Strategies: After the Managed Care Contract is Signed

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Vision for Medicaid
5 Years in the Future - How The Pieces Fit Together: MCO, PPS & HH

AGENDA
• Nursing Home Transition
• FIDA
• Medicare Advantage
• Internal Scans
• Legal Considerations

Managed Care - MLTC

<table>
<thead>
<tr>
<th>Enrollees</th>
<th>As of December 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York City</td>
<td>117,984</td>
</tr>
<tr>
<td>Rest of State</td>
<td>21,267</td>
</tr>
<tr>
<td>Statewide Total</td>
<td>139,251</td>
</tr>
<tr>
<td>Types of Plans</td>
<td>Actively Enrolling</td>
</tr>
<tr>
<td>Partial</td>
<td>33 (25 NYC)</td>
</tr>
<tr>
<td>PACE</td>
<td>8 (2 NYC)</td>
</tr>
<tr>
<td>MAP</td>
<td>8 (8 NYC)</td>
</tr>
</tbody>
</table>
### Managed Care – Current MLTC Leaders

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>County</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>GUILDNET</td>
<td>NASSAU</td>
<td>1557</td>
</tr>
<tr>
<td>GUILDNET</td>
<td>SUFFOLK</td>
<td>1474</td>
</tr>
<tr>
<td>ARCHCARE COMMUNITY LIFE</td>
<td>WESTCHESTER</td>
<td>435</td>
</tr>
<tr>
<td>FIDELIS CARE</td>
<td>ERIE</td>
<td>267</td>
</tr>
<tr>
<td>INDEPENDENT LIVING FOR SENIORS</td>
<td>MONROE</td>
<td>655</td>
</tr>
<tr>
<td>PACE CNY</td>
<td>ONONDAGA</td>
<td>476</td>
</tr>
</tbody>
</table>

### Managed Care – Nursing Home Phase-In

**Phase 1:** February 1, 2015  
New York City - Bronx, Kings, New York, Queens, and Richmond counties  
**Phase 2:** April 1, 2015  
Nassau, Suffolk and Westchester counties  
**Phase 3:** July 1, 2015  
Rest of State  
**October 1, 2015**  
Voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid.

### Managed Care – Conflict Free Eligibility Evaluations

- NY Medicaid Choice is performing the CFEEC activities for individuals in community seeking LTSS, which include:
  - Scheduling initial evaluations
  - Staffing nurse evaluators to perform in-home evaluations (hospitals and nursing homes)

*NOTE: Budget Bill 2015 included language to require expedited enrollment for “immediate need personal care and COPR cases”*

### Managed Care – Conflict Free Eligibility Evaluations

- The CFEEC will evaluate consumer’s eligibility for one of the four MLTC products:
  - Partially Capitated Plans
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Medicaid Advantage Plus (MAP)
  - Fully Integrated Duals Advantage (FIDA) (To be implemented January 2015)

*NOTE: Important to understand when arranging discharge*
Nursing Home Transition

- Effective 2/1/2015 the Nursing Home Population in the FIDA region began to transition into Managed Care.
- The Transition limited to New NH Residents in need of long term placement.
- Anyone that was permanently placed in a nursing home prior to the effective date of the transition will remain in FFS and will not be mandatorily enrolled in Managed Care.
- Residents under 21 will be excluded from the first wave of Mandatory NH transition.

- Existing MMCP enrollees will NOT be dis-enrolled if they require long term custodial placement.
- MMCP will be responsible for the NH benefit after January 31, 2015 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.

Internal Scan

- Verify transition status with your county
- Identify the MLTC and MMC Plans available
- Understand the enrollment numbers
- Review the status of everyone in the house
- Identify communication points with Plans and LDSS

- For 3 years after a county is deemed Mandatory Plans:
  - Benchmark Rate (updated 2x per year for case mix) including all scheduled rate changes; OR
  - Negotiated payment arrangement – required to be “alternative” – episodic, bundle, tier
- After the 3 year transition period, Plans and NHs will negotiate a rate of payment.
- The payment for the OON provider will be the fee for service rate in effect at the time of service.
Pharmacy will be covered by the MMCPs (Medicaid-only)
- The following will continue to be the responsibility of a nursing home and will be reimbursed within the nursing home benchmark rate:
  - Over the counter drugs
  - Physician administered drugs (J-code drugs)
  - Medical supplies
  - Nutritional supplements
  - Sickroom supplies
  - Adult diapers
  - Durable medical equipment
- Immunization services inclusive of vaccines and their administration will remain in the nursing home benchmark rate.

Absent a negotiated agreement the following will prevail:
- 3 year transition period - MMCPs must honor the current arrangements NHs have with pharmacies.
- If an enrollee is using a non formulary drug, member to continue receiving the drug for 60 days.
- After the 60 days, the MCO and provider may transition the member to a drug on the plan’s formulary, as appropriate.

