNF services for the FY 2019 payment year;

2. Estimate the total amount of reductions to SNFs' adjusted Federal per diem rates for that year, as required by statute;

3. Calculate the amount realized under the payback percentage proposal (60% proposed);

4. Order SNFs by their performance scores;

5. Assign a value-based incentive payment multiplier to each SNF that corresponds to a point on the logistic exchange function that corresponds to its SNF performance score.

Top 60% of homes quality for earn-back

Top performers will receive more than 2%

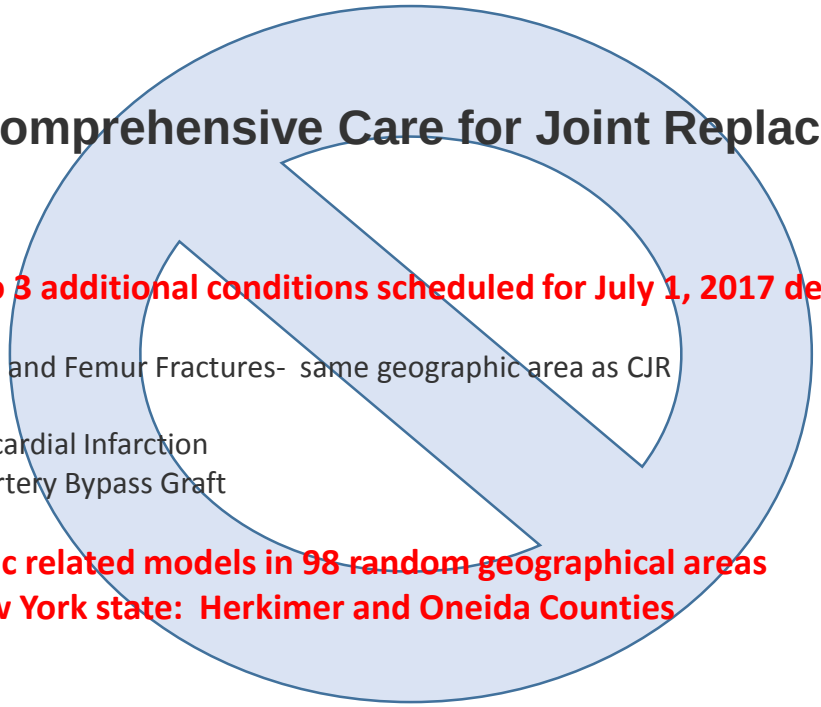
2018 Budgeting Tune Up - Medicare

Home Health Value Based Payment (VBP)

- **In targeted states** only: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington
- payment adjustments will be based on each HHA's total performance score on a set of measures already reported via existing reporting conventions or determined by claims data, plus three new measures where points are achieved for reporting data
- Payments will be adjusted (up or down) 3 percent in 2018 increasing to **8 percent** in 2022

2018 Budgeting Tune Up - Medicare

Expansion of Comprehensive Care for Joint Replacement (CJR)



- **Expansion to 3 additional conditions scheduled for July 1, 2017 delayed**
- (1) Surgical Hip and Femur Fractures- same geographic area as CJR
- (2) Acute Myocardial Infarction
- (3) Coronary Artery Bypass Graft
  - **Cardiac related models in 98 random geographical areas**
  - **In New York state: Herkimer and Oneida Counties**

CMS proposed a rule backing away from expanding to mandatory cardiac bundles and scaling back the number of geographic areas where CJR is mandatory. The proposal is the start of what CMS says will be an increase in the number of voluntary initiatives.

2018 Budgeting Tune Up - Medicare

Proposed Changes to CJR and Cardiac Bundle Expansion

- Would reduce the number of mandatory MSAs from the 67 current to 34 (mandated participation would continue in those MSAs with the highest average wage-adjusted historic episodic cost)
- Would allow currently participating hospitals in the remaining 33 CJR MSAs to voluntarily continue in CJR until the scheduled end of the program on Dec. 31, 2020
- Low-volume hospitals and rural hospitals in the 67 CJR MSAs would be automatically excluded beginning 2/1/18 but would have a one-time option to voluntarily continue in CJR

- ***CJR would remain mandatory for New York City MSA hospitals***
- ***CJR would become optional for Buffalo-Niagara MSA hospitals***
- ***Mandatory cardiac bundles would not be implemented in Utica MSA***

2018 Budgeting Tune Up - Medicare

Medicare Advantage Penetration (May 2017)

- Medicare VBP (and QRP) focused on Medicare FFS Population
- Nationwide Medicare Advantage penetration is 33.8% and growing
- Ranges nationwide from single digits in Alaska, Wyoming, Vermont to 57% in Minnesota
- New York ranks 10th with 38.8%; Third in overall enrollees behind CA & FL

Counties with Hightest and Lowest Medicare Advantage Penetration		
Rank	County Name	Penetration
1	Monroe	64.9%
2	Livingston	58.4%
3	Erie	58.3%
4	Ontario	58.1%
5	Bronx	57.2%
58	Dutchess	19.9%
59	Orange	19.4%
60	Putnam	19.3%
61	Suffolk	18.8%
62	Sullivan	14.8%

Counties With the Most Total Medicare Recipients		
County Name	Medicare Population	Penetration
Kings	358,060	42.8%
Queens	343,656	45.9%
Suffolk	278,909	18.8%
New York	273,760	36.7%
Nassau	255,605	23.1%
Bronx	197,675	57.2%
Erie	191,068	58.3%
Westchester	169,630	26.3%
Monroe	149,551	64.9%
Onondaga	90,892	43.1%

