Nursing Home Budgeting Considerations for 2016

These slides provide annual budgeting guidance for LeadingAge NY members, specifically on Medicare and Medicaid funding issues. Although in Power Point format, each issue is described in narrative detail with links to helpful resources. Please contact Patrick or Darius with questions.

Patrick Cucinelli, MBA, LNHA, EMT Vice President for Financial Policy
pcucinelli@LeadingAgeNY.org
518-867-8383, ext. 145

Darius Kirstein
Senior Policy Analyst
dkirstein@LeadingAgeNY.org
518-867-8383, ext. 104

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- New Initiatives

Member Tools

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- FASTracker Cost and Staffing Comparisons

Budgeting Considerations- Medicare

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) 2016. This rule implements the new SNF PPS Medicare Part A rates effective Oct. 1, 2015; Value-Based Purchasing; Quality Reporting, and Staffing Data Collection. CMS has also issued a fact sheet on the final rule.

Budgeting Considerations- Medicare

CMS has just issued a Survey and Certification Letter announcing the publication of the SNF PPS final rule and providing further information on the Value-Based Purchasing, Quality Reporting and Staffing Data Collection initiatives. Included are the links for registration and additional information re: the voluntary payroll-based data submission period.

Budgeting Considerations- Medicare

Section 215 of the Protecting Access to Medicare Act of 2014 established a SNF Value-Based Purchasing (VBP) program beginning in FY 2019 (which starts 10/1/18). Under VBP, a two percent withhold will be made to SNF Part A payments that can be partially earned back based on a SNF's re-hospitalization rate and level of improvement. For this purpose, the law requires CMS to: (1) to select a risk adjusted re-hospitalization measure; (2) calculate a score for each SNF, taking into account both relative performance and degree of improvement from a baseline period; and (3) provide the measure and score reports to SNFs for review and to make this information available to the public.

Budgeting Considerations- Medicare

The final rule adopts the SNF 30-Day All-Cause Readmission Measure, (SNFRM) (National Quality Forum/NQF #2510), as the all-cause, all-condition readmission measure that will be used in the SNF VBP Program. This measure estimates the risk-standardized rate of all-cause, unplanned, hospital readmissions for SNF Medicare beneficiaries within 30 days of their prior proximal short-stay acute hospital discharge. SNFRM is a claims-based measure, requiring no additional data collection or submission burden for SNFs. Links to the SNFRM technical specifications are available on the CMS Nursing Home Quality Initiative webpage.

Budgeting Considerations- Medicare

CMS is required to replace the SNFRM with an all-condition, risk-adjusted potentially preventable hospital readmission rate. The proposed rule included discussion on this successor measure, and also sought comment on several SNF VBP Program policies including public reporting, SNF-specific performance information and aggregate performance information. CMS advises it is taking these comments under consideration and intends to propose additional details of the SNF VBP in the FY 2017 SNF PPS proposed rule, including the revised hospital readmission measure.

Budgeting Considerations- Medicare

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires implementation of a quality reporting program (QRP) for SNFs and standardized data reporting across four post-acute care settings – home health agencies, inpatient rehabilitation facilities, long term care hospitals and SNFs. A recently released CMS PowerPoint summarizes the QRP.
- SNFs will submit data on the proposed functional status, skin integrity, and incidence of major falls measures by completing items on the MDS and then submitting the MDS to CMS through the Quality Improvement and Evaluation System (QIES), Assessment Submission and Processing System (ASAP) system. Certain elements of the MDS will be modified to collect the needed data.