Review Pharmacy arrangement
Negotiate with Plan
Identify non formulary drugs – 60 day timeframe for changes
Involve clinical staff

Primary Care Provider
- All MMCP enrollees must have a PCP.
- Members may retain their PCP when they transition from the community into a NH.
- MMCPs may use the NH physician as the PCP for a member but must inform DOH and ensure that the NH physician maintains the responsibilities similar to those of other network PCPs, including but not limited to:
  - Disease management, referrals, and hours of availability.
Internal Scan

- Review existing MD relationships and oversight
- Process for adding new PCPs if requested
- Process for managing relationships
- Does NH and Medical Director have mechanism to assure that medical care includes:
  - Disease management
  - Referrals (in-network)
  - Hours of availability that align with Plan standards

Nursing Home Transition

Reserved Beds

- MCOs are required to continue following the current methodology during the transition period unless an alternative is negotiated and agreed to.
- Reserved bed days related to leaves of absence for temporary hospitalizations shall be made at 50% of the Medicaid FFS rate.
  - 14 days in a 12 month period
- Reserved beds related to non-hospitalization leaves of absence shall be at 95% of the Medicaid rate.
  - 10 days in a 12 month period

NOTE: Could lead to variation by MCO contract

Nursing Home Transition

MC Network Standard NH Requirement:

- 8 – Queens, Bronx, Suffolk, Kings, Erie, Nassau, 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)

Nursing Home Transition

Network - 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.
- Members will be allowed to change Plans to access the desired nursing homes (no lock-in).
- If beds are not available at the time of placement, the Plan must authorize out of network.

NOTE: Identify any specialty beds separately; track occupancy closely; review decisions for taking out of network admissions; signing contracts
Nursing Home Transition

Networking Nuances:
- MCOs required to have Veteran’s NH in network
- Members can change Plans to access Veteran’s NH
- Plan must pay FFS rate to Veteran’s NH until Plan change
- FIDA Plans are required to have contracts with 8 nursing homes in each county where the plan operates
- FIDA plans must have contracts or payment arrangements with all nursing homes in each county the Plan operates

Nursing Home Transition

Credentialing
- Delegation of Credentialing NH employees to the NH.
- Plans must have a process to verify the NH is complying with Federal and State requirements.
- Plans will credential NH, but will minimize additional NH requirements.

NOTE: Review contract language and/or policy manual closely to assure the roles, responsibilities and reporting is clear.

Nursing Home Transition

Long Term Placement
- Nursing home physician or a clinical peer recommends permanent placement.
- Based upon medical necessity, functional criteria, and the availability of services in the community, consistent with current practice and regulation.
- Nursing home transmits the recommendation and supporting documentation to the MCO for review and approval.
- Once MCO has authorized the long term placement, the NH sends LDSS-3559 form with the approval from the MCO to the local district.

Nursing Home Transition

Medicaid Eligibility
- The nursing home and the MCO work together to assist the member in gathering documentation required by the LDSS to perform the eligibility determination.
- MCOs should utilize processes already in place at the NH for compiling required documentation and submitting the application for eligibility determination.
- Once an application is received, LDSS has 45 days to complete the eligibility determination for long term placement.
Nursing Home Transition

Medicaid Eligibility:
- MCOs must recoup for any period of ineligibility resulting from a transfer penalty.
- For current enrollees, MCOs are responsible for paying the nursing home the fee for service rate or agreed upon negotiated rate for that facility while long term eligibility is established by the local district.
- Individuals not currently enrolled in managed care and in need of long term placement will obtain long term eligibility determination from the local district prior to enrollment.

Nursing Home Transition

Medicaid Eligibility
- NAMI is being offset from the Medicaid Premium paid to the managed care plan.
- Plans have the Option to:
  1. Assume the responsibility to collect the NAMI and administer the personal needs allowance; or
  2. Negotiate with the Nursing Homes leaving the responsibility to collect NAMI with the homes

Internal Scan

- Identify the current processes for admission and eligibility – also discharge process
- Engage all appropriate clinical, financial and administrative staff
- Be clear about the communication process with the plan (each contract may have variations)
- Are the LDSS eligibility staff ready?
- Understand what documentation is needed for complete process this may impact on admissions agreement
- This should be in contract or clearly delineated in Policy Manual

Nursing Home Transition

Plan Selection and Enrollment
- After transition date, beneficiaries residing in a nursing home who are newly determined eligible for long term placement have 60 days to select a plan for enrollment.
- New York Medicaid CHOICE will be available to assist beneficiaries with education and plan selection.
- Beneficiary will select from plans contracting with the nursing home in which the individual resides.
- If a plan is not selected within 60 days, a plan that contracts with the nursing home will be assigned.
- Lock in rules will not apply to these individuals.
Internal Scan