2018 Budgeting Tune Up - Medicare

NOTICE OF COMING PROPOSAL: REPLACE RUG-IV with RCS-1

- CMS is considering a major overhaul to the nursing home Medicare Part A rate setting methodology.
- Advance Notice of Proposed Rulemaking (ANPRM) laid out a proposal to replace RUG-IV with a new case mix methodology, Resident Classification System, Version 1 (RCS-1).
- CMS has signaled intent to formally propose it as part of the SNF PPS Rule for FFY 2019
- ***CMS is seeking to remove service-based metrics (e.g., therapy minutes) from the rate setting methodology and derive payments from objective resident characteristics that are predictive of therapy and other service needs***
  - Less predictable rates
  - Focus will shift to effectiveness of therapy instead of minute counts
  - MDS diagnosis coding accuracy will be paramount and these skills will be in demand (fewer but higher stakes assessments)
  - Reimbursement will decline as the stay progresses

2018 Budgeting Tune Up - Medicare

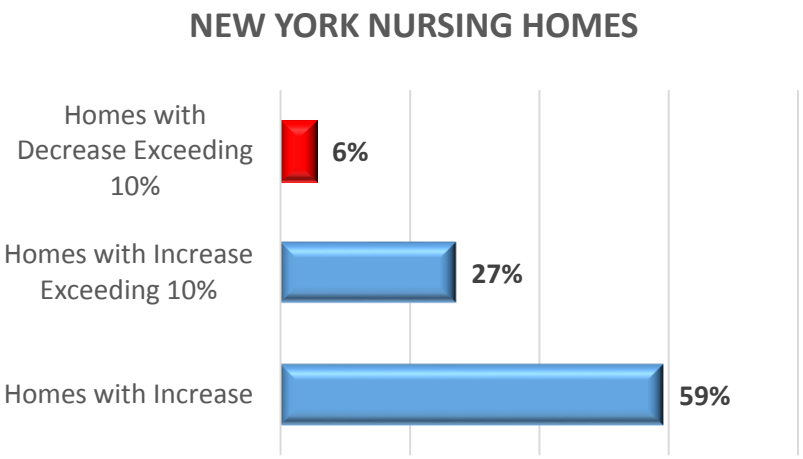
NOTICE OF COMING PROPOSAL: RCS-1 Structure

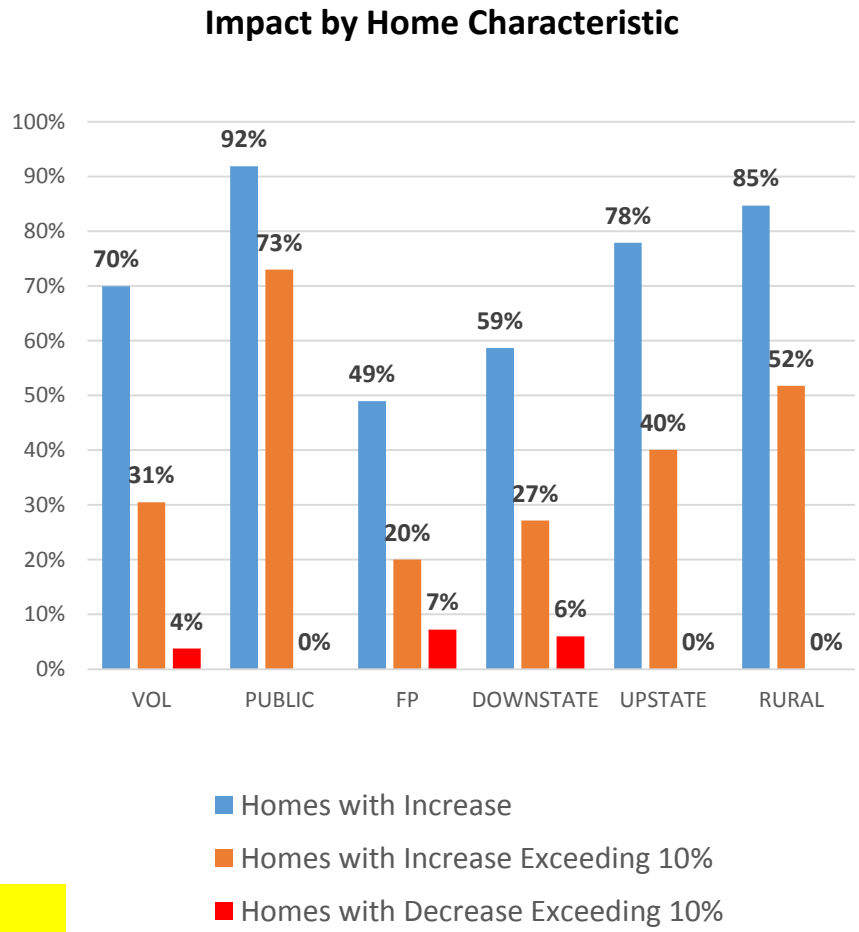
- ***Separate therapy minutes from payment***
  - no longer rely on minutes of therapy provided to a resident to classify the resident for payment
  - impose a 25% limit on group therapy and a 25% limit on concurrent therapy (i.e., residents receive at least 50% of their therapy minutes on an individual basis)
- ***Establish additional case-mix components***
  - classifies each resident into four case-mix adjusted components (PT/OT, SLP, nursing and non-therapy ancillaries (NTA)) based primarily on resident characteristics
  - Each component has separately adjusted price
- ***Front-load payments***
  - incorporate variable per-diem payment adjustments for the PT/OT and NTA components, which would reduce the payment for these components over time
- ***Reduce required assessments***
  - require only the 5-day Scheduled PPS Assessments, PPS Discharge Assessment and Significant Change in Status Assessments (as applicable)

