

Review of Critical Managed Care Contracting, Transition, and Operating Issues

Leading Age New York Downstate Financial Managers

Presented By:

Steven Herbst
Director, Managed Care

Wednesday, March 19, 2014





What's Going on in the Market Today?

- ***Pending final CMS approval, the SNF transition to Managed Care is scheduled for April 1, 2014***
- Finalizing MCO rate setting
- Rates will be reflective of benchmark rates
- DOH will publish detailed rates so plans can see various components
 - Ancillary, capital, quality, etc
- Retroactive CMI adjustments will be included
- DOH is working with Mercer to identify CMI element in premium
- If plan has no SNF contract, members can choose any SNF, at the benchmark rate
- If SNF has no MCO contracts, residents can choose any plan at the benchmark rate

Proposed Transition Dates

- All eligible recipients over age 21 in need of **new** Long Stay/Custodial Placement will be required to enroll in Medicaid Managed Care or a Managed Long Term Care Plan
- Current custodial care consumers in a skilled nursing facility prior to April 1, 2014 will remain FFS and will not be required to enroll in an plan

Nursing Home Transition Phase-In Schedule

Month	County
April 1, 2014 Phase 1	New York City – Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, Westchester
October 1, 2014	For the above counties - voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid.
October 1, 2014 Phase 2	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chenango, Clinton, Columbia, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Orange, Oswego, Otsego, Putnam, Rensselaer, Rockland, St. Lawrence, Saratoga, Schenectady, Schoharie, Steuben, Sullivan, Ulster, Warren, Washington
November 1, 2014 Phase 3	Chemung, Cortland, Schuylar, Seneca, Tioga, Yates
December 1, 2014 Phase 4	Genesee, Livingston, Ontario, Orleans, Tompkins, Wayne, Wyoming
January 1, 2015	All remaining counties – voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid.

FIDA Enrollment Timeline

Community Residents

- Eligible community-based LTSS individuals will be informed no earlier than **April 1, 2014** of the opportunity to opt into a FIDA Plan for coverage starting no earlier than July 1, 2014.
- **April 2014**, approved FIDA plans will be able to begin marketing and enrolling eligible members for a July 2014 effective date
- **July 1, 2014** initial membership in FIDA becomes effective
- Beginning no earlier than **July 1 2014**, eligible community-based LTSS individuals will be notified of the state's plan for passive enrollment, which would begin no earlier than **September 1, 2014**.

SNF Residents

- Eligible SNF-based LTSS individuals will be informed no earlier than **July 1, 2014** of the opportunity to opt into a FIDA Plan for coverage starting no earlier than October 1, 2014.
- **July 2014**, approved FIDA plans will be able to begin marketing and enrolling SNF residents for a October 2014 effective date
- **October 1, 2014** initial membership in FIDA for SNF residents becomes effective
 - If you enrolled in an iSNP, you will not be subject to passive enrollment
- Beginning no earlier than **October 1 2014**, eligible community-based LTSS individuals will be notified of the state's plan for passive enrollment, which would begin no earlier than **January 1, 2015**.

Who Are the Managed Care Organizations

What Was

SNF RESIDENT LONG TERM CARE DUAL ELIGIBLE INSURANCE COVERAGE OPTIONS

	MEDICARE	MEDICAID
NYC	Fee for Service Medicare Advantage	Fee for Service MLTC

The New Normal

WHO PAYS THE SNF					
		Sub Acute		Long Term (Custodial)	
Medicare	Medicaid	Services	Drugs	Services	Drugs
FFS	N/A	RUGs	Part D	N/A	N/A
FFS	FFS	RUGs	Part D	FFS Medicaid	Part D
Medicare Advantage	N/A	RUGs or Levels	Part D	N/A	N/A
Medicare Advantage	FFS	RUGs or Levels	Part D	FFS Medicaid	Part D
Medicare Advantage	MLTC	RUGs or Levels	Part D	MLTC	Part D
FFS	MLTC	RUGs	Part D	MLTC	Part D
FIDA	FIDA	RUGs or Levels	FIDA	FIDA	FIDA
N/A	Medicaid Managed Care	Levels	Plan	Plan	Plan
N/A	MLTC	Levels	FFS Medicaid	MLTC	FFS Medicaid
N/A	HIV SNP	Levels	Plan	Plan	Plan

What Kinds of Plans

Medicaid Only

- Medicaid Managed Long Term Care (MLTC)
- Medicaid Managed Care
 - Family Health Plus
 - Child Health Plus
- Medicaid HIV Special Needs Plan

Medicare Only and Duals

- Medicaid Managed Long Term Care (MLTC)
- Medicare Advantage
 - Dual Special Needs Plan
 - Institutional Special Needs Plan
- Medicaid Advantage Plus
- Fully Integrated Duals Advantage (FIDA)

