

# LeadingAge NY 2015

## Budget Guidance

September 2014

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LeadingAge NY

# Budget Guidance

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## SNF PPS Rule

The Centers for Medicare and Medicaid Services (CMS) has released the skilled nursing facility (SNF) prospective payment system (PPS) [final rule for federal fiscal year \(FY\) 2015](#). This rule mandates the new SNF PPS Medicare Part A rates effective Oct. 1, 2014 and other programmatic changes. CMS has also issued a fact sheet on the final rule available by [clicking here](#).

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## SNF PPS Rule

Except for a slight change in the calculation of the net market basket increase (MBI), the final rule is consistent with the original [notice of proposed rulemaking](#).

CMS is implementing a 2.5 percent MBI minus a 0.5 percent multifactor productivity adjustment for a **net increase of 2.0 percent** in SNF PPS rates (the proposed rule originally contained a 2.4 percent MBI minus 0.4 for the same net 2.0 percent increase).

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SNF PPS Rule

## **Calculation of MBFE Based on FY 2013 Data.**

Forecasted MBI	minus Actual Increase	equals Difference
2.5 %	2.2 %	(0.3)

0.3 < 0.5 threshold therefore -0- MBFE for FY 2015

***Source: CMS SNF PPS Final Rule for FY 2015***

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## Medicare Part A and Sequestration

With the net 2.0 percent MBI overall Medicare Part A payments are set to increase by approximately \$750 million nationwide. However, providers should always keep in mind and budget for the ongoing impact of “sequestration.” Medicare provider payments were cut by 2 percent beginning April 1, 2013 as part of the [spending reductions](#) required by the [Budget Control Act of 2011](#) (i.e., sequestration). This means that while the schedule of payment rates is not directly impacted, overall Medicare payments to providers will continue to be reduced by 2 percent. [H.J. Res. 59, the Bipartisan Budget Act of 2013](#) signed into law this past December further extended sequestration through 2023.

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## **LeadingAge Rate Tool**

As always, [LeadingAge](#) is providing members with their SNF PPS Rate Calculator. This is an Excel™ spreadsheet that provides the Medicare Part A rates per county, and is available with member log-in by [clicking here](#).

The spreadsheet allows members to insert their estimated Medicare days per Minimum Data Set (MDS) Resource Utilization Group (RUG IV) category and project Medicare revenue and also provides the rate adjustments under sequestration. If any member has difficulty accessing the tool, please let me know I will be happy to assist.

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## SNF PPS Rule

### ***Administrative Presumption (no change in final rule)***

CMS is continuing the administrative presumption of coverage for individuals scoring in one of the upper 52 RUG IV (out of 66) categories on the initial 5-day and subsequent Medicare required assessments. The administrative presumption automatically classifies these individuals as meeting the skilled level of care needed for Medicare Part A coverage under the following categories:

Rehabilitation plus Extensive Services.

Ultra High Rehabilitation.

Very High Rehabilitation.

High Rehabilitation.

Medium Rehabilitation.

Low Rehabilitation.

Extensive Services.

Special Care High.

Special Care Low.

Clinically Complex.

An individual scoring in one of the lower 14 RUG IV categories is not automatically assumed to meet the skilled level of care and must be evaluated on an individual basis in order to trigger Part A coverage.

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## SNF PPS Rule

### ***Consolidated Billing (no change in final rule)***

Under [consolidated billing](#), the nursing home is financially responsible for covering all services provided to the Medicare beneficiary in a Part A stay, unless the service is specifically excluded from consolidated billing. In general, [the following services](#) are excluded from consolidated billing:

- Physician's professional services;
- Certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services;
- Certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and roundtrip ambulance services furnished during the stay that transport the beneficiary offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services;
- Erythropoietin for certain dialysis patients;
- Certain chemotherapy drugs;
- Certain chemotherapy administration services;
- Radioisotope services; and
- Customized prosthetic devices.

CMS provides a [specific listing of excluded services](#) by Health Care Common Procedure Codes (HCPCs) that providers can use to determine if a specific service is excluded. With each notice of proposed rule-making CMS seeks stakeholder input on any additions or changes to the listing of excluded services. For FY 2015, the final rule does not make any changes to this listing.



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## **SNF PPS Rule**

CMS is revising the existing COT OMRA policy to permit providers to complete a COT OMRA for a resident who is not currently classified into a RUG-IV therapy group, or receiving a level of therapy sufficient for classification into a RUG-IV therapy group, but only in those rare cases where the resident had qualified for a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay and had no discontinuation of therapy services between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the patient into a RUG-IV therapy group.

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SNF PPS Rule

## ***Additional Research and Stakeholder Input***

CMS has contracted with Acumen, LLC and the Brookings Institution to identify potential alternatives to the existing methodology used to pay for therapy services under the SNF PPS. Under the current model, the therapy payment rate component of the SNF PPS is based solely on the amount of therapy provided to a patient during the 7-day look-back period, regardless of the specific patient characteristics. The amount of therapy received is used to classify the resident into a RUG category, which then determines the per diem payment for that resident. Phase 1 of this project was completed in Sept. 2013. [CMS is reporting](#) on the most promising and viable options to be pursued in phase 2. CMS will convene a Technical Expert Panel during phase 2 to discuss available alternatives and present initial data analyses. Comments on this project may be sent to [SNFTherapyPayments@cms.hhs.gov](mailto:SNFTherapyPayments@cms.hhs.gov). Information can also be found on the [project website](#).