2018 Budgeting Tune Up - Medicare

Provider Level Impact Modeling: RCS-1 vs RUG-IV

CMS used 2014 Medicare claims and MDS data to crosswalk 2014 resident days into RCS-1 categories





Source: CMS RCS-I Provider Specific Impact Analysis, Updated July 20, 2017

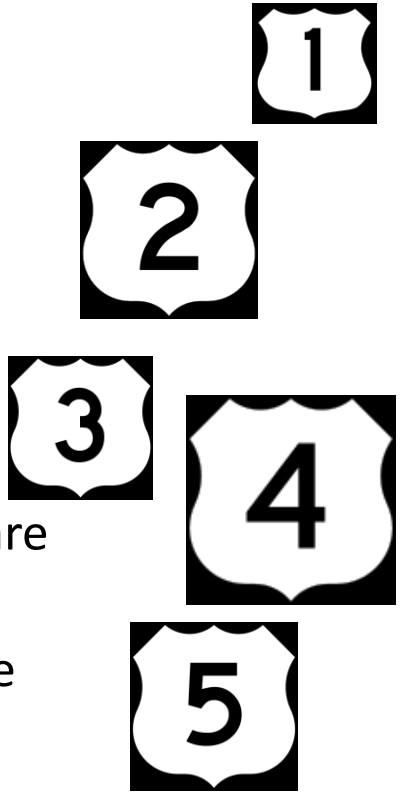
RCS-1 Audio Program on Dec. 5!!
www.leadingageny.org/leading-u/

2018 Budgeting Tune Up – Dates & Deadlines

- Medicare Cost Report (5 months after end of year, Low Volume Waiver only if less than $200,000 in Medicare A + B revenue)
- Medicaid Cost Report (most likely due early July in 2018)
- Immunization Reports (May)
- Executive Compensation Report (end of June or Medicaid Cost Report Due Date, whichever later)
- MDS Census Submission for CMI (April & September)
- Capital Component Review (Early Fall)
- PBJ Submissions (45 days after end of each quarter)
- Monthly Cash Receipt Assessment Reports
- Minimum wage surveys

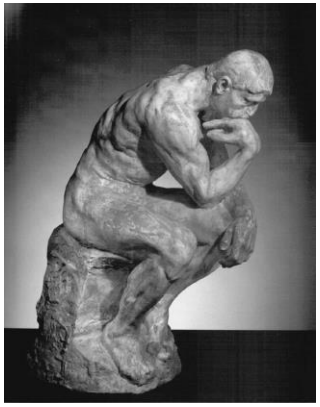
2018 Budgeting Tune Up - Considerations

5 Big Themes for NY LTC Providers



1. Federal Funding
2. State Value Based Payments
3. Potential Major Payment Reform in Medicare
4. Alternative Payment Structures in Medicare
5. State Medicaid Dynamics & MLTC

2018 Budgeting Tune Up - Considerations



Considerations

- State Medicaid Global Cap
- Minimum Wage & Other Wage Mandates
- Managed Care Dynamics
- Continuation of NH Benchmark Rate
- Increasing Focus on Quality Measures
- VBP Impact Approaching
- Potential Federal Changes to Medicaid

2018 Budgeting Tune Up - Considerations

Gov. Cuomo has warned of potential $4B state budget deficit in 2018 suggesting:

- potential for a tougher budget
- possibility of "continuing resolution" approach = unpredictability

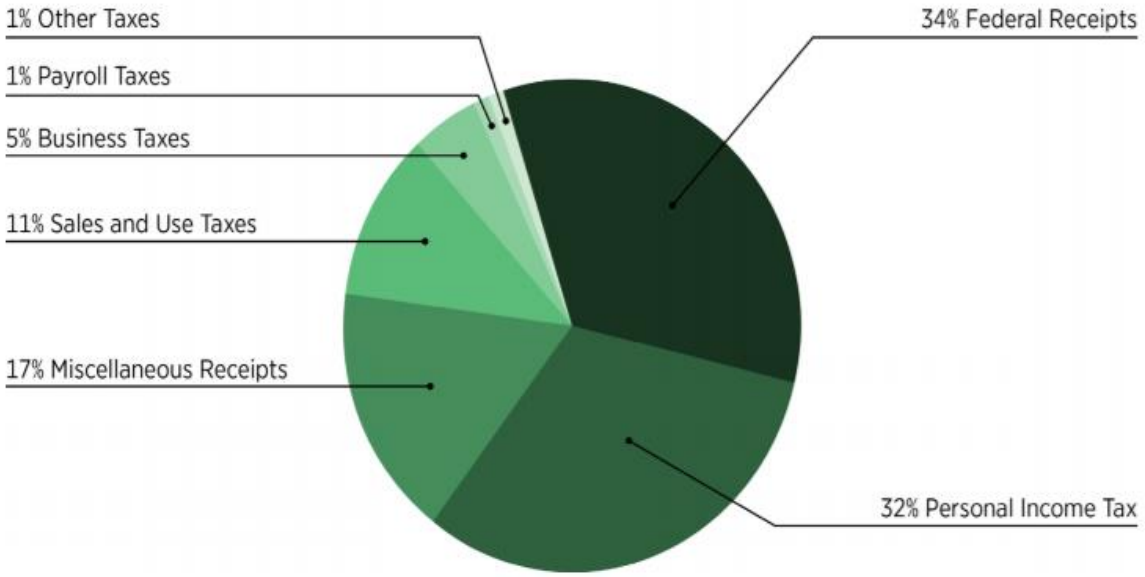
"How do you lock yourself into a budget with numbers until you know what you're going to get from Washington?"