Services Plans will Pay For

PROVIDER SERVICES AUTHORIZED BY MANAGED CARE PLAN TYPE							
	<i>Medicare Advantage</i>	<i>MLTC</i>	<i>Medicaid Managed Care</i>	<i>FHP/ CHP</i>	<i>Medicaid Advantage Plus</i>	<i>FIDA</i>	<i>HIV SNP</i>
Sub-Acute SNF	✓	✓ (<i>Medicaid Only</i>)	✓	✓	✓	✓	✓
Custodial SNF		✓	✓ (<i>As of 4/1/14</i>)	✓ (<i>As of 4/1/14</i>)	✓	✓	✓ (<i>As of 4/1/14</i>)
Medical Adult Day Care		✓	✓ (<i>Limited</i>)	✓ (<i>Limited</i>)	✓	✓	✓ (<i>Limited</i>)
Social Adult Day Care		✓			✓	✓	
CHHA	✓	✓	✓	✓	✓	✓	✓
LHCSA		✓	✓ (<i>Limited</i>)	✓ (<i>Limited</i>)	✓	✓	✓ (<i>Limited</i>)

MLTC Plans

MLTC Region 1 Enrollment Analysis- February 2014

Plan	Feb '14		Feb '13		Growth #	Growth %
	Enrollment	Share	Enrollment	Share		
AETNA BETTER HEALTH	2,366	2%	151	0%	2,215	1467%
AGEWELL NEW YORK	2,609	2%	267	0%	2,342	877%
ALPHACARE	288	0%	0	0%	288	
AMERIGROUP	2,827	3%	2,637	3%	190	7%
ARCHCARE COMMUNITY LIFE	1,787	2%	137	0%	1,650	1204%
CCM SELECT	9,767	9%	7,179	9%	2,588	36%
CENTERS PLAN FOR HEALTHY LIVING	1,202	1%	1	0%	1,201	120100%
ELDERPLAN	10,674	10%	7,254	10%	3,420	47%
ELDERSERVE	10,319	9%	7,762	10%	2,557	33%
EXTENDED MLTC	207	0%	0	0%	207	
FIDELIS CARE AT HOME	6,907	6%	3,025	4%	3,882	128%
GUILDNET	14,347	13%	11,063	14%	3,284	30%
HHH CHOICES	2,358	2%	1,814	2%	544	30%
HIP OF GREATER NEW YORK	1,364	1%	497	1%	867	174%
INDEPENDENCE CARE SYSTEMS	5,067	5%	3,970	5%	1,097	28%
INTEGRA	817	1%	0	0%	817	
METROPLUS	472	0%	22	0%	450	2045%
MONTEFIORE HMO	135	0%	0	0%	135	
NORTH SHORE-LIJ HEALTH PLAN	515	0%	0	0%	515	
SENIOR HEALTH PARTNERS INC	11,011	10%	6,787	9%	4,224	62%
SENIOR WHOLE HEALTH	704	1%	131	0%	573	437%
UNITED HEALTHCARE	621	1%	78	0%	543	696%
VILLAGE CARE	2,631	2%	1,272	2%	1,359	107%
VNS CHOICE	17,541	16%	18,453	24%	-912	-5%
WELLCARE	5,384	5%	3,839	5%	1,545	40%
Grand Total	111,920		76,339		35,581	47%

NYC Medicaid & HIV SNP Plans

Medicaid Managed Care Enrollment Analysis- February 2014

Plan	Feb '14		Feb '13		Growth #	Growth %
	Enrollment	Share	Enrollment	Share		
Affinity Health Plan	203,789	8%	200,067	8%	3,722	2%
Amerigroup	346,549	13%	355,073	14%	-8,524	-2%
HealthFirst PHSP	700,083	27%	703,543	27%	-3,460	0%
HIP of Greater New York	194,633	8%	202,071	8%	-7,438	-4%
Hudson Health Plan	51,582	2%	47,330	2%	4,252	9%
MetroPlus Health Plan	362,230	14%	382,927	15%	-20,697	-5%
NYS Catholic Health Plan	387,322	15%	356,130	14%	31,192	9%
United Healthcare Plan of NY	279,295	11%	257,043	10%	22,252	9%
Wellcare of New York	64,679	2%	54,489	2%	10,190	19%
Grand Total	2,590,162		2,558,673	100%	31,489	1%

HIV SNP Enrollment Analysis- February 2014

Plan	Feb '14		Feb '13		Growth #	Growth %
	Enrollment	Share	Enrollment	Share		
Amida Care SN	5,915	36%	5,659	33%	256	5%
MetroPlus Health Plan SN	5,315	33%	5,628	33%	-313	-6%
VNS Choice SN	4,999	31%	5,676	33%	-677	-12%
Grand Total	16,229		16,963		-734	-4%

