1986: NYS develops RUGS II reimbursement methodology for Medicaid combining cost-based and CMI driven reimbursement. PRI is basis for resident assessments. Base year costs adjusted by trend factor drove reimbursement.

Under RUGS II nursing homes were paid based on 4 rate components:
- Direct Component – CMI based.
- Indirect Component – Peer Group based.
- Non-Comparable – Pass through.
- Capital – Pass through.
- Wage Equalization Factor.
All based on the legendary 1983 base year.

1992: CMS adopts case mix system – RUGS III based on the NYS model. RUGS III is case mix driven, and is a pure pricing system. Almost all services under Medicare Part A are “bundled” into the rate. Nursing homes paid based on RUG category and responsible for all services provided under consolidated billing. MDS 2.0 is the evaluation tool.
2010: CMS moves to RUGS IV and MDS 3.0. Now includes 66 RUG categories.

1997: Medicare Part C
CMS begins offering beneficiaries Medicare HMO option instead of traditional FFS. Nursing homes begin negotiating first managed care contracts.

Medicare Part C leads to development of Medicare “special needs” plans that assume some of the risk of caring for the resident under a capitated system. Focus on reducing hospitalizations.

Terminology: Medicare Part C a.k.a.:
- Medicare+Choice
- Medicare Advantage
- Medicare HMO
Part C plan must at a minimum cover all services covered under Parts A and B, and generally offer enhanced coverage.
A Very, Very Brief History of Nursing Home Reimbursement

NYS Modified Case Mix System

- Labor Intensive Rate Setting System.
- Essentially FFS based.
- Resulted in numerous law suits and appeals.
- Subject to legislative trend factor freezes and other rate reductions.
- No regular base year updates.
- Requires significant auditing and analysis.
- Preserves critical capital funding.

2012 – Pricing System

5 year transition of nursing home rates from modified case mix system to regional pricing system. Pays facilities based on a regional price with some adjustment for case mix and regional wage difference.

An Even Briefer History of Managed Care in NY

Starting in the early 1990’s state policy makers began promoting managed care as a means of obtaining the “triple aim.”

As part of transition case mix is frozen. Case mix freeze lifted in 2012.

7% plus increase in case mix results in case mix audits by OMIG.
NY Medicaid develops “managed long term care model” to cover individuals needing long term chronic care, including nursing home residents, and dual eligibles. Most of the Medicaid MLTC enrollment and plan activity focused in NYC. Provider based plans develop.

MLTC includes two models—the dually (i.e., Medicare and Medicaid) capitated Program of All-inclusive Care for the Elderly (PACE) and Medicaid-only Managed Long Term Care programs. These programs offer many benefits, including comprehensive coordination of services; integration of payment sources; multidisciplinary care; customized service packages dictated by need rather than programmatic restrictions; financial incentives that reward good outcomes; and increased access to community-based services for the state’s most vulnerable population.

Early experience with small population of voluntary enrollees in MLTC demonstrates positive outcomes:

- Lower rates of hospitalization and institutionalization.
- Good clinical outcomes.
- Cost savings.
- High customer satisfaction.
- Total enrollment remained small and focused in NYC.

Federal Patient Protection and Affordable Care Act

New office created in CMS to coordinate care of “dual eligibles” to coordinate Medicare and Medicaid coverage, eliminated inefficient or duplicative coverage, and reduce hospitalizations.

Patient Protection and Affordable Care Act

Provides for enhanced federal funding and grant monies for states to implement innovative payment and care management systems.
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The Medicaid Redesign Team

- Federal Focus on:
  - Insurance exchanges and addressing the uninsured
  - Medicare and Medicaid cost containment
  - New care coordination models (ACOs, medical homes, health homes)
  - Shared savings models (e.g., value-based purchasing) that reward providers and states for reducing federal outlays
  - " Bundling of services and payments for episodes of care
  - Addressing dual eligibles through managed care and managed fee-for-service options
  - Quality measurement and incentives
  - Community-based service options
  - Health information technology deployment and interoperability among providers

Why Medicaid Redesign?
Overview –
Historical Medicaid Spending ($ in Billions)

Why Medicaid Redesign?
Overview:
Medicaid Spending NYS vs. U.S.