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## **SNF PPS Rule**

CMS is implementing a revised system of delineating the Core Based Statistical Areas (CBSAs) used to determine the Medicare wage index in a geographic region. For member convenience, LeadingAge NY has summarized the impact of the proposed changes in Table 2 by individual county. Unlike prior years, it is important that you check your wage index by specific county. There are instances in which an individual county in a CBSA will have a different wage index from the general index for the overall CBSA (note: Jefferson, Yates, Orange, Putnam, and Dutchess counties highlighted on the chart). Also, both Jefferson and Yates counties moved from “Rural” to “Urban” with a resulting net positive impact on the wage indices for these areas.

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## **DMEPOS Competitive Bidding**

Under the new rules, selected durable medical equipment, prosthetics orthotics and supplies (DMEPOS) will be subject to sole-source coverage by only those suppliers granted awards by CMS. The new Round 2 covers:

- Oxygen, oxygen equipment, and supplies
- Standard (Power and Manual) wheelchairs, scooters, and related accessories
- Enteral nutrients, equipment, and supplies
- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Negative Pressure Wound Therapy pumps and related supplies and accessories
- Support surfaces (Group 2 mattresses and overlays)

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## Medicare Part B

The Centers for Medicare and Medicaid Services (CMS) has released the proposed rule for the calendar year (CY) 2015 Medicare Physician Fee Schedule (MPFS), which includes Medicare Part B rates and policies for ancillary services provided by nursing homes and home health agencies. The rule in its entirety is available by [clicking here](#). In addition, a fact sheet issued by CMS is available by [clicking here](#). A separate CMS fact sheet on the quality initiatives in the proposed rule is available by [clicking here](#).

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## Medicare Part B

***Non Face-to-Face Payments:*** The CY 2014 final rule authorized a payment mechanism for service not related to a face-to-face visits effective Jan. 1, 2015. The CY 2015 proposed rule seeks to establish the details for how such a payment mechanism would work (see Chronic Care Management below).

***Transparency in Payment Policies:*** CMS is proposing a process that would increase transparency in the development of payment policies to take effect in 2016.

***Quality Reporting Initiatives:*** Proposed changes in this area would impact the Physician Quality Reporting System (PQRS), Medicare Shared Savings Program, and Medicare Electronic Health Record (EHR) Incentive Program, as well as changes to the Physician Compare tool on the Medicare.gov website.

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## Medicare Part B

***Sustainable Growth Formula (SGR):*** For several years now, the fact that annual payment adjustments have been tied to the SGR formula has created the unfortunate circumstance of projecting ever increasing negative rate adjustments that require Congress to act to override. This current proposal does not include the impact of the SGR on CY 2015 rates. Since the application of the SGR formula is mandated under statute, CMS does not announce the final rates until Nov. However, we can predict from recent trends that once again the SGR will mandate a significant reduction in rates, which Congress will need to override. Due to special legislation passed by Congress this year, current rates are protected through March 31, 2015. However, for the remainder of 2015 the SGR will likely call for a negative rate adjustment in excess of 20 percent. Again, Congress has always acted to avert these large negative adjustments as CMS continues to struggles with developing an alternative to the SGR. For budgeting purposes I would assume Medicare Part B 2015 payment rates level with 2014.

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## Medicare Part B

***Physician Value-Based Purchasing:*** The proposed rule continues the phase in of the physician value-based payment modifier as mandated under the Affordable Care Act tying traditional physician and other professionals Medicare fee-for-service payments to certain quality and cost measures.

***Primary Care and Chronic Care Management (CCM):*** As part of its initiative to promote primary care services, CMS is proposing a policy to implement separate payment for non-face-to-face chronic care management services for Medicare beneficiaries with multiple chronic conditions, including care planning, coordination of services and medication management. The rule does not include separate CCM standards as CMS believes the methodology established last year is sufficient for CCM purposes. CMS is, however, looking for stakeholder input on whether additional standards are needed specifically to deal with electronic health records under CCM.



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## Medicare Part B

**Misvalued Codes:** CMS continues its efforts to identify and correct potentially misvalued codes, both through their own internal algorithms and based on public input. In the case of radiation therapy services, they are seeking a reduction in payments that would be redistributed to other MPFS services. They are also seeking to update the practice expense units associated with new digital x-ray technology replacing analog film.

**Global Surgery:** The proposed rules seeks to split the global surgery code between services provided on the day of surgery and those provided post-surgery beginning in 2017.

**Telehealth Services:** CMS is proposing to add the following to the list of services that can be reimbursed under the telehealth benefit: annual wellness visits, psychoanalysis, psychotherapy, and prolonged evaluation and management services.

**Adjustments to Malpractice RVUs:** CY 2015 represents the third consecutive review and update of the malpractice relative value units, based on updated professional liability insurance premiums.

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## Medicare Part B

***Revisions to Geographic Practice Cost Indices (GPCIs):*** The proposed GPCIs reflect the elimination of the 1.0 work GPCI floor from April 1, 2015 through December 31, 2015.

***Off-Campus Provider-Based Departments:*** CMS is proposing a new modifier to report services furnished in off-campus provider-based departments on both hospital and physician claims in order to collect data on such services to be used to further evaluate the payment policies in this area.

***Open Payments:*** Open Payments is a national disclosure program that publishes information about these financial relationships between drug and device manufacturers and certain health care providers on a publicly accessible website developed by CMS. It also requires certain manufacturers and group purchasing organizations (GPOs) to report ownership, interests, or payments involving physicians or their immediate family members. Under the proposed rule, CMS is recommending several changes to the program.