Provisions included in federal tax bills could have significant impact:

- Squeeze Medicaid/Medicare funding by increasing deficit
- Medical expense deduction elimination hurts seniors
- Deductions for state and local tax could make it hard for states to make up federal cuts
- Several provisions harmful to financing senior housing

2018 Budgeting Tune Up - Considerations

Federal Receipts as Percent of State Revenue



Source: FY 2018 Executive Budget Financial Plan, Jan. 2017.

PROGRAM	FEDERAL $
Medicaid	$33.56B
Essential Plan	$3.75B
Temporary & Disability Assistance	$3.65B
K-12 School Aid	$2.72B
Public Health	$2.32B
Capital projects (largely transportation) & debt service	$2.16B
Homeland Security & related	$1.13B
Children's Services	$1.01B
Special education programs	$830M

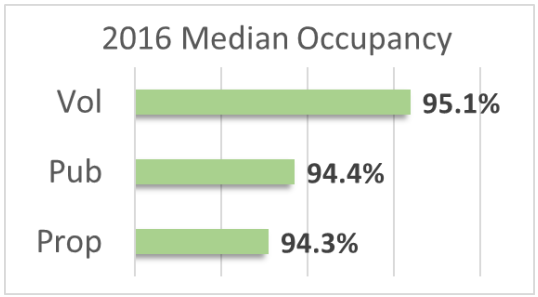
(continues…)

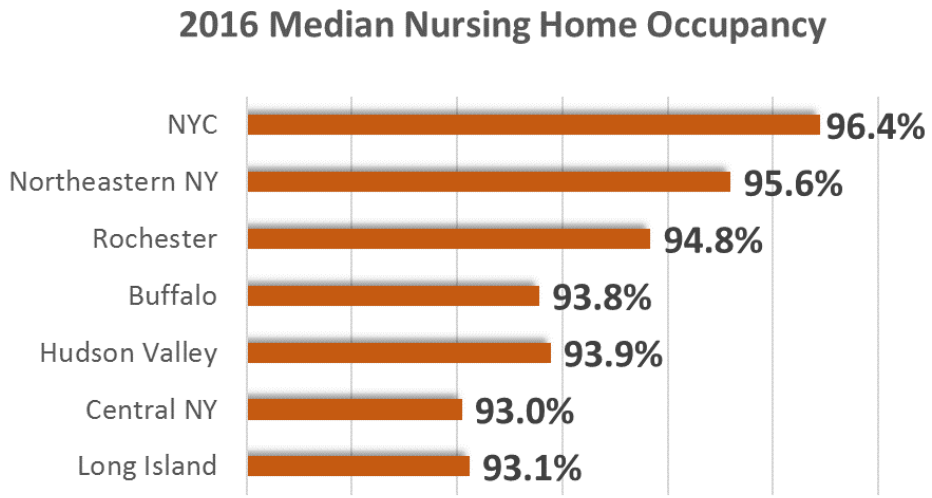
Source: Fiscal Policy Institute New York State Economic and Fiscal Outlook 2017-2018