The most important slide of all time:

- ACO = Accountable Care Organization = a product of the Affordable Care Act
- BHO = Behavioral Health Organization / Utilization Management focus
- BIP = Balance Incentive Payment
- CSB = Complex Needs Service Coordination
- DSRIP = Delivery System Reform Incentive Payment
- FFS = Fee for Service
- FSA = Fully Integrated Duals Advantage
- HMO = Health Maintenance Organization (in Medicaid, generally based on a national basis with integration of provider networks)
- MLTC = Managed Long Term Care Plan
- MCO = Medicaid Advantage Plus = combination of Medicaid managed long term care plan and Medicare Advantage plan
- MCO = Managed Care Organization in U.S. Health Plan
- Medicare Advantage = Medicare managed care for dual eligible not in need of LTC
- Medicare Advantage + Medicare managed care
- MALT = Managed Long Term Care Plan
- MMCP = Mainstream Medicaid Managed Care Plan
- NYQ = Program for All Inclusive Care for the Elderly
- NAP = Vital Access Provider

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An Even Briefer History of Managed Care in NY

Medicaid Redesign in NY
- Implement global cap on state Medicaid spending
- Add more services to managed care benefits
- Require more recipients to join "mainstream" plans
- Require most HCBS recipients to join MLTC plans
- Enroll certain dual eligibles in integrated Medicare/Medicaid managed care starting in 2014
- Use health homes, medical homes and ACOs to coordinate care and network services
- Enroll all Medicaid recipients in managed care/ coordinated care models within 5 years

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The Medicaid Redesign Team

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Overall Enrollment Plan

- Mandatory population: dual eligible, aged 21+, need community-based LTC services for 120 days or more
  - Includes personal care, CPAP, CHHA, LTCHP, ADHC
- Mandatory enrollment slated to began Summer 2012 in NYC for new cases in the mandatory population
- Phased in by service type, NYC borough and zip code
- People will have 60 days to choose an MLTC plan
- Phase-in to other areas of state in process as MLTC capacity is established

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The Medicaid Redesign Team

“...The Centers for Medicare & Medicaid Services (CMS) and the State of New York, Department of Health (State / NYSDOH) will establish a Federal-State partnership to implement the Medicare-Medicaid Alignment Initiative (Demonstration) to better serve individuals eligible for both Medicare and Medicaid (“Medicare-Medicaid Enrollees”). The Federal-State partnership will include a Three-way Contract with Fully Integrated Duals Advantage (FIDA) Plans, which are Medicare-Medicaid Plans (MMPs) that will provide integrated benefits to those Medicare-Medicaid Enrollees who reside in the targeted geographic area and who choose to participate in the Demonstration (Participants).”

Joint Statement on FIDA

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The Medicaid Redesign Team

NYS DOH: MRT 101 - Develop initiatives to integrate and manage care for eligible duals

Fully Integrated Duals Advantage (FIDA) Enrollment Update

Individuals in Bronx, Kings, Nassau, New York, Queens, and Richmond counties will be able to join the FIDA Demonstration on January 1, 2015. Passive enrollment will be phased in beginning April 1, 2015, until all eligible individuals are enrolled.

Individuals in Suffolk and Westchester will be able to join the FIDA Demonstration no earlier than April 1, 2015. Passive enrollment will begin no earlier than July 1, 2015, until all eligible individuals are enrolled.

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Effective October 2014, the State will implement a Conflict-Free Evaluation and Enrollment Center (CFEEC) for individuals seeking Community-Based Long Term Care (CB LTC) services for more than 120 days.

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The Medicaid Redesign Team

- Maximus will serve as the CFEEC providing evaluation and education services.
- The State will expand Maximus’ current role as enrollment broker New York Medicaid Choice (NYMC) to perform CFEEC activities which will include:
  - Scheduling initial eligibility evaluations for people new to service seeking CB LTC
  - The CFEEC will have 5-7 business days to schedule the evaluation from when the call is received
  - Staffing nurse evaluators to perform in-home evaluations (including hospitals, nursing homes) using the UAS-NY

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The Medicaid Redesign Team

State Resolves Final Approval of $8 Billion Medicaid Waiver

On April 14, 2014, Governor Cuomo announced that the federal government has officially signed off on New York’s Medicaid waiver, which will allow the State to institute, over the next five years, $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms.

The $8 billion reinvestment will be allocated as follows:

- $6.42 billion for the Balance System Reform Incentive Payment (SORIP) Program – including DSRIP Planning Grants, GPRP Provider Incentive Payments, and other administrative costs.
- $200 million for the Hospital Access Assurance Fund – temporary, open-ended funding to ensure current trusted and viable Medicaid-ady net providers can fully participate in the DSRIP transformation without disruption; and
- $1.08 billion for other Medicaid Redesign purposes – funding to support Health Home development, and investments in long-term care, workforce and enhanced behavioral health services.
Defining Features of Managed Care

- Care coordination and management
- Preventative health benefits
- Capitation and risk
- Single point of contact
- Provider network
- Added benefits or lower cost-sharing

It is important to know the distinctions:

- “mainstream” and MLTC.
- FIDA and MLTC.
- Medicare and Medicaid plans.
- Variety of MLTC plans.
- PACE as a unique model.
- Commercial and Medicaid plans.