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## Medicare Part B

President Obama has signed the [Pathway for SGR Reform Act of 2013](#) into law. This new law prevents a scheduled payment reduction in the [Medicare Physician Fee Schedule](#) (MPFS). The MPFS includes Medicare Part B rates for therapy and other ancillary services provided by nursing homes, home health agencies, and suppliers.

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## Medicare Part B

The new law contains three important features:

**Section 101** of the new law overrides the previously announced 20.1 percent reduction in Medicare Part B rates and substitutes an overall 0.5 percent increase in the MPFS for the period of Jan. 1, 2014 through March 31, 2014;

**Section 103** extends the therapy caps exceptions process and application of the KX modifier through March 31, 2014 (for the CMS therapy caps and the exceptions process website, please [click here](#)); and

By extending certain provisions of the [American Taxpayer Relief Act of 2012](#), **Section 103** also extends the mandate that Medicare perform manual medical review of therapy services for the same period of Jan. 1, 2014 through March 31, 2014. This review applies when the exceptions process is triggered and the beneficiary has reached a dollar aggregate threshold amount of \$3,700, including hospital outpatient department therapy services. The two separate \$3,700 aggregate annual thresholds remain unchanged: (1) physical therapy and speech-language pathology services combined and (2) a separate threshold for occupational therapy services.

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## **CMS Electronic Prescribing Incentive Program**

The Medicare Electronic Prescribing Incentive (eRx) Program for eligible professionals includes a combination of incentive payments and negative payment adjustments related to meeting eRx thresholds. The incentive percentages are one percent of total Medicare Part B payments in 2012 and 0.5 percent in 2013. The eRx program ends after 2014.

[MLN Matters # SE1206](#)

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## New Timely Filing Requirements

- For **institutional claims** that include span dates of service (i.e., a “From” and “Through” date span on the claim), the **“Through” date on the claim will be used to determine the date of service for claims filing timeliness.**
- For **professional claims (CMS-1500 Form and 837P)** submitted by physicians and other suppliers that include span dates of service, the line item **“From” date will be used to determine the date of service and filing timeliness. (This includes supplies and rental items).**

[MLN MM7080](#)

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## State Receives 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 reinvest, 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 [Delivery System Reform Incentive Payment \(DSRIP\) Program](#) – including DSRIP Planning Grants, DSRIP Provider Incentive Payments, and DSRIP administrative costs;

\$500 Million for the Interim Access Assurance Fund – temporary, time-limited funding to ensure current trusted and viable Medicaid safety 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.

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## **State Delays FIDA Enrollment**

- DOH announced new enrollment schedules for the Fully Integrated Dual Advantage (FIDA) demonstration. FIDA is a model of managed long term care that will integrate Medicaid and Medicare funding and services in New York City, Long Island and Westchester County. Voluntary enrollment for community based populations originally scheduled to begin in September of 2014 will now begin in October. The start date for voluntary enrollment for dually eligible nursing home residents was, and remains, October 2014.
- Passive enrollment for community based populations originally scheduled to begin in September of 2014 will now start in January 2015. Passive enrollment for dually eligible nursing home residents was, and remains, January 2015.



# Vocabulary

- ACO = Accountable Care Organization – a product of the Affordable Care Act
- BHO = Behavioral Health Organization / Utilization Management focus
- BIP = Balance Incentive Program
- DISCO = Developmental Disability Individual Service Care Organization
- DSRIP = Delivery System Reform Incentive Payment
- FFS = Fee for Service
- FIDA = Fully Integrated Duals Advantage
- HARP = Health and Recovery Plan (set of behavioral services available from an MCO)
- Health Homes = Care Coordination / Management on a regional basis with integration of provider networks
- MAP (Medicaid Advantage Plus) = combination of Medicaid managed long term care plan and Medicare Advantage plan
- MCO = Managed Care Organization a.k.a. Health Plan
- Medicaid Advantage = Medicaid managed care for dual eligible not in need of LTC
- Medicare Advantage = Medicare managed care
- MLTC = Managed Long-Term Care Plan
- MMCP = Mainstream Medicaid Managed Care Plan
- PACE Program = Program for All-Inclusive Care for the Elderly
- VAP = Vital Access Provider

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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 LTC populations.

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## **Transition to Managed Care for Nursing Home Residents**

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.

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## **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.

# Budget Guidance

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## **Transition to Managed Care for Nursing Home Residents**

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.

# Budget Guidance

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## **Transition to Managed Care for Nursing Home Residents**

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.

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## **Transition to Managed Care for Nursing Home Residents**

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.



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## **Transition to Managed Care for Nursing Home Residents**

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)

# Budget Guidance

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## **Transition to Managed Care for Nursing Home Residents**

- 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.

# Budget Guidance

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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/IPA 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.