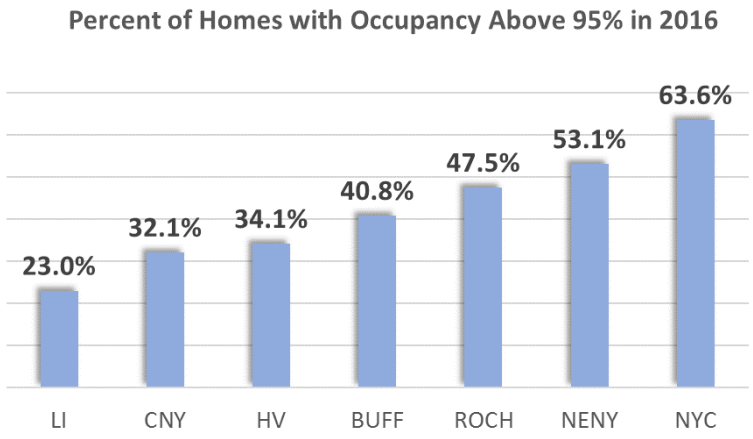
2018 Budgeting Tune Up - Considerations

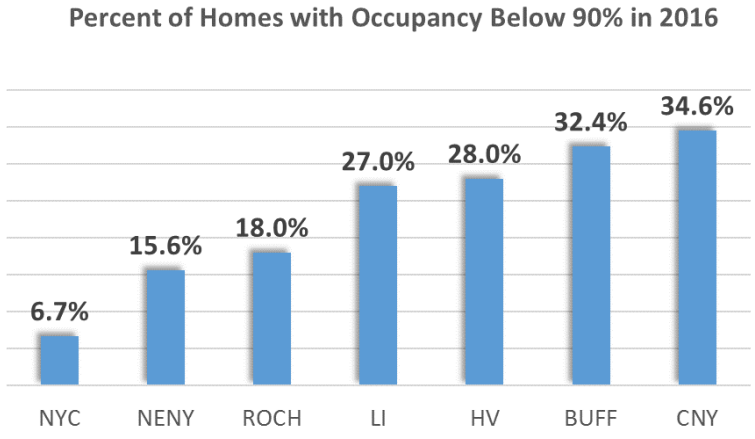
2016 Occupancy

- *Source: Weekly bed availability report submissions to DOH*





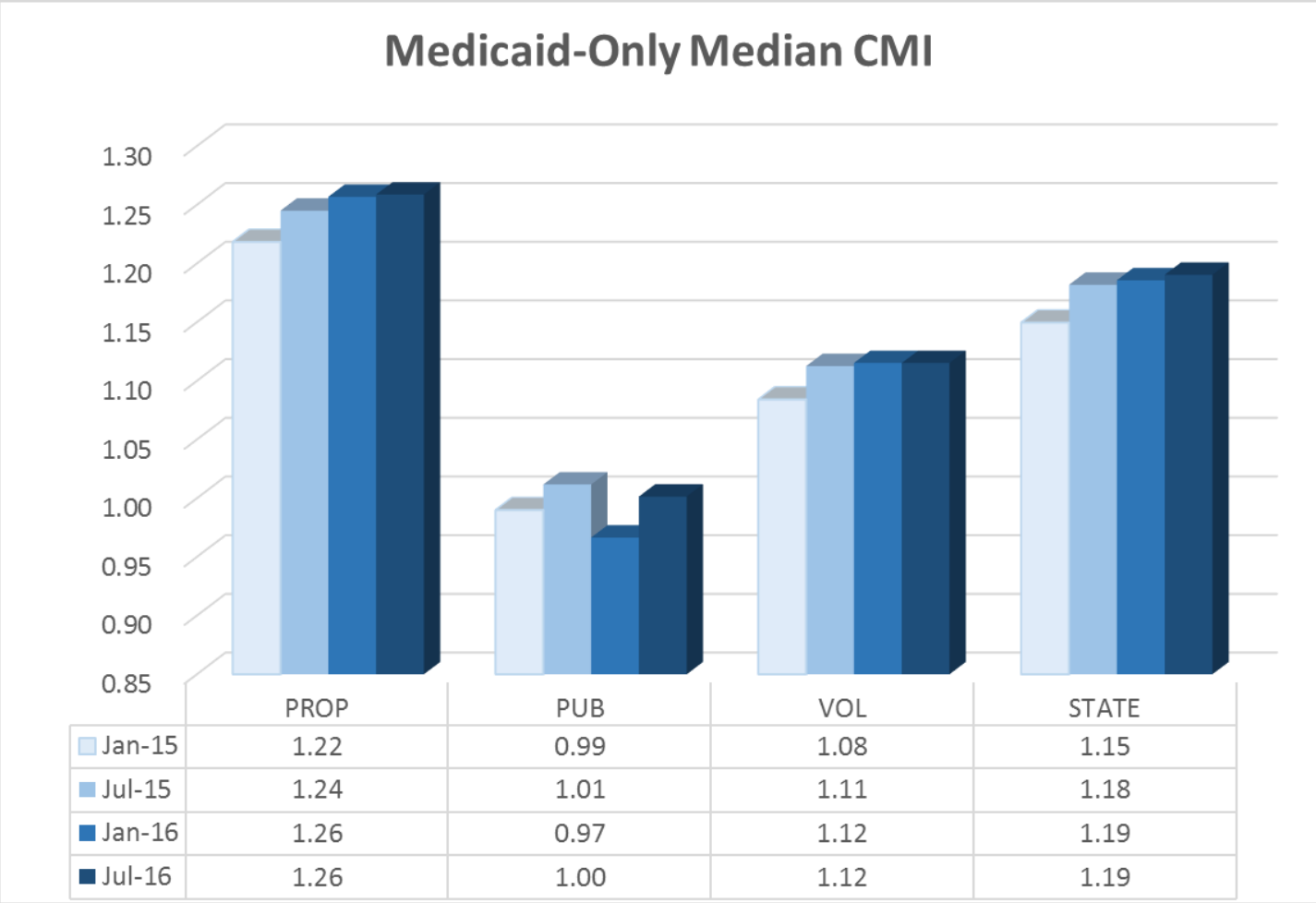




Source: LeadingAge NY Analysis of Weekly Bed Availability Data