Budgeting Considerations- Medicare

- To establish the initial QRP measures, data will be collected for the October 1-December 31, 2016 timeframe and must be submitted by May 15, 2017. SNFs unable to provide QRP data to CMS can submit written requests for data submission exceptions or extensions within 90 days of "extraordinary circumstances" occurring that would prevent data submission. Beginning with FY 2018, SNFs that do not satisfactorily report required quality data to CMS under the SNF QRP will have their market basket percentage updates reduced by two percentage points.
- For the FY 2018 SNF QRP and beyond, CMS is adopting three measures addressing the three quality domains identified in the IMPACT Act: (1) skin integrity and changes in skin integrity; (2) incidence of major falls; and (3) functional status, cognitive function, and changes in function and cognitive function. The finalized measures are identified in the table below. CMS intends to propose additional quality measures and resource use measures in future rulemaking.

Budgeting Considerations- Medicare

Domain	Finalized Measures
Skin Integrity and Changes in Skin Integrity	Outcome Measure: Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short-Stay) (NQF #0678; Measure Steward: CMS)
Incidence of Major Falls	Outcome Measure: Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (NQF #0674; Measure Steward: CMS)
Functional Status, Cognitive Function, and Changes in Function and Cognitive Function	Process Measure: Percent of Patients or Residents With an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF#2631) (Endorsed on July 23, 2015; Measure Steward: CMS)

Budgeting Considerations- Medicare

CMS intends to begin collecting nursing home staffing data through the new Payroll-Based Journal (PBJ) reporting system. CMS has set up PBJ web page and posted a draft manual and vendor software specifications. The initial Oct. 1 start date is for those facilities seeking to participate in the data submission on a voluntary basis in anticipation of a mandatory start date of July 1, 2016.

Budgeting Considerations- Medicare

- In its final rule, CMS makes some additional adjustments to the rate calculation that result in a net increase slightly below the amount projected in the proposed rule. With the additional refinements, CMS projects that aggregate payments in FY 2016 under the SNF PPS payment system will increase by $430 million, or 1.2 percent, as compared to FY 2015.
- The formula for the estimated increase takes a 2.3 percent Market Basket Increase (MBI) and subtracts 0.6 percent for the Market Basket Forecast Error Adjustment (MBFE) and makes a further reduction of 0.5 percent for the mandated Multifactor Productivity Adjustment (MPA) for a net 1.2 percent. As noted, this is slightly lower than 1.4 percent found in the proposed rule.

Budgeting Considerations- Medicare

Calculation of MBFE Based on FY 2014 Data.

Actual MBI Increase	**minus Projected Increase**	**equals Difference**
2.3 %	1.7 %	(0.6)

0.6 > 0.5 threshold therefore (0.6) MBFE for FY 2016

Source: CMS SNF PPS Final Rule for FY 2016

Budgeting Considerations- Medicare

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.

Budgeting Considerations- Medicare

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.

Budgeting Considerations- Medicare

Medicare Part B

LeadingAge New York provided members with a detailed analysis of the "Doc Fix" measure passed by Congress (*H.R. 2 The Medicare Access and CHIP Reauthorization Act of 2015*). Among other things, this measure repeals the current Sustainable Growth Rate (SGR) formula based methodology for determining annual updates to the Medicare Physician Fee Schedule (MPFS). The MPFS determines Medicare Part B rates paid to physicians and other practioners, along with the ancillary rates paid to nursing homes and home care providers for ancillary services.

Budgeting Considerations- Medicare

Medicare Part B

April 1 MPFS rates - the immediate impact on payments will be to eliminate the scheduled 21.2 percent reduction in Part B rates and keep rates at their current levels through June 2015. There would be a 0.5 percent minimum increase effective July 2015 through 2019.

Budgeting Considerations- Medicare

Medicare Part B

A “Merit-based Incentive Payment System” (MIPS) quality program would implement some features of Medicare’s current quality programs, including the Physician Quality Reporting System (PQRS), Meaningful Use (MU), and Value Based Payment Modifier (VBM) programs.

Budgeting Considerations- Medicare

Medicare Part B

Income-related Premium Adjustment (effective 2018) provides for an increase in the percentage that beneficiaries pay toward their Part B and D premiums in two income brackets (roughly 2 percent of beneficiaries): for individuals with income between $133.5-160K ($267-$320K for a couple), the percent of premium paid increases from 50 percent to 65 percent. For those with income between $160-214K ($320-$428K for a couple), the percent increases from 65 percent to 75 percent.