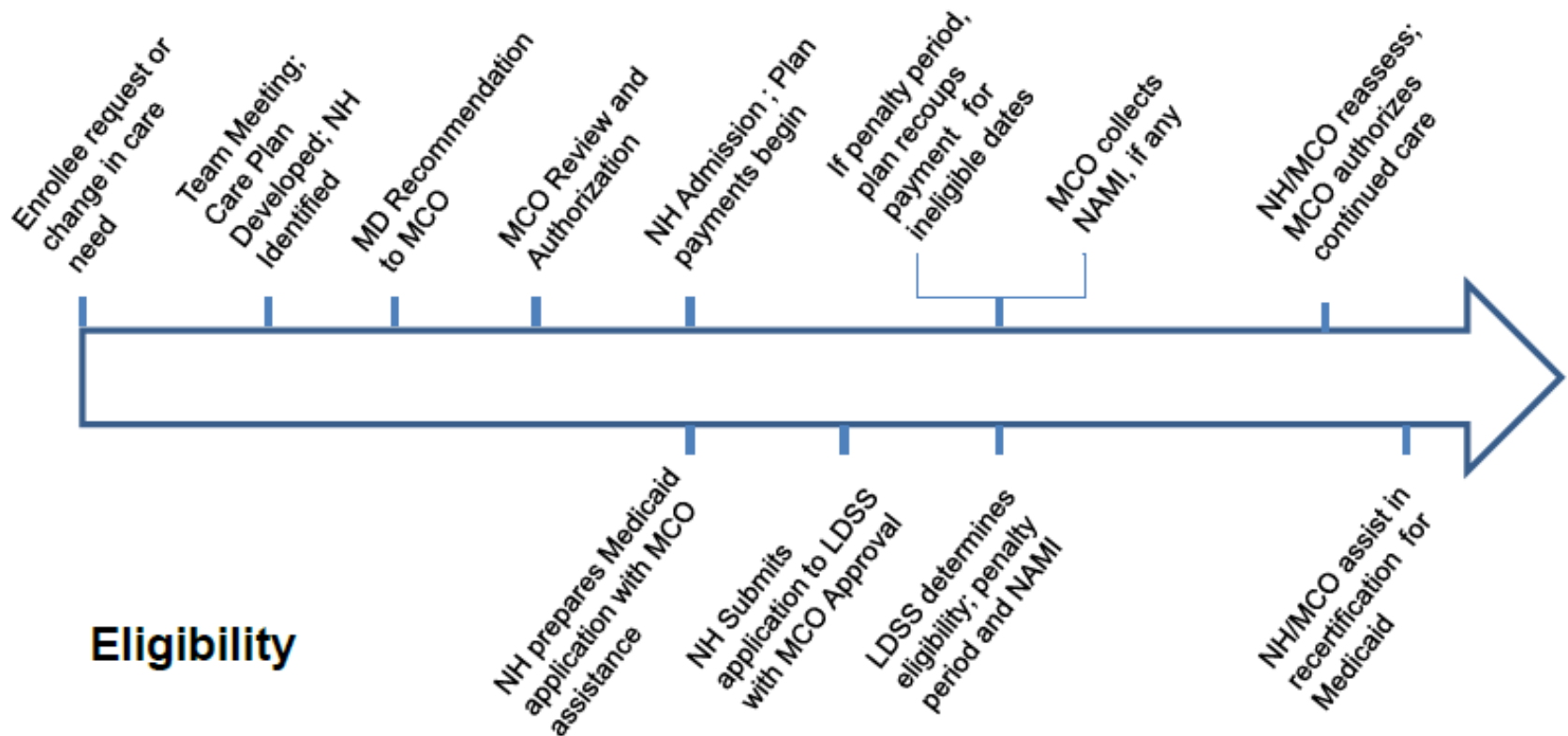
LeadingAge NY has prepared FAQs on the details of the transition that are currently being reviewed by DOH.

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## Timeline of Eligibility and Placement

### Placement Process



Source: NYS DOH Presentation on NH Resident Transition to MC

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## State's Target Managed Care Enrollment

Medicaid Fee for Service Transition to Managed Care (Populations) FY 2015					
Effective Date	Populations	From (COS)	To (COS)	# of Targeted Enrollees	FY 2015 Enrolled
June 2014	Community Based LTC – Rest of State	OLTC	MLTC	16,503	5,903
October 2014	Nursing Home – Primary FIDA Region	NH	MMC / MLTC	4,556	
January 2015	BHO/HARPS	OMH / Various	MMC	TBD	

# Budget Guidance

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## **Nursing Home Bed Hold Changes**

The Bed Hold [DAL](#) sets out three varieties of bed reservation days:

1. Leave of absence for temporary hospitalization (reimbursed 50 percent of Medicaid rate);
2. Leave of absence for visits to a health care professional that are expected to improve the patient's physical condition or quality of life (95 percent of the rate); and
3. All other leaves of absence (95 percent of the rate).

The 12-month combined limit for hospitalization and health care professional leaves (numbers 1 and 2 above) is 14 days. The 12-month limit for “other” leaves of absence is 10 days (in addition to the combined 14 day limit). These changes do not apply to residents under the age of 21.

The DAL also provides new rate codes associated with each type of leave.

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Governor Cuomo's \$137.2 billion Executive Budget for state fiscal year (SFY) 2014-15 increases overall spending by 1.7%, the fourth consecutive year of 2% or less growth. The plan provides for 3.8% growth in Medicaid spending, restores the 2% across-the-board Medicaid provider cut, authorizes global cap shared savings and advances a \$489 million tax cut package.

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***Global Cap Authority:*** Extends the Medicaid global spending cap for one year to March 31, 2016 along with the authority of the Commissioner of Health and State Budget Director to reduce spending if Medicaid expenditures are exceeding projections.

State share Medicaid spending is limited to \$17.1 billion in SFY 2014-15 and \$17.9 billion in SFY 2015-16. The Legislature added detailed reporting requirements around how the cap is set and tracking of expenditures by service line.