2018 Budgeting Tune Up - Considerations

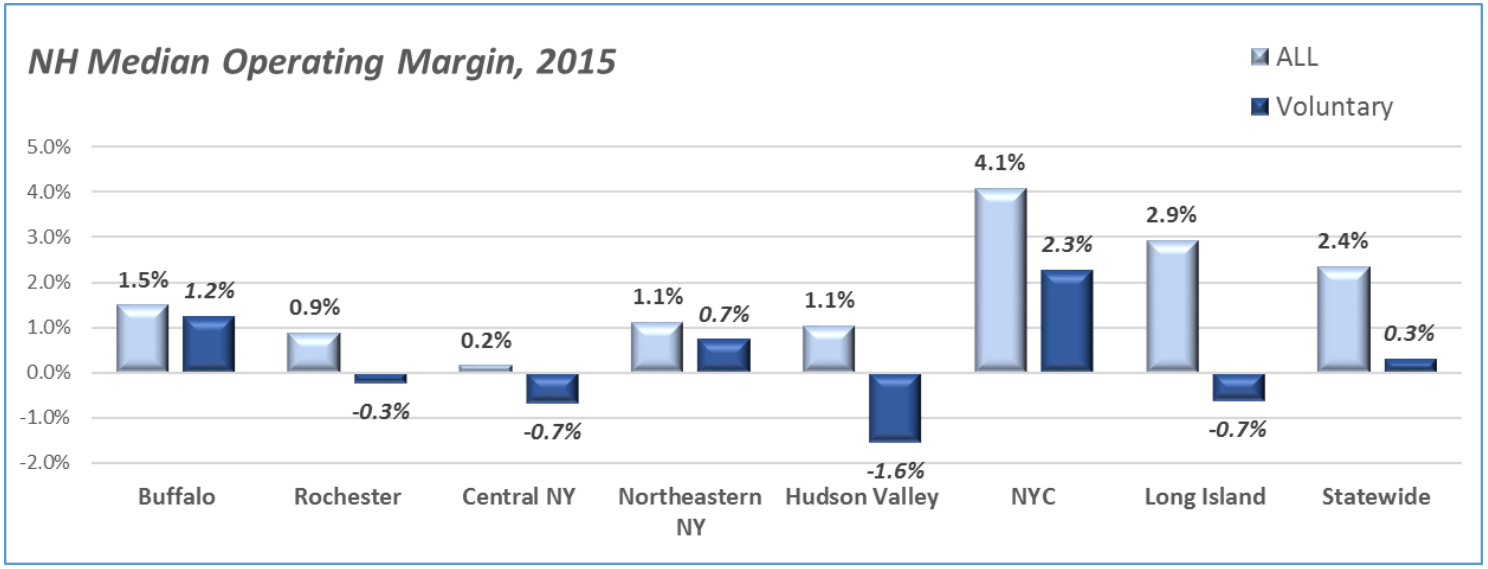
CMI Data 2015-2016

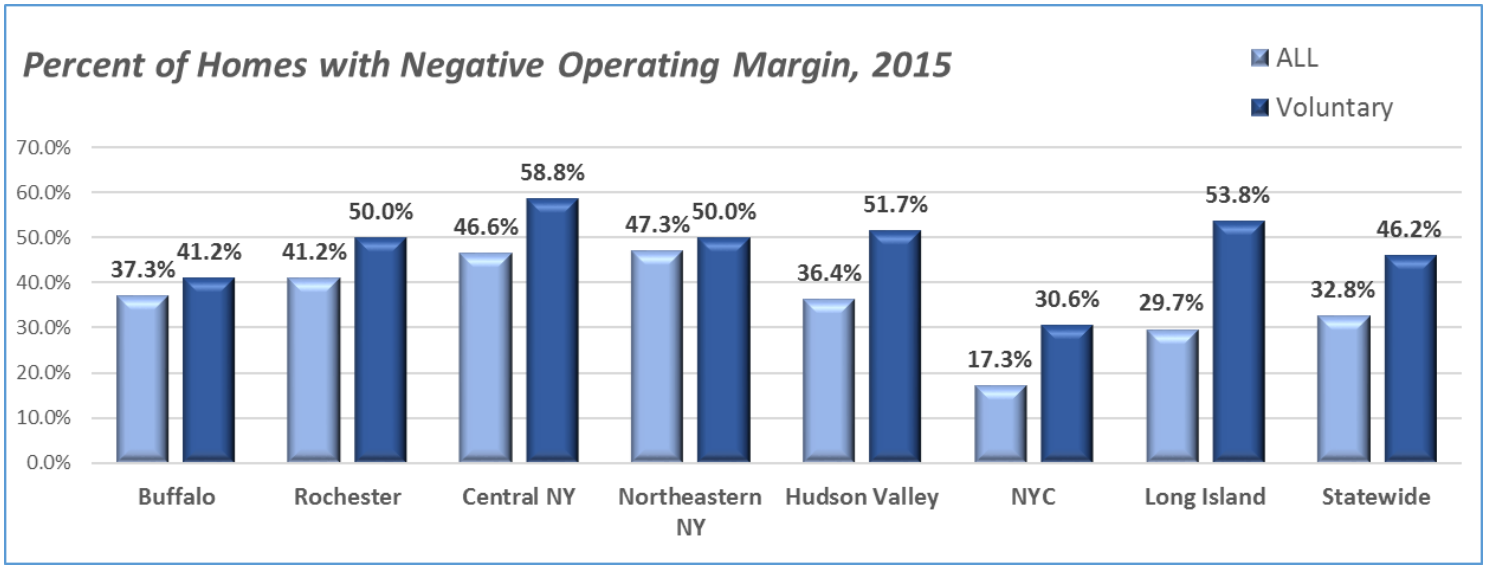


	PROP	PUB	VOL	STATE
Jan-15	1.22	0.99	1.08	1.15
Jul-15	1.24	1.01	1.11	1.18
Jan-16	1.26	0.97	1.12	1.19
Jul-16	1.26	1.00	1.12	1.19