Medicare Plans

Medicare Advantage Enrollment Analysis- February 2014						
Plan	Feb '14		Feb '13		Growth #	Growth %
	Enrollment	Share	Enrollment	Share		
AETNA	25,201	4%	21,526	4%	3,675	17%
AFFINITY HEALTH PLAN	3,878	1%	3,564	1%	314	9%
ALPHACARE	225	0%	0	0%	225	#DIV/0!
AMERICAN HEALTH	15	0%	23	0%	-8	-35%
AMERIGROUP	9,790	2%	8,466	1%	1,324	16%
ANTHEM	534	0%	522	0%	12	2%
ARCHCARE	1,279	0%	1,003	0%	276	28%
ATLANTIS HEALTH PLAN	775	0%	554	0%	221	40%
BCBS OF MI	14	0%	0	0%	14	#DIV/0!
CENTERLIGHT HEALTHCARE	3,862	1%	3,140	1%	722	23%
CUATRO	3,240	1%	2,089	0%	1,151	55%
ELDERPLAN	12,824	2%	13,761	2%	-937	-7%
EMBLEM	136,654	22%	135,637	24%	1,017	1%
EMPIRE	103,126	17%	104,767	19%	-1,641	-2%
FIDELIS	10,502	2%	6,621	1%	3,881	59%
GUILDNET	608	0%	376	0%	232	62%
HEALTH FIRST	116,724	19%	106,537	19%	10,187	10%
HEALTHNOW NY	278	0%	11	0%	267	2427%
HIGHMARK	93	0%	99	0%	-6	-6%
HUMANA	840	0%	344	0%	496	144%
KAISER FOUNDATION	17	0%	19	0%	-2	-11%
LIBERTY HEALTH	4,695	1%	4,794	1%	-99	-2%
MCS ADVANTAGE	31	0%	29	0%	2	7%
METROPLUS	7,906	1%	6,432	1%	1,474	23%
MMM HEALTHCARE	126	0%	189	0%	-63	-33%
NY HOTEL TRADES COUNCIL	3,647	1%	3,510	1%	137	4%
PHYSICIANS UNITED PLAN	46	0%	15	0%	31	207%
PREFERRED MEDICARE CHOICE, INC.	0	0%	25	0%	-25	-100%
QUALITY HEALTH PLANS OF NY	277	0%	115	0%	162	141%
SENIOR WHOLE HEALTH	15	0%	30	0%	-15	-50%
TOUCHSTONE	13,129	2%	11,915	2%	1,214	10%
TRIPLE-S SALUD	11	0%	11	0%	0	0%
UNITED	113,820	18%	98,955	17%	14,865	15%
VNSNY CHOICE	15,802	3%	10,951	2%	4,851	44%
WELLCARE	25,505	4%	19,769	3%	5,736	29%
TOTAL	615,489		565,799		49,690	9%

Medicare Advantage dSNP Enrollment Analysis- February 2014						
Plan	Feb '14		Feb '13		Growth #	Growth %
	Enrollment	Share	Enrollment	Share		
AFFINITY	3,946	3%	3,578	3%	368	10%
ALPHACARE	91	0%	0	0%	91	
AMERIGROUP	5,632	4%	4,620	4%	1,012	22%
CUATRO	755	1%	0	0%	755	
ELDERPLAN	2,565	2%	2,051	2%	514	25%
EMBLEM	13,605	9%	12,607	10%	998	8%
FIDELIS	7,783	5%	4,727	4%	3,056	65%
GUILDNET	608	0%	379	0%	229	60%
HEALTH FIRST	65,133	45%	58,319	48%	6,814	12%
HUMANA	14	0%	0	0%	14	
LIBERTY HEALTH	766	1%	868	1%	-102	-12%
METROPLUS	6,205	4%	4,821	4%	1,384	29%
SENIOR WHOLE HEALTH	21	0%	35	0%	-14	-40%
TOUCHSTONE	2,006	1%	1,705	1%	301	18%
UNITED	7,848	5%	7,327	6%	521	7%
VNSNY CHOICE	12,328	9%	7,817	6%	4,511	58%
WELLCARE	15,113	10%	11,886	10%	3,227	27%
Grand Total	144,419		120,740		23,679	20%

Preliminary FIDA Applicants

Aetna Better Health of New York	HIP/Emblem
AgeWell New York	Independence Care System
AlphaCare of New York	Integra MLTC
Amerigroup New York	MetroPlus Health Plan
Archcare	Montefiore
CenterLight Healthcare	North Shore-Long Island Jewish
Centers Plan for Healthy Living	<i>Partners Health Plan (OPWDD FIDA)</i>
Elderplan	Senior Whole Health of New York
ElderServe Health	UnitedHealthcare of New York
Fidelis	Village Care of New York
GuildNet	VNS Choice
HealthFirst	WellCare of New York

Contracting

Long-Stay SNF Services Contracting

Proposed Managed Care Plan SNF Network Requirements

Counties	Contracted SNFs per County
Kings, Queens, Bronx, Suffolk, Nassau, Westchester, Erie, Monroe	8
New York, Richmond	5
Oneida, Dutchess, Onondaga, Albany,	4
Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster	3
All other counties	2 where available

- Plans must contract with 2 of each specialty SNF per county
 - HIV
 - Vent
 - TBI
 - Neuro
- FIDA and Medicare Advantage contracting requirements do differ from the above