# Budget Guidance

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## Medicaid Spending By Category (April-June 2014)

Medicaid Spending – FY 2015 (dollars in millions)			
Category of Service	Estimated	Actual	Variance Over / (Under)
Medicaid Managed Care	\$2,858	\$2,861	\$3
Mainstream Managed Care	\$2,119	\$2,130	\$11
Long Term Managed Care	\$739	\$731	(\$8)
Family Health Plus	\$148	\$165	\$17
Total Fee For Service	\$2,360	\$2,337	(\$23)
Inpatient	\$758	\$762	\$4
Outpatient/Emergency Room	\$104	\$107	\$3
Clinic	\$150	\$147	(\$3)
Nursing Homes	\$820	\$815	(\$5)
Other Long Term Care	\$183	\$178	(\$5)
Non-Institutional	\$345	\$328	(\$17)
Medicaid Administration Costs	\$113	\$117	\$4
OHIP Budget / State Operations	\$38	\$28	(\$10)
Medicaid Audits	(\$72)	(\$63)	\$9
All Other	\$572	\$562	(\$10)
Local Funding Offset	(\$1,844)	(\$1,844)	\$0
<b>TOTAL</b>	<b>\$4,173</b>	<b>\$4,163</b>	<b>(\$10)</b>

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## Regional Medicaid Spending (April-June 2014)

Medicaid Regional Spending – FY 2015 (dollars in millions)	
Economic Region	Non-Federal Total Paid
New York City	\$3,491
Long Island	\$583
Mid-Hudson	\$558
Western	\$282
Finger Lakes	\$244
Capital District	\$205
Central	\$145
Mohawk Valley	\$121
Southern Tier	\$109
North Country	\$83
Out of State	\$31
<b>TOTAL</b>	<b>\$5,852</b>

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## Medicaid Enrollment Changes (April-June 2014)

Medicaid Enrollment Summary FY 2015			
	March 2014	June 2014	Increase / (Decrease)
Managed Care	4,116,631	4,383,461	266,830
New York City	2,589,433	2,730,083	140,650
Rest of State	1,527,198	1,653,378	126,180
Fee-For-Service	1,578,313	1,413,140	(165,173)
New York City	785,320	692,926	(92,394)
Rest of State	792,993	720,214	(72,779)
TOTAL	5,694,944	5,796,601	101,657
New York City	3,374,753	3,423,009	48,256
Rest of State	2,320,191	2,373,592	53,401

*NOTE: Most current four months counts are adjusted by lag factors (2.33%, 1.08%, 0.43% and 0.15%, respectively to account for retroactive eligibility determinations)*

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***Global Cap Shared Savings:*** Authorizes distribution of savings accruing from the Medicaid global cap to be distributed proportionately to Medicaid providers and Medicaid managed care plans. Up to 50 percent of the funding would be earmarked for distribution to financially distressed and critically needed providers.

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***Two-percent Cut Restoration:*** Restores the across-the-board two percent cut to Medicaid rates effective April 1, 2014 while maintaining the authority to continue alternative cost containment arrangements (e.g., assessment taxes, etc.) that were made in lieu of the two percent cut.

Cut was eliminated then put back pending CMS approval.

For nursing homes, the .8 percent un-reimbursable assessment will continue. When CMS approval to restore two percent cut is received, state intends to increase Medicaid rates.

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***Vital Access Provider (VAP) Program:*** Authorizes the VAP program in law for all currently eligible providers (i.e., hospitals, nursing homes, Certified Home Health Agencies (CHHAs) and clinics), and expands eligibility for the program to also include licensed home care services agencies, consumer directed personal assistance programs and behavioral health providers. A total of \$313 million was appropriated for the program in SFY 2014-15.

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## The Vital Access Provider/Safety Net (“VAP”) Program

- Authorizes temporary Medicaid rate adjustments to financially challenged providers to reconfigure their operations in a way that promotes financial stability, improves access to services, enhances quality of care and/or reduces Medicaid costs
- Successful applicants receive a temporary Medicaid rate adjustment for a specified period of time, as approved by DOH, of up to three years. The amount of the adjustment is based on the project operating costs approved through the application process and incurred subsequent to application approval. Capital costs are **not** eligible for VAP funding.
- In order to qualify for VAP funding, an eligible provider (i.e., nursing home, hospital, CHHA, DTC, LHCSA or CDPAP FI) must demonstrate that it has financial need and also meets one or more of the following baseline requirements:
  - is undergoing closure;
  - is impacted by the closure of other health care provider(s) in its service delivery area;
  - is undergoing a merger, acquisition, consolidation or restructuring; and/or
  - is impacted by the merger, acquisition, consolidation or restructuring of other health care provider(s) in its service delivery area.

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## The Vital Access Provider/Safety Net (“VAP”) Program

- Providers that are interested in applying for VAP funding may submit their applications at any time. However, DOH reserves the right in the future to accept applications through formal Requests for Applications or Requests for Proposals.
- The first step in the process is for the applicant to complete and submit the VAP Mini Application (and Excel-based form) to the Bureau of Vital Access Provider Reimbursement at: [BVAPR@health.state.ny.us](mailto:BVAPR@health.state.ny.us).
- Once DOH receives a Mini Application, it is evaluated by examining measures such as operating margin, Medicaid payer mix, occupancy rate, cash on hand and debt. Other criteria include the entity’s financial viability, community needs, quality improvement and health equity. Applications from all provider types are evaluated, with the top scoring applications selected to receive award letters and develop full proposals.