Source: LeadingAge NY Analysis of DOH Roster Submission Data

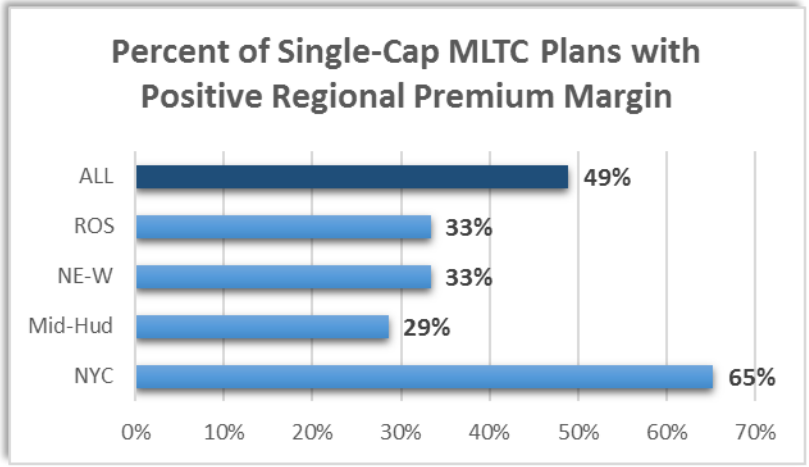
2018 Budgeting Tune Up - Considerations

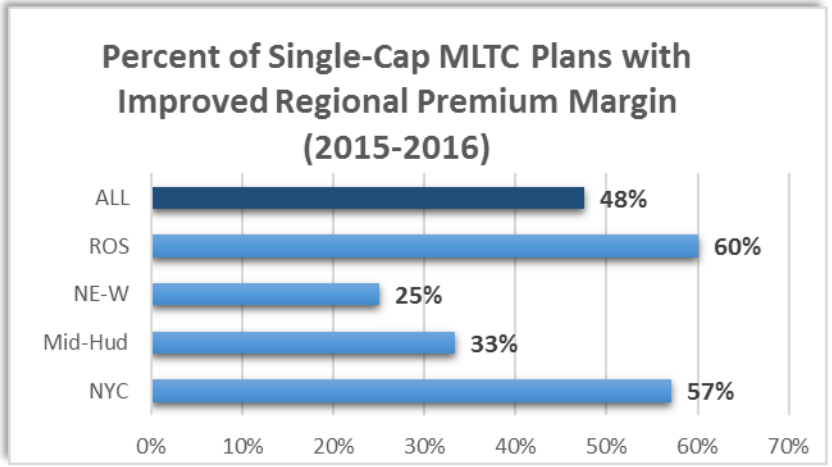


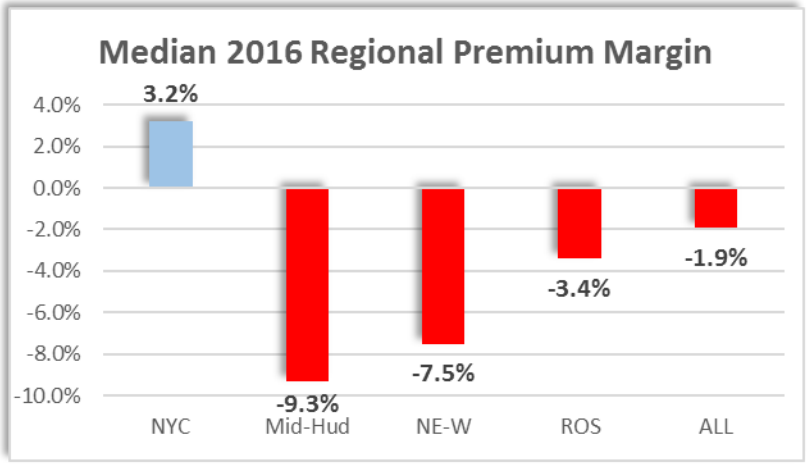


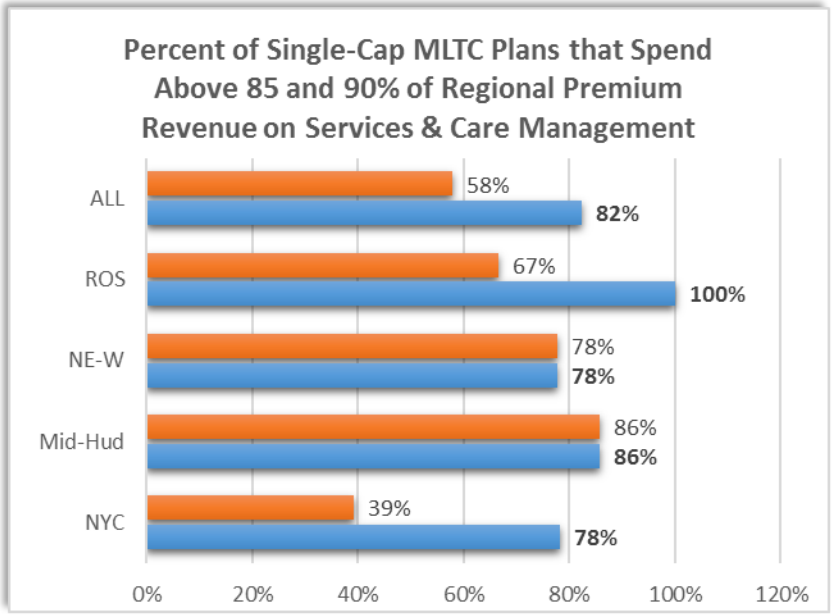
Source: LeadingAge NY Analysis of 2015 RHCF Medicaid Cost Report Data