Long-Stay SNF Services Contracting

- Plans will be required to contract with a minimum of 2–8 SNFs depending on the county
- Plans must enter into payment arrangements with any SNF if a resident enrolls in that plan
- Plans must authorize out of network SNF placement when the in-network providers do not have capacity
- Members will be allowed to change plans to access a preferred SNF

Provider Contracting

- All agreements must be negotiated in good faith
- All Agreements will have the “New York State Standard Clauses for Managed Care Provider/IPA Contracts”
- Due process rights must be included for providers that allow the provider to appeal any determination identified by the MCO

Provider Contracting

- 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 out of network providers will be the fee for service rate in effect at the time of service during the 3-year rate transition
- MCOs will establish a process to train contracted providers relating to claims adjudication

What to look for when contracting

- Rates
- Payment terms
- Early exit clauses
- Claim submission timeframes
- Denial timeframes

What to look for when contracting

- Appeals & grievance process and procedures
- Reporting expectations
- Care management requirements
- Quality & performance measures
- Provider manual

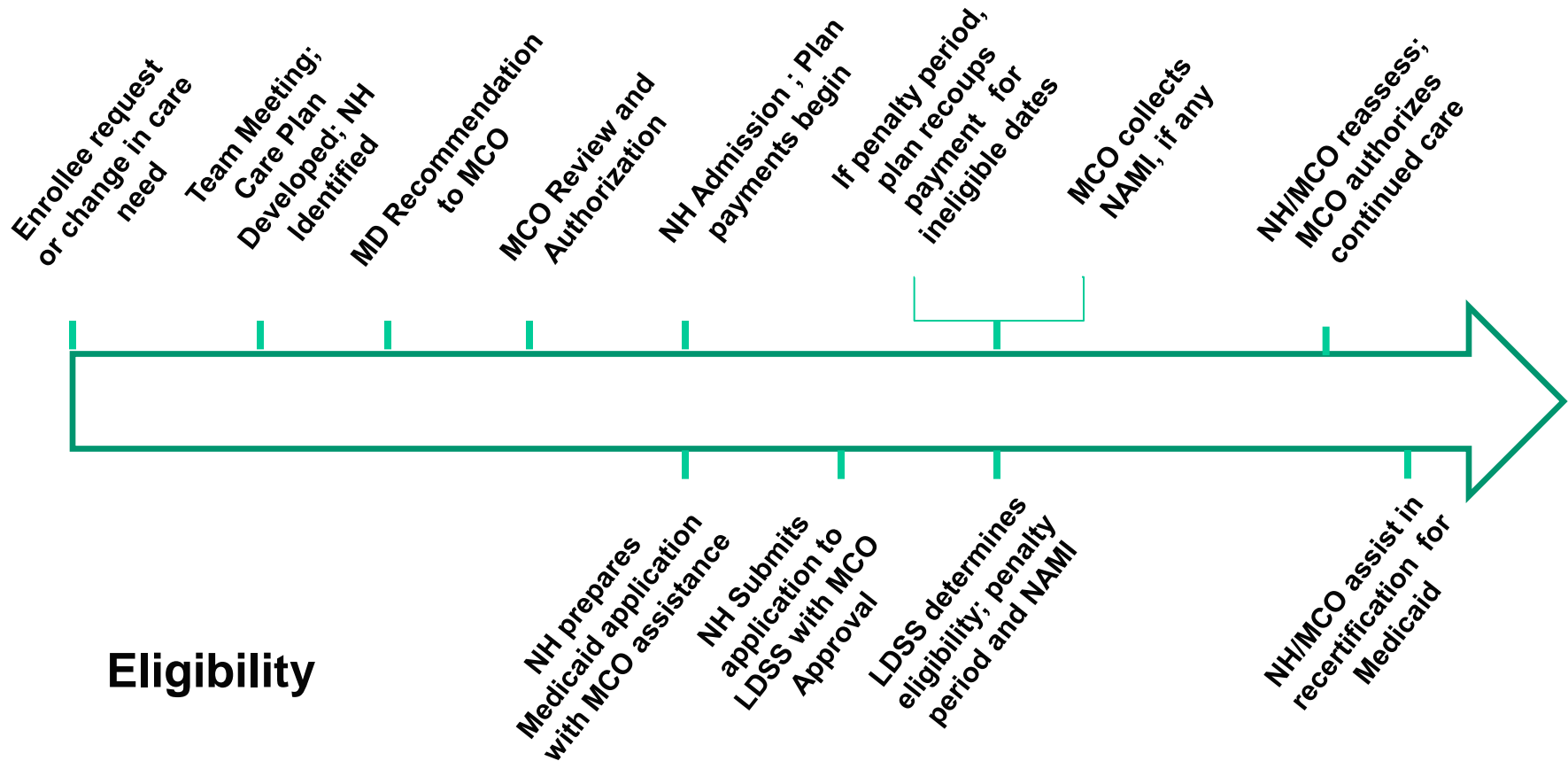
Credentialing

- Plans must credential the SNFs
- Credentialing of SNF staff may be delegated to the SNF
- MCOs must verify that the SNFs credentialing process complies with Federal and State requirements