“...individuals transitioning from fee-for-service Medicaid to MLTC must continue to receive services under the enrollee’s pre-existing service plan for at least 90 days after enrollment or until a care assessment has been completed by the Plan, whichever is later. In addition, the patient/worker(s) relationship must be preserved for the same 90 day period.”

Applies to dual eligibles 21 years and over who receive home or community-based LTC for more than 120 days.

Applies to:
- Personal Care services (housekeeping, meal preparation, bathing, toileting, and grooming);
- Consumer Directed Personal Assistance Program;
- Certified Home Health Agency (“CHHA”) services;
- LT/HCP services; and
- Adult Day Health Care services.

In March 2013, the New York State Department of Health began implementation of the Uniform Assessment System for New York (UAS-NY). The overall goal of the UAS-NY is to utilize a comprehensive assessment system within eight Medicaid community-based long term care services and programs across New York State.
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Mandatory Enrollment Timetable

Mandatory Enrollment Timetable

- Phase 9 – Jan 2013: Westchester & Long Island
- Phase 10: Scheduled June 2013: Erie, Monroe, Orleans, Allegany Counties
- Phase 11: June 2013: Other counties with capacity
- LTCHP (Medicaid only): in progress
- SMMTP (Medicaid only): in progress
- \( ^* \) NH residents in upstate FDI region: January 2014 (proposed)
- NH residents in rest of state: April 2014 (proposed)
- NH residents permanently placed prior to dates above would remain in FFS
- ADHC added to Mainstream Medicaid MC Benefit: August 1, 2013

\( ^* \) ADHC possible accelerations if required to meet budget constraints.

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Transition to Managed Care for Nursing Home Residents

Nursing Home Transition work group convened by the Department of Health (DOH) has finalized policies that will govern the transition of the nursing home benefit and population into managed care. Subject to federal approval, Medicaid enrollees in downstate areas in need of permanent care in a nursing home will be required to join a managed care plan starting in October of 2014 (but further delays are possible).

The DOH transition guidance document and power point slides from a March webinar are available on the DOH and LeadingAge websites.

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Transition to Managed Care for Nursing Home Residents

For upstate counties, this requirement will be phased-in starting in April 2015 (pending federal approval). Individuals who are already permanent nursing home residents at the time that the requirement goes into effect in their county will not be required to enroll into a plan and may continue in fee-for-service Medicaid.

LeadingAge NY website contains updated chart outlining the transition to managed care for all LTEC populations.

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Are you in the network?

New York is not an “any willing provider” state, therefore a managed care organization can choose to exclude a provider from its network for any reason.

Number of contracts to manage and number of available plans in an area.

Managed Care Organizations (MCOs) will be required to pay a nursing home provider the DOH-calculated fee-for-service (FFS) rate for three years, instead of the two years originally proposed. However, a plan and provider may negotiate an alternative rate acceptable to both parties. The three year period will start in October 2014 downstate and on April 1, 2015 upstate. DOH will reassess whether there is a need for a longer transition after one year. The FFS rate includes cash receipts assessment reimbursement amount.
Transition to Managed Care for Nursing Home Residents

- Existing MMCP enrollees will NOT be dis-enrolled if they require long stay custodial placement.
- MMCP will be responsible for the NH benefit after transition date for enrolled members.
- No individual will be required to change nursing homes resulting from this transition.
- New placements will be based on the individual’s needs and the plan’s contractual arrangements.
- Plans must ensure that placement is in the most integrated, least restrictive setting available to meet the enrollee’s needs.

Provisions included in the previous version of the policy document that would have established a mechanism to address MCO cost anomalies of providing nursing home care to their enrollees have been removed. Risk mitigation related to nursing home placements as well as a separate nursing home rate cell for MLTC plans were adamantly opposed by consumer advocates and ultimately removed. DOH has promised to closely monitor the adequacy of the blended rate. DOH has proposed high-cost and high-capital cost nursing home pools for managed care plans to neutralize intrinsic disincentive for plans to avoid utilizing higher cost homes.

Contracts between providers and MCOs will be required to include due process rights for the provider and must allow the provider to remedy any identified problems prior to imposition of penalties or termination of the agreement. If an agreement should be terminated for reasons other than imminent patient harm or a finding of fraud, the MCO must continue the member’s placement in the nursing home as an out of network placement and pay Medicaid fee-for-service rates.