2018 Budgeting Tune Up - Considerations









Source: LeadingAge NY Analysis of 2016 Annual Single-Cap MLTC Medicaid Cost Report Data

2018 Budgeting Tune Up - Considerations

2017 LeadingAge NY Nursing Home Salary Report

Salary Survey Criteria

- Participants were asked to report wages and benefits as of January 2017.
  - 2016 bonus data
- 140 surveys were completed by both not-for-profit and public nursing homes
- Only those that participated in the survey are allowed access to the Salary Report
- Contacted as many Administrators, CFOs, and HR Directors as possible

2018 Budgeting Tune Up - Considerations

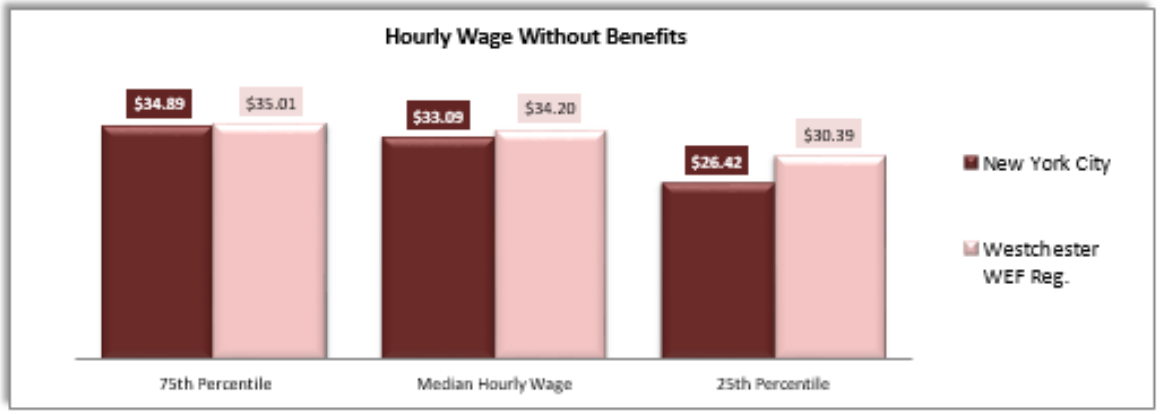
Salary Report Details

- Salary information on 17 management positions
- Wage information on 20 non-management positions
  - Average hourly
  - Starting hourly
  - All positions are analyzed with and without benefits
- Interactive excel spreadsheet
  - Allows adjusting position and geographic region
    - Regions include statewide, DOH regions, voluntary only, upstate and downstate, WEF regions, upstate hospital based, and upstate public homes
- Outliers are identified and omitted during data collection
- Sample size must be at least five for each region

2018 Budgeting Tune Up - Considerations

Social Worker (MSW) Wage Data

2017	New York City		Westchester WEF Reg.	
	Hourly Wage	*Hourly Wage with Benefits*	Hourly Wage	*Hourly Wage with Benefits*
Number of Homes Reporting	14	*8*	7	*6*
Average Hourly Wage	$31.47	*$44.29*	$32.31	*$49.27*
Median Hourly Wage	$33.09	*$48.13*	$34.20	*$50.37*
25th Percentile	$26.42	*$38.91*	$30.39	*$47.09*
75th Percentile	$34.89	*$51.92*	$35.01	*$54.20*
Average Starting Hourly Wage	$29.50	*$41.02*	$30.21	*$46.17*
Median Starting Hourly Wage	$30.24	*$43.68*	$29.89	*$47.27*



Notes

Percentiles were calculated by arranging wage figures from highest to lowest and dividing them into four quarters. The 25th percentile

2018 Budgeting Tune Up - Considerations

Director of Nursing Salary Data

2017	New York City		Westchester WEF	
	Annual Salary	*Salary with Benefits*	Annual Salary	*Salary with Benefits*
Number of Homes Reporting	18	*17*	7	*6*
Average Annual Salary	$158,500	*$218,300*	$158,200	*$217,000*
Median Annual Salary	$160,200	*$223,600*	$136,000	*$200,900*
25th Percentile	$128,700	*$177,000*	$135,000	*$178,400*
75th Percentile	$177,100	*$240,000*	$171,100	*$252,500*
Small Facility* Median	sts	*sts*	sts	*sts*
Large Facility* Median	$160,200	*$218,800*	sts	*sts*

Notes

Percentiles were calculated by arranging salary figures from highest to lowest and dividing them into four quarters. The 25th percentile

2018 Budgeting Tune Up

Tools

- Medicaid Template w/ CMI modeler
- Medicare RCS-1 Memo & Template
- Medicare PPS Memo & Rate Calculator
- Medicare Part B Calculator
- FASTracker- Expenses & Staffing
- Quality Benchmarker
- LeadingAge Quality Metrics / 5-Sar Reports
- Salary Report
- Intel Articles, DataPoint
- LeadingAge National- Website, Listservs
- DOH Medicaid Update
- MRT Listserv
- DOH Website/MRT Sites
- Medicaid Benchmark Rate List & Letter

Thank you!

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