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## **SFY 2013-14 and 2014-15 Vital Access Provider (VAP) Awards**

VAP Program Awards (dollars in millions)				
Provider Type	# of Providers	Total Amount Awarded	FY 2014 Disbursed	FY 2015 Actual - YTD
Hospitals	25	\$148	\$64	\$9
Diagnostic & Treatment Centers	18	\$36	\$3	-
Nursing Homes	8	\$33	\$17	\$3
Critical Access Hospitals	23	\$16	\$5	-
Certified Health Home Agencies	2	\$5	\$2	-
<b>TOTAL</b>	<b>76</b>	<b>\$238</b>	<b>\$91</b>	<b>\$12</b>

# Budget Guidance

September 2014

***Delivery System Reform Incentive Payment (DSRIP) Program:***

Authorizes funding for incentive grants under DSRIP, a major component of the state's \$8 billion MRT waiver with the Federal government. The legislation: (1) seeks to ensure that DSRIP incentive payments are made available statewide; (2) establishes a panel to advise the Commissioner on applications for funding; (3) requires the Commissioner to report quarterly to the Legislature on DSRIP progress; and (4) authorizes state agencies to waive regulations to eliminate duplicative requirements and promote efficiency.

# Budget Guidance

September 2014

- ***Capital Restructuring Financing Program***
- ***Health Care Facility Restructuring Pool***
- ***Health Information Technology***
- ***Certificate of Need***
- ***Regional Health Improvement Collaboratives***
- ***Private Equity Ownership of Hospitals, Nursing Homes and Clinics***

# Budget Guidance

September 2014

***Spousal Refusal:*** Rejects the Governor's proposal to eliminate the ability of individuals to qualify for Medicaid when living with spouses who refuse to support them.

***Medicaid Liens:*** Modifies the authority to impose liens on the property of certain individuals permanently placed in nursing homes and intermediate care facilities.

***Medicaid Estate Recoveries:*** Limits recoveries from the estates of beneficiaries, who qualify for Medicaid under the Modified Adjusted Gross Income test, to amounts expended for nursing home services, home and community-based services, hospital services and prescription drugs.

***Integrated Eligibility System:*** Allows the state to enter into a non-competitive contract to implement an integrated eligibility system covering Medicaid and human services programs, subject to the availability of enhanced federal financial participation.

***Eligibility Integrity:*** Authorizes DOH to enter into a non-competitive contract to review the accuracy of determinations of eligibility and eliminate duplicative benefits.

# Budget Guidance

September 2014

**Supportive Housing:** The final budget **decreases** funding for MRT supportive housing initiatives from \$260 million in the Executive Budget Proposal over a two year period, to \$222 million. The MRT Affordable Housing allocation plan is predicated on \$100 million being available in 2014-15. We do not know whether the reduction in funding will be attributed to this budget year or 2015-16 or both. Included is funding generated from Medicaid savings (\$6.6 million state share) associated with the closure of three nursing homes and four hospitals and the decertification of nursing homes and hospital beds effective April 1, 2014. Funding will be used for MRT supportive housing initiatives. LeadingAge NY is working to ensure that our members benefit from these initiatives and that funding will go to support affordable senior housing.

**Expand Affordable Housing Opportunities:** \$100 million is allocated in a final agreement for storm recovery funds to be invested to create and preserve 3,000 affordable housing units in multi-family developments.

**House NY Program Investments:** Adds \$40 million in new capital resources, supplementing the House NY program that was initiated last year.

**Neighborhood and Rural Preservation Programs:** Funded at \$1,594,000 and \$665,000, respectively.

**Naturally Occurring Retirement Community (NORC)/Neighborhood NORC:** Maintains previous year's funding levels of \$2.027 million for each program.

# Budget Guidance

September 2014

**EnAble:** As advocated by LeadingAge NY, includes approximately \$7 million in additional past EnAble funds, including funding for the purchase of generators.

**Criminal History Record Checks:** Requires all adult care facilities (ACFs) to conduct criminal history record checks for prospective employees, and authorizes reimbursement for them as is done in nursing homes and home care agencies. The budget allocates \$3.3 million for expenses related to this new initiative.

**Supplemental Security Income (SSI) Enriched Housing Subsidy:** The SSI Enriched Housing Subsidy was funded at \$475,000; the same level as last year. The subsidy is for up to \$115 per month for each SSI recipient who resides in not-for-profit certified enriched housing programs, and is paid directly to the certified operator. If appropriations are insufficient to meet the \$115 monthly amount, the subsidy will be reduced proportionately.

**EQUAL Program:** Maintains funding at \$6.5 million.

**ALP expansion:** Extends the deadline for DOH to award a total of 6,000 new ALP beds by two years, through 2016, and requires DOH to provide progress reports to the Legislature on the development of additional capacity.

**Respite Stays:** Increases the maximum respite stays for non-residents within ACFs from six weeks to 120 days during a twelve month period. and allows providers to start respite programs upon notice—rather than application- to DOH.

**Expedited application review:** Creates an expedited review process for EALRs and SNALRs that are in good standing to get approval to operate up to nine additional beds. DOH currently allows such a process for up to five additional beds.