• Understand who is receiving information from Medicaid Choices – track dates for enrollment
• Utilize resources of Medicaid Choices and Conflict Free Evaluations
• If residents or family have questions be prepared to assist and direct
• Will likely make process even more complex for residents and families in crisis – be prepared

Nursing Home Transition

Patient Care After Placement

• No change in Nursing Home responsibility for care
  • Conducts mandatory assessments and evaluations
• MCO now part of care plan development
  • Arranges for UAS-NY assessment every 6 months and when enrollee condition changes
  • Coordinates with nursing home to share assessment data
  • May review for service coverage and medical necessity
  • Reauthorizes stay under concurrent review at identified intervals, e.g., at time of assessment

• No change in Nursing Home responsibility for care
• MCO oversees quality of care provided; care plan implemented and sufficient to meet enrollee’s needs
• MCO arranges for other covered services enrollee needs
• MCO ensures enrollee has PCP
• Refer to case management, if needed
• MCO and NH coordinate efforts to meet quality goals

NOTE: This is in addition to all existing regulatory requirements of State and CMS

FIDA

• Individuals residing in nursing homes prior to January 1, 2015 will not be passively enrolled into FIDA.
• Individuals new to custodial status in nursing homes as of January 1, 2015 will be passively enrolled into FIDA on or after August 1, 2015
• Enrollment #s are low
**FIDA - Enrollment**

- All enrollments (Opt-in and Passive) will be through NY Medicaid Choice, which will provide counseling and assistance. Plans cannot perform enrollments into FIDA.
- FIDA eligible individuals enrolled in a Managed Long Term Care (MLTC) plan will “convert” to their Plan’s FIDA product, unless they choose another FIDA plan.
- Individuals may disenroll from FIDA at any time.

**FIDA Approved Plans**

<table>
<thead>
<tr>
<th>PLAN Name</th>
<th>Approximate Current Enrollment in FIDA Region</th>
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<tbody>
<tr>
<td>VNS Choice</td>
<td>82,000</td>
</tr>
<tr>
<td>Catholic Managed Health, Inc</td>
<td>400</td>
</tr>
<tr>
<td>Managed Health, Inc.</td>
<td>200</td>
</tr>
<tr>
<td>Elderplan, Inc.</td>
<td>11,000</td>
</tr>
<tr>
<td>ElderCare Health, Inc.</td>
<td>10,000</td>
</tr>
<tr>
<td>Centerlight Health, Inc.</td>
<td>2,700</td>
</tr>
<tr>
<td>NY Ash Catholic Health, Inc</td>
<td>460,000</td>
</tr>
<tr>
<td>Catholic Managed Long Term Care, Inc</td>
<td>400</td>
</tr>
<tr>
<td>Integra, MLTC</td>
<td>1,000</td>
</tr>
<tr>
<td>Centers for Healthy Aging, LLC</td>
<td>2,000</td>
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<tr>
<td>North Shore-LIJ Health Plan, Inc</td>
<td>1,200</td>
</tr>
<tr>
<td>Wellcare of New York, Inc.</td>
<td>169,000</td>
</tr>
<tr>
<td>Senior Whole Health of New York</td>
<td>1,580</td>
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<tr>
<td>Health Insurance of Greater New York</td>
<td>245,000</td>
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<tr>
<td>Medicare Health Plus, Inc.</td>
<td>416,000</td>
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<tr>
<td>Independence Care System, Inc</td>
<td>1,200</td>
</tr>
<tr>
<td>Atrisk New York, LLC</td>
<td>500</td>
</tr>
<tr>
<td>Montefiore HMO, LLC</td>
<td>500</td>
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**Medicare Advantage**

- 14 NY Counties have greater than 50% Medicare Advantage Penetration Rates (most are Upstate)
- Participation is expected to grow:
  - baby boomers familiar with managed care
  - lower cost to beneficiary
- Impacts on referrals based on Network partners
Medicare Advantage

- May represent a private pay opportunity
- Even in counties like Livingston, Ontario and Genesee, more than 50 percent of Medicare-eligible beneficiaries are enrolled in MA plans.