Eligibility and Enrollment

Timeline of Eligibility and Placement

Placement Process





Long Term Placement

- Nursing home physician or a clinical peer makes the recommendation for permanent placement
- Recommendation is 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

Eligibility Process

- The nursing home and the MCO work together to gather documentation required by the LDSS to perform the eligibility determination
- Once all documentation is received, LDSS has 45 days to complete the eligibility determination for long term placement
- Eligibility will be determined using institutional rules, including a review of assets for the 60 months look-back period and the transfer of assets rules
- Budgeting rules will be used to determine NAMI that must be contributed toward the cost of nursing home care for individuals who are otherwise eligible and are not subject to a transfer penalty
- If LDSS determines there are uncompensated transfers during the look-back period, a transfer penalty is imposed and the individual is ineligible for coverage of nursing home care until the completion of the penalty period

Restriction/Exemption Codes

- The LDSS, upon approval of post eligibility budgeting, will enter specific Restriction/Exception (R/E) codes into WMS to identify the type of long term placement for managed care enrollees
- These R/E codes will appear on plan rosters
- ePACES will also reflect this information
- R/E codes will also drive MC premium rate payment

Restriction/Exemption Codes

Mainstream R/E codes

- N1 Regular SNF Rate
- N2 SNF AIDS
- N3 SNF Neuro-Behavioral
- N4 SNF TBI - MC Enrollee
- N5 SNF Ventilator Dependent
- N6 NH Penalty (*consumer is ineligible for NH services for determined period*)

MLTC R/E code

- N7 MLTC enrollee placed in SNF

Rosters

- MCOs will receive the following enrollee information via the Roster system:
 - MC Rate Code
 - NH Provider ID
 - Effective Date of Long Term placement
 - Exception Code (R/E)

- Nursing Homes will continue to receive their FFS roster

MCO Eligibility Process

- MCOs must recoup for any period of ineligibility resulting from a transfer penalty
- MCO is responsible for collecting any NAMI **but may delegate** this function to the nursing home
- 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

Plan Selection and Enrollment

- New long term residents in a nursing home who are determined eligible 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
- If a beneficiary wishes to transfer to another nursing home not in their MCO's network, the individual will be allowed to transfer to the plan that contracts with their desired facility

Scenario 1 – Current Enrollee Prior to 4/1/14

■ 3/30/ 2014

- Permanent placement is recommended by NH for current MMCP enrollee
- Individual is dis-enrolled to FFS Medicaid

■ 8/1/2014

- LDSS completes long term eligibility determination
- Enters eligibility determination into SDOH systems
- Notices sent to NH
- NH is responsible for Medicaid Renewals, NAMI collection

Scenario 2 – Current MCO Enrollee Post 4/1/14

■ 4/1/2014

- Permanent placement is recommended by NH for current MMC enrollee
- NH transmits recommendation to MCO for approval
- NH transmits LDSS-3559 with approval from MCO to LDSS

■ 9/1/2014

- LDSS completes long term eligibility determination, enters results of determination and RE code into SDOH systems
- Notices are sent to MCO and NH
- Roster is sent to MCO, including date of eligibility and NAMI
- NH receives its fee for service/negotiated rate from MCO during the period eligibility is being established
- MCO can bill retrospectively for appropriate enhanced rate for periods of eligibility
- NH can bill MCO retrospectively for appropriate enhanced rate

Scenario 3 – New Enrollment Post 4/1/14

4/1/2014

- Individual in community or FFS Medicaid enters NH
- Permanent placement is recommended by NH
- NH transmits LDSS-3559 to local district

8/1/2014

- LDSS completes long term eligibility determination, enters results and RE code into SDOH systems
- Notices are sent to NH
- Beneficiary selects MCO for enrollment within 60 days or is auto assigned to a plan
- Dually eligible individuals must enroll in MLTCP

11/1/2014

- Effective date of plan enrollment
- Roster is sent to MCO, including associated NAMI
- MCO can begin billing prospectively
- No retroactive enrollment or billing for period prior to enrollment

Scenario 4

MLTC Member Failed Transition to Custodial Medicaid

- MLTC member placed long term in a SNF and the local district denies their conversion to custodial Medicaid, they are to be disenrolled from the MLTC
- The MLTC is to return the premium to the State and collect what it paid from the SNF; the SNF is to collect its cost from the resident
- If the member is going back to the community, they would remain enrolled in the MLTC and the plan would be required to refund the State for the periods of ineligibility while in the SNF
- The MLTC would be allowed to keep the premium for the month in which they are working with the SNF on transitioning to make sure HCBS are provided for the member in the community
- If the person remains in the SNF, they will be discharged from the MLTC

Finance and Reimbursement

Transition Payments

- For at least 3 years after a county is deemed mandatory for the NH population and benefit, plans will be required to pay contracted NHs either:
 - Benchmark Rate (FFS Rate)
 - Negotiated Rate which is agreed to by both parties