Standard NH Network Requirement- managed care plans must contract with a minimum number of nursing homes based on the following criteria:

- 8 – Queens, Bronx, Suffolk, Kings, Erie, Westchester, Monroe
- 5 – New York, Richmond
- 4 – Oneida, Dutchess, Onondaga, Albany
- 3 – Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster
- 2 – All other counties (or 1 if only one NH in the county)

While a separate rate cell will be used for enrollees of mainstream Medicaid Managed Care plans requiring permanent nursing home placement, a blended rate cell will be used for this population when the Managed Long Term Care (MLTC) plan premium is calculated. This change was made to allow the proposal to go forward.

MCOs will be required to make bed hold payments for Medicaid residents based on the same rules (i.e., day limitations and 95 percent occupancy threshold) and rates (50 percent of Medicaid rate for hospitalization bed hold, 95 percent for therapeutic leave bed hold) governing fee-for-service Medicaid bed hold.

- Specialty Nursing Homes
  - A minimum of two of each type if available in each county.
  - If plans do not have a nursing home to meet the needs of its members, it must authorize out of network services.
  - Members will be allowed to change plans to access the desired nursing homes (no lock-in).
  - If network beds are not available at the time of placement, the plan must authorize out of network.
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Transition to Managed Care for Nursing Home Residents
- All Agreements will have the "New York State Standard Clauses for Managed Care Provider/PA Contracts".
- Due process rights must be included for providers that allow the provider to appeal any determination identified by the MCO.
- In the event a contract is terminated, for reasons other than imminent harm or fraud and abuse, the MCO may not require members to transfer to a participating NH.
- The rate of payment for the OON provider will be the fee for service rate in effect at the time of service.
- MCOs will establish a process to train contracted providers relating to claims adjudication.

LeadingAge NY has prepared FAQs on the details of the transition that are currently being reviewed by DOH.

Managed Care Standard Contracting Language

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Managed Care Strategies for Your Nursing Home

Scope of Nursing Home Services: A Nursing Home will:
- Provide any or all Nursing Home Services to Nursing Home Participants, as agreed to with the MCO;
- Report to the MCO on activities and services in a format and within timeframe designated by the MCO and/or NYSDOH, which requirements are negotiated and mutually agreed upon between the MCO and Nursing Home and promptly respond to the MCO’s requests for information regarding specific services provided to Members; and
- Provide data management to the MCO in compliance with the data submission requirements of the MCO and NYSDOH.

Managed Care Standard Contracting Language

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Managed Care Strategies for Your Nursing Home

Quality, Data and Reporting Requirements: Nursing Home shall comply with MCO Nursing Home data and reporting requirements, which are provided to Nursing Homes and includes adhering to MCO quality performance measures, and JCAHO/NCQA accreditation standards, as applicable to care management activities. As a condition of payment, Nursing Home shall report all required care management and patient data to MCO and NYSDOH, as required.

Managed Care Standard Contracting Language

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Managed Care Strategies for Your Nursing Home

Nursing Home Participant Re-Assignment or Termination: The parties recognize that there are many ways in which Nursing Home Participant status may change that may result in Re-Assignment or De-Activation. Upon prior reasonable notice to Nursing Home, MCO shall have the authority to De-Activate a Nursing Home Participant or Re-Assign Nursing Home Participants to another designated nursing home if the Nursing Home is not effectively providing or managing Nursing Home Services to the Member, not achieving quality goals, not adhering to the MCO’s protocols, or not meeting specific Member’s needs, as determined by the MCO after consultation with the Nursing Home. In addition, MCO may Re-Assign a Nursing Home Participant to another Nursing Home if the Member: a) requests Re-Assignment, b) relocates, or c) transfers to a Primary Care Provider who is affiliated with another nursing home. The MCO will De-Activate a Nursing Home Participant from the Nursing Home if the Member is no longer enrolled in the MCO or the MCO determines, in consultation with the Nursing Home, that the Member is not engaged in the Nursing Home Services or adhering to the plan of care.

Contracting process.

Determine your value proposition to the managed care plans.
Teamwork – Everyone Plays a Role in Success:

- Admissions
- Social Work
- Business Office
- Nursing/Clinical
- Administration
- Everyone Else

Cash Flow
Capital Reimbursement
Clean Claims
Resident Assessments

Although much of the contract language is standardized and proscribed, each plan is unique. More importantly, the billing manual drives the claims process and is subject to frequent revisions.

Service authorizations, pre-authorizations, clinical documentation submissions, and care planning issues need constant attention.

Plans may also have quality assurance and satisfaction survey requirements.

Plans also have certain oversight responsibilities.
Is there a UAS in your future?

Plans maintain their own care planning and care supervision responsibilities.

Fundamental to managed care is reducing rates of institutionalization.

The ultimate goal of managed care – risk sharing.

QUESTIONS?

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