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>ELIGIBLES</th>
<th>ENROLLED</th>
<th>PENETRATION RATE</th>
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<tr>
<td>ALBANY</td>
<td>54,493</td>
<td>20,956</td>
<td>38.46%</td>
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<tr>
<td>NASSAU</td>
<td>241,644</td>
<td>124,046</td>
<td>51.33%</td>
</tr>
<tr>
<td>SUFFOLK</td>
<td>263,172</td>
<td>142,183</td>
<td>54.03%</td>
</tr>
<tr>
<td>WESTCHESTER</td>
<td>161,135</td>
<td>82,970</td>
<td>51.49%</td>
</tr>
<tr>
<td>NEW YORK</td>
<td>1,181,969</td>
<td>467,890</td>
<td>39.58%</td>
</tr>
<tr>
<td>ERIE</td>
<td>183,758</td>
<td>44,714</td>
<td>24.33%</td>
</tr>
</tbody>
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Increased Medicaid Enrollment

- New York State of Health Exchange
- New York picked up the Medicaid Expansion option
- The Medicaid population expanding due to effort; each year will continue to increase.

Increased Medicaid Enrollment – NYS of Health Data – April 2014

<table>
<thead>
<tr>
<th>Total Enrolled in Coverage</th>
<th>Eligible for Assistance</th>
<th>Medicaid/CHP Eligible</th>
<th>Number Selected a Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>960,762</td>
<td>103,769</td>
<td>590,158</td>
<td>370,604</td>
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</tbody>
</table>
State Budget Update

- In setting reimbursement rates, DOH will consider costs borne by the managed care program.
- Billing codes for community-based long-term care services will be based on universal standards for coding of payment.
- Long-term care providers will be paid via electronic funds transfer.
- Thirty days prior to submission of rates to CMS, managed care providers will receive an actuarial memorandum, along with all actuarial assumptions and other data used in the development of the rates.
- DOH will provide the Senate and Assembly annual Medicaid managed care operating reports from the managed care plans that are under contract with the state.

Internal Scan

- Identify the processes, trends & other factors driving performance
  - Intake processes – follow thru to billing
  - Documentation: regulations, accuracy, completeness & timeliness
  - Billing routines, timeliness & completeness
  - Payer mix
  - Software systems
  - Clinical & billing personnel performance
  - Quality of Care Processes
  - Personnel accountability for communications

Internal Scan

- Reviewing contracts from all perspectives:
  - Administration
    - Type of contract; scope of opportunity; network
  - Finance
    - Rates; costs
  - Clinical
    - Service definitions; supervision; assessments; training

Internal Scan – Quality

- Best practices
- Outcome measurement
- Electronic communications
- Using technology
- Patient and family involvement
- Training of patient and family
- Staff training, engagement
Legal Considerations

KEY QUESTIONS:
• Do you understand your contract and can you comply?
• Have you read and understood the Plan policies with the details of what you will need to do?
• How can this contract be terminated and what does that mean for you?
• Is the rate adequate and when will you be paid?
• Can payment be interrupted or delayed?
• Are you prepared to maintain and share data?
• How can disputes with plans resolved and how likely is a dispute with a plan?

Do You Understand Your Agreement?

• Is your agreement complete or missing key terms?
• Complete agreements are enforceable legal contracts that create civil liability
  • If you do not understand it, how can you comply?
  • Noncompliance can create civil liability and/or reportable incidents
• Reviewing Plan policies is critical
• Have you made a mistake?
  • Better to discover your mistake, than to let yourself breach the agreement
  • Mistakes can often be fixed

Legal Considerations

• How can the agreement be terminated – by Provider and Plan?
  • Many contracts are for a 1 year term
  • Some allow short-term termination option
    • Breach / "for cause" termination
    • "Not for cause" termination
  • Usually easier for the Plan to terminate
  • DOH notified of termination
  • Post-termination: NH required to continue providing services to Members indefinitely or for a defined period or until Plan makes other arrangements
    • Make sure you are paid for these services
Legal Considerations

- Is the rate adequate?
  - Internal Scan: do you need to reduce costs?

- What is your payment cycle?
  - Internal Scan: review effect on cash flow
  - This can be a point of negotiation

- Can payment be interrupted or delayed?
  - Payment delays and "errors"
  - Retroactive eligibility adjustments
  - Appeals process
  - Recoupment

- Data sharing and access
  - General record access
  - Record maintenance periods (usually 6-10 years)
  - Exceptions to confidentiality and privacy duties
    - Encounter Data for NYS Medicaid Program
    - Healthcare Effectiveness Data and Information Set (HEDIS)
    - Record retention requirements can be extended

- Plan agreements offer different types of dispute resolution mechanisms (continued)
  - Typically arbitration is the mechanism
    - American Arbitration Association is popular
    - Usually offers confidentiality, faster process
    - DOH is not bound by arbitration decisions so Plan and DOH will say they have no precedential value
  - Plans try to dictate a favorable location (venue)
  - Require written notice of dispute with a detailed explanation of the nature and basis
  - Short timeframe for submitting dispute

- Examples of areas of dispute
  - Plan amendment of policy or plan contract
  - Payment
  - Overpayment or recoupment claim
Questions? Need assistance?

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