- After the 3 year transition period, plans and NHs will negotiate a rate of payment

Pharmacy Services

- Pharmacy will be covered by the MMCPs
- Pharmacy costs are not included in the NH FFS rates
- Absent a negotiated agreement for this service the following will prevail:
 - During the 3 year transition period MMCPs must honor the current arrangements NHs have with pharmacies
 - If an enrollee is using a non formulary drug, MMCPs must allow the 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

Reserved Beds - Bed Holds

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

Cash Flow

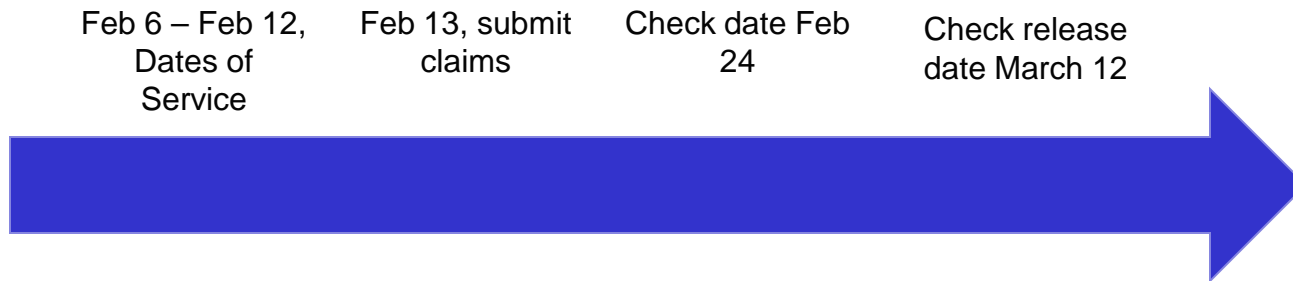
Cash Flow:

- Scenario 1 – Mainstream Managed Care patient is at NH for rehabilitation and goes into chronic care budgeting (CCB), the Plan will pay the NH at the benchmark rate during this period
- Scenario 2 – Managed Long Term Care patient regresses from the community into a long term NH stay, the Plan will pay NH the benchmark rate during the CCB process
- Scenario 3 – Fee-For-Service (FFS) patient requires long term NH stay and goes into CCB, the NH must wait until a determination is made and the member is deemed eligible for long term placement; then NH can bill FFS retro to the eligibility date. Once enrolled in Managed Care, the NH must bill the Plan