Budgeting Considerations- Medicare

Medicare Part B

One Percent Market Basket Update for Post-Acute Providers replaces the market basket update in 2018 with a one percent update for long-term care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health providers and hospice providers.

Budgeting Considerations- Medicare

Medicare Part B

Medicare Therapy Caps

The doc fix legislation extends the current Medicare therapy caps exceptions process for another two years, through December 31, 2017. We will continue to work with Congress on a bipartisan basis to resolve this issue.

Budgeting Considerations- Medicare

Medicare Part B

To watch in the future, the physician payment reform is not fully funded and concern has been raised as to how this will be addressed.

Medicaid Budgeting Considerations

- Provider Payment Issues
  - Universal Settlement
  - Projecting FFS rate
  - CMI considerations
  - Outstanding adjustments (Quality Pool, Assessment, IGT)
  - Changes to NHQI
  - Capital Corrections
  - Capital Funding
  - VAP
- Overarching Issues
  - NH Resident Transition to Managed Care
  - Global Cap
  - Value Based Purchasing
  - DSRIP
- New Initiatives
  - Refinancing shared savings
  - Advanced Training Initiative
  - Energy efficiency initiative
  - Care for residents with neurodegenerative conditions
  - Young Adult Initiative

Medicaid Budgeting Considerations

Universal Settlement - Background

- Up to $850 million in additional payments to nursing homes over a five-year period
- Roughly $350 million derived from continuing the 0.8 percent un-reimbursed cash receipts assessment
- In exchange for these payments, nursing homes 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)
- LeadingAge NY and our legal counsel have 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
- CMS has provided verbal approval of the settlement but will need to sign off on the final release documents (a Medicaid State Plan Amendment is NOT required)
- Virtually all substantive issues relating to the settlement agreement have been resolved

Medicaid Budgeting Considerations

Universal Settlement- Latest News

- DOH has posted facility-specific listings of facility-submitted appeal exclusion requests along with an explanatory DAL on the Health Commerce System (HCS)
- To allow for the prompt payment of funds, and ensure that the distribution of funds is managed in a fair, objective and impartial manner in accordance with the terms of the settlement agreement, the State has requested that the two statewide Associations (i.e., NYSHFA and LeadingAge NY) manage the payment process and that the Associations utilize their general counsels to oversee the payment process
- DOH attorneys and association counsels are finalizing the release documents that each home will be asked to sign. When complete, the documents with a home-specific addendum listing items excluded from the settlement will be made available to each home. This listing will reflect any reconsiderations DOH made in response to the most recent opportunity for homes to provide additional materials to support exclusions DOH had originally denied.
- DOH is contemplating three mass signing events (NYC, Capital Region and Western NY) in November to help expedite the process.
- Timing of payments is contingent on the execution of final release documents by all participating homes. If the process follows the expected schedule, the first payment may be made as early as December with the possibility of two payment being made in this state fiscal year (i.e., by April 2016).
- Facility specific amounts are available from LeadingAge NY upon request. Note that outstanding Medicaid liabilities will be offset against settlement distributions.

Medicaid Budgeting Considerations

Projecting Your Medicaid Operating Rate

- 2016 represents the fifth year of the phase-in of the pricing methodology for nursing homes and the final year of constraint on gains and losses resulting from the new methodology. Impact of 2016 rates will be limited to a ten percent increase or decrease when compared to a home's July 2011 rate with the CMI held constant. The gain/loss limitation in 2015 was 7.5 percent. In 2017 the stop-loss/stop-gain provision will no longer apply.
- The operating component will increase by roughly $0.60 over 2015 due to the rate phase-in. No trend factor is expected.
- The largest potential driver of change to the operating rate is the case mix adjustment and the special population add-ons. The January 2016 rate will eventually be updated to reflect the case mix calculated based on the July 2015 MDS census roster.
- The LeadingAge NY Rate Template that can be downloaded from the LeadingAge NY Data page by clicking here allows you to project your home's rate by entering the Case Mix Index (CMI) you want to model along with the counts of residents that meet the special population add-on criteria.
- Operating rates for discrete specialty units are frozen at 2009 rates and remain unchanged