# Budget Guidance

September 2014

**Home Care Worker Wage Parity:** Includes language requiring DOH to adjust Medicaid rates for services provided by CHHAs and LTHHCPs, to address cost increases from wage increases required by the Wage Parity Law. Total funding of \$380 million will be provided to CHHAs, LTHHCPs and Medicaid managed care plans to compensate home health aides at the 2014 level under the Home Care Worker Wage Parity law. Wage parity applies to home health aides providing services in the counties of Westchester, Suffolk, Nassau, and New York City.

**LTHHCP Program Slots:** Eliminates the cap on Long Term Home Health Care Program slots allotted to each program.

**LHCSA Vital Access Provider:** As noted above, LHCSAs are now eligible for VAP funding if they are planning closure; impacted by another agency's closure; subject to a merger or restructuring; impacted by a merger or restructuring; or otherwise seeking to ensure access to care.

**HCBS Workgroup:** As advocated by LeadingAge NY, continues the work of the 11-member workgroup through SFY 2014-15, and requires the group to also make recommendations on clean claims submission and related dispute resolution.

# Budget Guidance

September 2014

***Recruitment Training and Retention Program:*** The final budget rejects the proposal to repeal the R&R funds for various home health and community-based service providers. The final budget extends funding through 2017 in the annual amount of \$100 million.

***Personal Care Recruitment Training and Retention Reprogramming:*** The final budget extends Recruitment Training and Retention funds for personal care services providers located in social service districts which do not include a city with a population of over one million persons. The final budget extends funding through 2017 in the annual amount of \$28.5 million.

***Home Care Conditions of Participation:*** We understand that the final budget includes \$17 million to support the additional costs associated with managed care plans contracting with agencies that meet the federal conditions of participation.



# Budget Guidance

September 2014

***CMI Cap:*** Thanks to strong advocacy from LeadingAge NY, its members and other groups, the Legislature rejected the governor's proposal to cap the growth of each nursing home's case mix index at two percent for any six month period. (Note that individual facility CMI change continues to be constrained to maximum of 5 percent over a six month period pending MDS audit) .

***Standard Compensation:*** Does not include the governor's proposal to require nursing homes to pay a standard rate of compensation. The proposal would have required Medicaid managed care plans to contractually require their nursing home providers to pay these state-set rates, without any additional reimbursement. LeadingAge NY worked with a broad coalition to defeat this proposal.

# Budget Guidance

September 2014

***Safe Patient Handling:*** Imposes safe patient handling (SPH) requirements on hospitals and nursing homes, despite our concerns. The legislation establishes a statewide SPH workgroup and requires individual facilities to form SPH committees and have policies in place by 2017. Reduced worker's compensation rates will be developed for facilities implementing safe patient handling.

***Managed Care Rate Protection:*** LeadingAge NY secured amendments to this proposal by the Governor, which requires Medicaid managed care plans to reimburse nursing homes for permanently placed Medicaid residents at the full fee-for-service rate in effect at the time the service was provided, unless there is a different agreed upon rate.

***Quality Pool:*** Provides DOH with statutory authority to make quality pool adjustments retroactive to 2013, and includes LeadingAge NY language effective October 2014 enabling facilities to qualify for funding in cases when there were findings against individual employee(s) but the facility was not cited or culpable for the violation.

***IGT Payments:*** Extends authority for the state to make intergovernmental transfer payments to public nursing homes through SFY 2016-17 of up to \$500 million per year.

# Budget Guidance

September 2014

**Managed Care Consumer Advisory Review Panel:** Expands the Managed Care Consumer Advisory Review Panel to include consumer representatives of dual eligible beneficiaries and individuals with behavioral health needs.

**Fair Hearings:** Provides that fair hearing and aid continuing rights attach to determinations by managed care plans, regardless of the expiration of any prior authorization period.

**FIDA Appeals:** Authorizes the Commissioner to use contract staff to conduct FIDA appeals, in addition to State employees.

**Medicaid Prescription Drug Co-payments:** Modifies Medicaid co-payment amounts to permit Medicaid managed care plans to charge a lower (\$1) co-payment for preferred brand name drugs on the plans' formularies.

**Investment in Behavioral Health Initiatives:** Includes several provisions to invest in the behavioral health delivery system, including: reinvestment of savings derived from the managed care behavioral health carve-in into community-based and residential behavioral health services; managed care premium increases to support payment of APGs to OASAS providers; VAP funding for behavioral health providers; and funding for managed care plans and health homes for infrastructure development related to the carve-in.

**Home Care Conditions of Participation–Managed Care Contracting:** We are told that the final budget includes \$17M to support the additional costs associated with contracting with agencies that meet the federal conditions of participation.

# Budget Guidance

September 2014

***Nursing home rates under managed care:*** Managed care and MLTC plans would be required to reimburse nursing homes for permanently-placed Medicaid residents based on Medicaid fee-for-service rates in effect at the time the service was provided. Exceptions would be allowed for negotiated agreements between a plan and provider. This provision stems from the efforts of the Nursing Home Resident Transition to Managed Care Workgroup. Although the budget proposal does not specify an expiration date for this requirement, the state expressed its intention to maintain it for three years.

# Budget Guidance

September 2014

***Extension of intergovernmental transfer (IGT) payments:*** Authorization to make IGT payments of up to \$500 million per year to public nursing homes would be extended for three years through March 31, 2017.

# Budget Guidance

September 2014

***Bed Hold payment audits:*** As part of the Office of Medicaid Inspector General (OMIG) audit program, the contractual audit firm HMS will review nursing homes not already audited by OMIG to identify inappropriate Medicaid bed hold payments.