Cash Flow- Sample Timeline

FFS Long Term

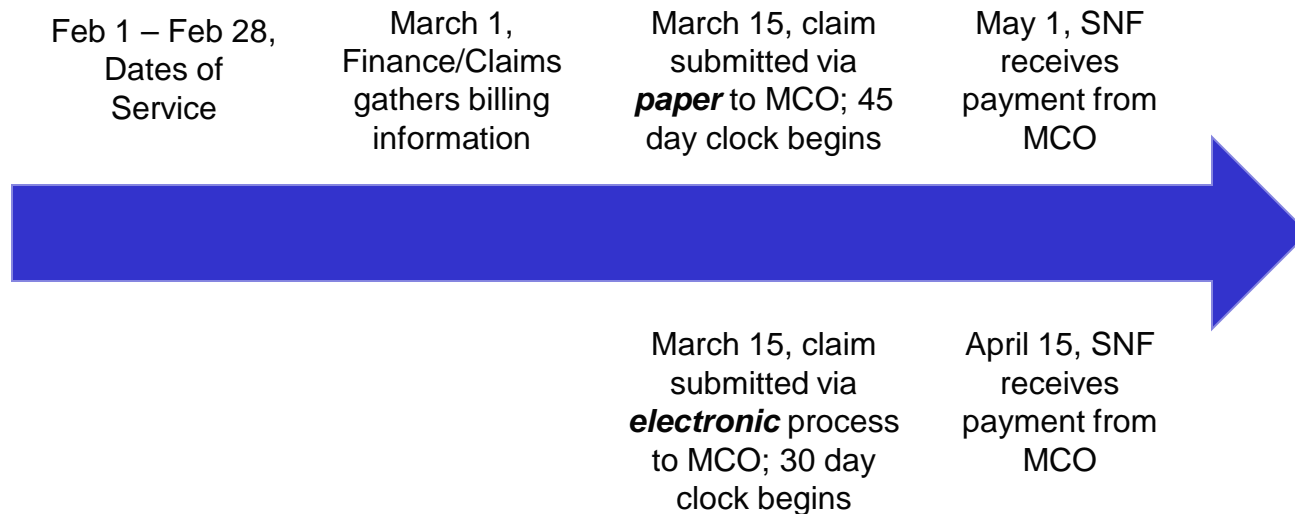
Current State



Cash Flow- Sample Timeline

MCO Long Term

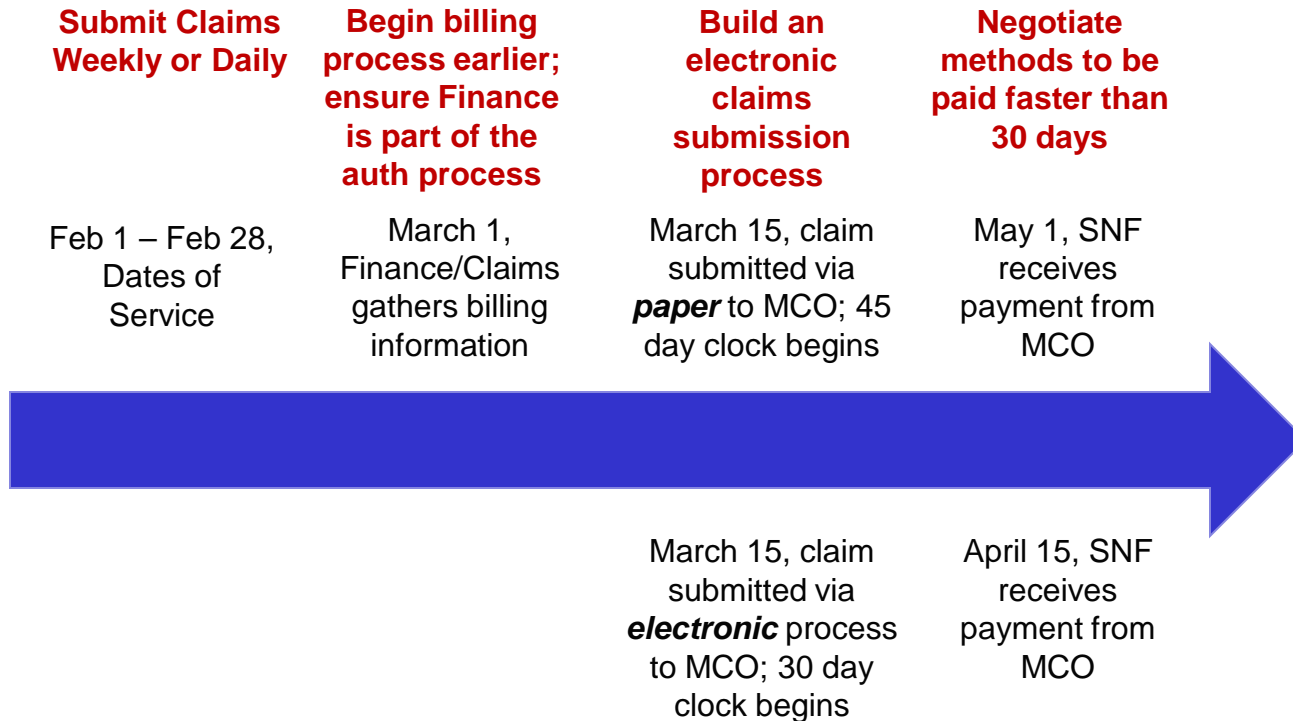
Future State



Cash Flow- Sample Timeline

MCO Long Term

Future State



Ancillary Services Plan Billing

- Mainstream – Included in premium/benefit
 - Scenario 1 – NH does cover physician benefit (in benchmark), Plan pays NH as part of benchmark rate
 - Scenario 2 – NH does not cover physician benefit (not in benchmark), Plan pays physician

- MLTC – Not included in premium/benefit
 - Scenario 1 – NH does cover physician benefit (in benchmark), NH bills FFS
 - Scenario 2 – NH does not cover physician benefit (not in benchmark, physician bills FFS)

- Therapeutic/ Hospital Leave days where a Nursing Home is required to reserve the bed for the patient the Plan will be required to pay the NH
 - Associated costs are reflected in the plan premium

NAMI

- It is anticipated that NAMI will be collected by the Plans, however, **Plans may delegate the responsibility to the NH via the contract process as currently allowed under MLTC**
- Upon the completion of the chronic care budgeting the Local District will notify the Plan of the NAMI amount to facilitate the collection process
- Distribution of the Personal Needs Allowance should be coordinated between Plans and providers during the contracting process
- In the future, the State is proposing to take over the collection of the NAMI for NH residents

Capital

- DOH is confident that CMS will approve the three year transition proposal related to the operating and capital components, and additionally, the continuation of capital component of the benchmark beyond the three year period
- This current proposal is intended to maintain stability and provide Nursing Homes with the resources to continue to pay long term debt commitments and access capital markets for future investments

Retroactive Rate Adjustments

- The FFS benchmark rate will be updated at a minimum of twice a year to account for case mix updates
- MCOs will be responsible for ensuring that any retroactive changes to the benchmark rates will result in a payment to Nursing Homes that are utilizing the rate in their contracts
- Plans and providers who choose to negotiate an alternate payment arrangement that is not based on the benchmark will likely avoid retroactive payments

Benchmark Rates

- The benchmark rate will include all aspects of the Nursing Homes reimbursement for a FFS patient, including but not limited to Operating, Capital, Per Diems, Cash Assessment and Quality
- The benchmark rate will be updated and published on the DOH Public Website at least twice a year <https://www.health.data.ny.gov>
- The contracting process should include the benchmark rate