Medicaid Budgeting Considerations

CMI Considerations

- Although DOH has not announced the census rosters dates that will be used in 2016 for CMI calculation purposes, we anticipate that it will be the last Wednesday in January and the last Wednesday in July.
- Homes whose Medicaid CMI changes by more than 5 percent when compared with their CMI six months prior, will have their CMI change capped at 5 percent when their rate is calculated. When OMIG completes MDS audits and DOH processes rate changes from any audit findings for that census roster submission cycle the cap will be removed.
- Homes should file an MDS with CMS for any resident that may be listed on their case mix census roster, even if not required by regulations. If DOH is unable to match a resident listed on the roster with an MDS in the CMS database, ANY resident on the roster without an MDS match is presumed to be Medicaid and defaults to the lowest RUG category.
- DOH clarified that all managed long term care residents, including those that integrate Medicaid and Medicare such as PACE, FIDA and MAP, are counted in the Medicaid CMI calculation
- OMIG most common MDS audit findings continue to revolve around:
  - Inaccurate ADL Coding
  - Physicians visits not counted properly
  - Therapy not recorded properly

Medicaid Budgeting Considerations

Medicaid Rates: Add-on Criteria

The roster submission system should automatically identify residents who qualify based on their MDS data for BMI ($17), Dementia ($10) or TBI ($36) add-ons but it is worthwhile to validate that this is in fact occurring. Note that the add-ons are based on the criteria below.

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 (Weight-lbs/ (Height-inches {squared}))*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))

Medicaid Budgeting Considerations

Retroactive Adjustments Due

- The Medicaid rate that providers are receiving currently (October 2015) is the 1/1/15 rate reflecting a July 2014-based CMI. Eventually DOH will issue 7/1/15 rate sheets reflecting a January 2015-based CMI and make retroactive rate adjustments back to 7/1/15.
- Five areas of outstanding rate adjustments include:
  - 2013 and 2014 Nursing Home Quality Initiative payments
  - A one percent increase in the operating rate retroactive to 4/1/14 to reflect reinvestment of the .08 percent assessment that is scheduled to continue
  - July 2015 update to the rate to reflect Jan 2015 CMI
  - The release of the CMI constraint on homes whose CMI changed by more than five percent
  - Reissuance of rates reflecting OMIG MDS audit findings for homes that had MDS audits

DOH has forwarded rate revisions stemming from 2012 MDS audit findings to the Division of the Budget (DOB). Once approved, homes with MDS audit findings will receive retroactive rate adjustments reflecting the findings and the five percent Case Mix Index (CMI) constraint on 1/1/13 rates will be removed. DOH hopes to send revised rates based on 2013 MDS audit findings to DOB in November.

The tables on the following slides show the timing and status of CMI adjustments as well as outstanding rate adjustments by rate period (as of Oct 28, 2015).

Medicaid Budgeting Considerations

Rate Update Update (CMI)

Rate Effective Date	Should contain CMI based on Census Rosters from:	Currently Contain CMI based on Census Rosters from:	5 Percent CMI Constraint Released?	Impact of associated MDS audit in rates?	Status Notes
1/1/2012	Jan. 2011	Jan. 2011 ✓	na	na	
7/1/2012	Jan. 2012	Jan. 2012 ✓	YES ✓	NO	Release of 5% CMI constraint under DOB review
1/1/2013	Jul. 2012	Jul. 2012 ✓	NO	NO	OMIG audit rate revisions and release of 5% CMI constraint under DOB review
7/1/2013	Jan. 2013	Jan. 2013 ✓	NO	NO	
1/1/2014	Jul. 2013	Jul. 2013 ✓	NO	NO	
7/1/2014	Jan. 2014	Jan. 2014 ✓	NO	NO	Correction to 5% constraint calc made Aug. 2015
1/1/2015	Jul. 2014	Jul. 2014 ✓	NO	NO	1/1/15 rate updated using Jul. 2014 CMI in Aug. 2015
7/1/2015	Jan. 2015	*RATES NOT YET ISSUED*			Issue date not announced
1/1/2016	Jul. 2015	*RATES NOT YET ISSUED*			