# Budget Guidance

September 2014

## Medicaid Rates

- The Medicaid rates that nursing homes are currently receiving have also been updated to reflect a Jan. 1, 2014 rate calculated using a July 2013 CMI (constrained at five percent change relative to Jan 2013 CMI).
- The 2013 [quality pool adjustments](#) are still pending but will eventually be paid as a lump retro. Multiply adjustment amount by 2013 Medicaid days to calculate 2013 annual impact for your home.
- Bed-hold related cut (“adj per PHL Section 2808(25)(C)”) should be adjusted each April but should not change greatly (below \$1 for most non-specialty homes)
- CMI and special population add-ons (BMI and dementia) remain only opportunity for homes to impact their Medicaid operating rate
- DOH shared a [listing of nursing home rates](#) with managed care plans
- LeadingAge NY [template to model operating rate](#) is posted on website Data Page

# Budget Guidance

September 2014

## **Medicaid Rates: Add-on Criteria**

### **BMI:**

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

(PHL §2808(2-b)(b)(ix). Residents with a BMI greater than 35 have been identified using the weight and height data from the relevant MDS data. The Department has employed the formula used by the National Institute of Health to calculate a resident's BMI of  $(\text{Weight-lbs} / (\text{Height-inches}^2)) * 703$

### **Dementia:**

- Qualifies under both the RUG-III impaired cognition and the behavioral problems categories
- OR
- Has been diagnosed with Alzheimer's disease or dementia, and is classified in the RUG-III reduced physical functions A, B, or C categories,
- OR
- Is classified in the RUG-III behavioral problems A or B categories and has an activities of daily living index score of ten or less. (PHL §2808(2-b)(b)(viii))



# Budget Guidance

September 2014

## **Medicaid Rates-Capital**

- In an attempt to minimize the need for rate appeals, DOH issued preliminary 2015 nursing home capital rate sheets in September. This will allow homes to review the calculations and notify DOH of corrections that may be needed. The hope is that this will minimize the need for formal appeals when official rates are released.
- Approximately 590 homes submitted all required 2013 Medicaid cost report materials on time and will receive full points on that measure in their quality pool scoring. Homes whose cost reports were submitted after the Aug. 15 due date may not have a preliminary rate sheet available.
- DOH still hopes to revise the RHCF-4 Medicaid cost report (for 2014 reporting year) to allow providers to calculate capital reimbursement amounts for their home. Additional edits and safeguards will be incorporated into the software, but homes would be responsible and accountable for the accuracy of their capital calculations. The final reimbursable capital would be determined through audit, which will be done by the Office of the Medicaid Inspector General (OMIG) or its contractor.
- The transition to mandatory managed care for nursing home residents should not impact capital reimbursement during the three year phase-in period. The calculation of the capital component of nursing home Medicaid rates will remain mostly intact. In concert with the [Transition of Nursing Home Benefit and Population to Managed Care](#) policy document that requires managed care plans to pay nursing home fee-for-service rates, including capital and assessment reimbursement, for three years for permanently placed enrollees, this decision ensures some level of capital reimbursement stability for nursing homes for the transition period.

# Budget Guidance

September 2014

## **Nursing Home Quality Pool**

- For 2014, the overall point distributions in the NHQI are being revised to increase the total points in the quality component from 60 to 70 and correspondingly decrease the weight given to Potentially Avoidable Hospitalizations (PAH) from 20 to 10 points. Each of the 14 quality measures will now be worth five points.
- A new improvement standard is being introduced to reflect changes from the 2013 NHQI results (i.e., homes will receive points for improved measure scores as well as high scores).
- The three Quality Measures (QMs) for vaccinations are being revised, with the resident flu and pneumococcal vaccine QMs now based on more restrictive measures of actually receiving the vaccinations, and the employee flu vaccine measure based on an 85 percent threshold.
- The PAH measure is being revised to reflect the primary diagnosis in the hospital discharge record rather than the previously-used admitting diagnosis.
- An adjustment will be applied to the Five-Star survey rating to reflect regional variations in survey results.
- Legislative change in the 2014-15 State budget eliminated the facility exclusion from receiving NHQI funding based on a determination of fraud and abuse by the Attorney General due to findings made against individual workers in the facility.

# Budget Guidance

September 2014

## Universal Settlement

- The prospects for reaching an agreement on the settlement remain somewhat cautiously optimistic.
- A group of legal counsels representing nursing homes in various pending Medicaid rate litigation matters has been actively discussing the terms of a proposed universal settlement of outstanding nursing home litigation and rate appeals. LeadingAge NY legal counsel has been involved in the entire process. Working with officials from the Department of Health (DOH), the Office of the Attorney General, the Division of the Budget and the Governor's office, the goal of the exercise is to arrive at a consensus proposal and settlement amounts that would be advanced to facilities in September.
- While the specifics of the settlement proposal remain under discussion and are subject to legal privilege, the overall settlement would provide up to \$850 million in additional payments to nursing homes over a five-year period. Included in this figure is an estimated \$350 million derived from continuing the 0.8 percent unreimbursed cash receipts assessment. In exchange for these payments, nursing homes in the State would have to agree to drop nearly all pending lawsuits and rate appeals involving rates in effect prior to Jan. 1, 2012 (i.e., the implementation of statewide pricing). DOH indicated that there are approximately 400 lawsuits and 7,900 rate appeals currently pending.

# Budget Guidance

September 2014

## Two more managed care issues...

NAMI payments and \$50 PNA under managed care.

# Thank You!

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