Quality Pool & Published SNF Rates

- Quality pool for 2013 is estimated to be \$50M
- MCOs will include the quality pool score into their reimbursement
- The published SNF long-term rate cost components include

Non Medicare Direct Component	Misc Per Diem Adjustment
Medicare Eligible Direct Component	Bed Hold Per Diem Adjustment
Indirect Component	Case Mix Percent Adjustment
Non-Comp Component	Bed Count
Capital	Cash Receipts (CRA) Per Diem
TBI, BMI, Dementia Add On	Total Payment for NH Rate + CRA
Transition Adjustment	NHQP (Quality) Adjustment - Not Yet Approved
Quality Adjustment	Transportation In Direct Price

Shared Savings

- DOH is encouraging Plans and provider to work toward alternative payment arrangements, rather than FFS
- Shared Savings is being encouraged between all Plans and providers and has been included as a proposal in the 2014-15 Executive Budget
- All Plans and providers participating in the Fully Integrated Dual Advantage (FIDA) Demonstration will be encourage to enter into Shared Saving arrangements



Payment Model Concepts

■ Fee-for-Service

- Conventional reimbursement for every service provided

■ Capitation

- Lump sum payment for each enrolled member, per period of time, whether or not that person seeks care or uses services

■ Performance Bonuses

- Conditional income, paid out only if certain operational, quality or financial measures are met



Payment Model Concepts

■ Gain Sharing

- Assumes some financial responsibility for the profit and none for the potential loss in serving members

■ Partial Risk

- Assumes some financial responsibility for the profit and the potential loss in serving members

■ Full Risk

- Assumes full financial responsibility for the profit and the potential loss in serving members

Rate Codes

Mainstream	
Type	Rate Code
Regular SNF Rate	1821
SNF AIDS	1822
SNF Neuro-Behavioral	1823
SNF Traumatic Brain Injury	1825
SNF Ventilator Dependent	1826

MLTC	
Type	Rate Code
Partial Cap 21+ Nursing Home Certifiable	3479
HIV SNP	
Type	Rate Code
HIV SNP	TBD

Nursing Home Clean Claim Requirements

- A Clean Claim is a claim that can be processed without obtaining additional information

Member ID Number	Admission Source
Patient Name	Patient Discharge Status Code
Patient Date of Birth	Condition Code(s)
Patient Sex	Occurrence Codes and Dates
Subscriber Name/Address	Value Code(s) and Amounts
Patient Control Number	Revenue Code(s)
Facility Name and Address	Service Units
Tax ID Number	Charges per Service and Total Charges
National Provider Identifier -NPI	Principal, Admitting, and Other ICD-9 Diagnosis Codes
Type of Bill	Prior Payments
Statement Covers Period	Attending Physician Name and NPI
Admission Date and Type	Authorization Number

Common Causes of Claim Denials

- Claim missing required information
- Claim billed with invalid information, e.g.:
 - Incorrect Member ID#
 - Incorrect Provider NPI or TIN#
 - Invalid Rev Codes/Diagnosis Codes
- Member not eligible for date of service billed
- Wrong revenue code
- No prior authorization not obtained
- Untimely filing
- Duplicate claim

Preparing for the Transition

What Should You be Doing to Prepare for Managed Care?

- Business development
 - What's your value proposition
 - Growth strategies
 - Marketing and sales

What Should You Be Doing to Prepare for Managed Care?

- Negotiate and execute contracts
 - Specify payment terms

 - Develop acceptable payment options
 - e.g., incentive payments or risk sharing

 - Develop payment for quality outcomes

What Should You Be Doing to Prepare for Managed Care?

■ Know your financial operation

● Review cost structure

- Where can you be more efficient without reducing quality?
- Where can you invest to improve outcomes and quality?
- Who can you partner with to solve problems and achieve savings (e.g., shared services across providers?)

● Know your claims and accounts receivable processes

● What is your average managed care billed to collected timeframe

What Should You Be Doing to Prepare for Managed Care?

- Know your quality and outcomes
 - Know your readmission and hospitalization rate
 - Know your quality rating
 - Know your special programs and services that set you apart
 - What new products can you launch

What Should You Be Doing to Prepare for Managed Care?

- Systems and data
 - Electronic health records
 - Internal reporting capacity
 - Ability to share data with managed care companies

What Should You Be Doing to Prepare for Managed Care?

- Develop Managed Care strategy
 - Review your current managed care contracts
 - Identify who do you want to partner with?
 - How many contracts do you want to sign?
 - Why are you a good partner for a managed care plan?

Key Take-Aways

- Review the state of your operations
- Consider your counterparts as partners and not vendors/payers
- Negotiate value based contracts
- Develop alternative care models
- Focus on readmission avoidance programs
- Increase your focus on quality and outcomes
- Form alliances, such as IPAs

Questions?

Steven Herbst

Director of Managed Care
sherbst@loebandtroper.com

(212) 697-3000