Medicaid Budgeting Considerations

Outstanding Rate Updates

Rate Effective Date	Outstanding Issue #1	Outstanding Issue #2	Outstanding Issue #3	Outstanding Issue #4
1/1/2012				
7/1/2012		Reissuance of rates reflecting OMIG MDS Audit*		
1/1/2013	2013 Quality Pool Adjustment		Release of 5% CMI Constraint**	
7/1/2013				
1/1/2014	2014 Quality Pool Adjustment			1% rate increase (Re-investment of 0.8% assessment)
7/1/2014				
1/1/2015	2015 Quality Pool Adjustment			

** for homes that have OMIG MDS audit with findings*

*** for homes with constrained CMI*

Medicaid Budgeting Considerations

Cash Receipts Assessment Reconciliation

DOH intends to update the per-day assessment reimbursement to the 2013 reconciled per-day amount and is currently working on the 2014 reconciliation

Assessment Payment Year	Assessment Reimbursement Per-Diem Based on:	Payments Reconciled?
2013	2010	YES
2014	2010	NO
2015	2010	NO
2016	2013 (intended)	*na*

Note: The per-day assessment reimbursement amount shown on the 1/1/15 benchmark rate listing is the **2012** reconciled amount (NOT the 2010-based amount that is actually being used in 2015)

Medicaid Budgeting Considerations

Two-percent Cut Restoration

- **The cash receipts assessment continues at 6.8 percent (6 percent reimbursable 0.8 percent not reimbursable)**
- **DOH intends to supplement Medicaid rates by one percent retroactive to 4/1/14 to reinvest funds collected by the 0.8 percent assessment**

In 2011, the State enacted a 0.8 percent increase in the cash receipts assessment on nursing homes in lieu of the two percent across-the-board cut imposed on most other Medicaid providers. While the two percent cut has expired, the 0.8 percent nursing home assessment continues. DOH has indicated that proceeds of the .8 percent assessment will be reinvested in nursing home care: a portion will help fund the Universal Settlement with the rest slated to fund an increase in the Medicaid operating rate.

On Sep. 30th, the State filed a Medicaid State Plan Amendment (SPA) with the Centers for Medicare and Medicaid Services (CMS) to make the reinvestment. This formalizes the commitment DOH had made to reinvest half of the savings that accrued from the assessment after April 2014 into nursing home rates. When approved, the provision will increase nursing home Medicaid operating rates by approximately one percent retroactive to the time that the cut was repealed on April 1, 2014.

Medicaid Budgeting Considerations

Intergovernmental Transfer (IGT) Payments

Most recent information from DOH indicates that the state is responding to CMS questions on the 2014 UPL calculation meaning that the next round of IGT payments is not imminent.

- Although the authorization to make IGT payments of up to $500 million per year to public nursing homes was extended through March 31, 2017, dynamics of transitioning to Medicaid managed care will result in a decrease of IGT funding

IGT in broad strokes:

Statewide Medicaid **FFS** Revenue of Public Homes

– Statewide Medicaid **FFS** Expenses of Public Homes

= Funding Gap (IGT can fill gap up to $500 M)

As statewide Medicaid FFS revenue and expenses decrease and are replaced by Medicaid managed care revenue and expenses, the calculation will result in a lower dollar amount. Solution to this may be thwarted by federal regulation.

Medicaid Budgeting Considerations

Nursing Home Quality Initiative (NHQI)

Although the 2013 and 2014 NHQI has been approved by CMS and rate adjustments have been calculated, the state is not moving forward with making the adjustments until litigation challenging the NHQI is resolved, meaning timing remains uncertain.

- DOH is in the process of calculating 2015 NHQI scores
- 2014 and 2013 facility score sheets are posted on the Health Commerce System
- Detailed 2013 and 2014 scores are available to the public
- The LeadingAge NY Quality Pool Benchmarker available here provides comparative data by individual measure
- CMS has approved the 2013 and 2014 NHQI
- Amounts are shown on the benchmark rate listings available on the DOH Medicaid rate web page
  - the 2014 NHQI adjustment amounts are listed on the "January 2015 Nursing Home and Specialty Rates" document
  - 2013 NHQI adjustment amounts appear on the July 2014 benchmark rate lists accessible by clicking on Historical Benchmark Rates

Medicaid Budgeting Considerations

Nursing Home Quality Initiative (NHQI)

Homes excluded from the 2015 quality pool (i.e., don't contribute and can't benefit):

- Non-Medicaid facilities
- Any facility designated by CMS as a Special Focus Facility at any time during 2014 or 2015
- Specialty facilities and units
- Continuing Care Retirement Communities
- Transitional Care Units

Any home with a J/K/L level deficiency between July 1 of the measurement year (2014) and June 30 of the reporting year (2015) (allowing time for IDR) is ineligible to receive funding but will contribute to the pool

Medicaid Budgeting Considerations

NHQI Quality Measure calculation changes for 2015

- Long stay resident antipsychotic medication measure
  - The CMS antipsychotic measure has been replaced by the Pharmacy Quality Alliance measure for Antipsychotic use in Persons with Dementia to now focus on residents with dementia who have a history of receiving an antipsychotic medication
- Long stay resident pneumococcal vaccination measure
  - Preliminary 2014 MDS data shows that the statewide average for the percent of long stay residents who received the pneumococcal vaccine is below 85%. Therefore, this measure will be assigned points based on quintiles rather than a threshold value of 85% as was done previously.

Medicaid Budgeting Considerations

Test measures included in 2015 NHQI

The two measures described below will appear on the 2015 NHQI score sheets but will be for informational purposes only. They will not be used for computing the 2015 NHQI score.

Number	Measure	Measure Steward	Data Source and Measurement Period	Measure description
1	Staffing rate (nurse hours per day for RNs, LPNs, and Aides)	NYS DOH	2014 nursing home cost report and 2014 MDS 3.0	• The hours reported are taken from the hours worked field for RNs, LPNs, and Aides on the nursing home cost report. • The hours expected are computed using the MDS RUG distribution of the nursing home residents and the CMS Time Staff Measurement Studies. • The hours reported are divided by the hours expected and multiplied by the statewide average to create a case-mix-adjusted staffing rate.
2	Percent of staff turnover	NYS DOH	2014 nursing home cost report	• The total number of RNs, LPNs, and Aides at the end of each quarter, and the total number of RNs, LPNs, and Aides terminated at the end of the year will be taken from the nursing home cost report. • The total number of above-mentioned staff members terminated will be divided by the average number of staff members per quarter to calculate the percent of staff turnover. • Contract and per diem staff are excluded from this measure.

Medicaid Budgeting Considerations

Streamlined Capital Rate Corrections

DOH has established a streamlined process to correct capital component errors while minimizing appeals. Providers that identify errors in the Department's calculation are able to submit a corrected capital component calculation along with an attestation form provided by DOH certifying that the calculation being submitted is correct to the best of their knowledge.

DOH will do a brief review of the calculation but final, comprehensive review will be performed by the Office of Medicaid Inspector General (OMIG). Draft capital rate sheets for 2016 were posted to the Health Commerce System (HCS) in late October with any rate corrections and attestations due by December 15.

- DOH will accept facility capital correction requests
- Homes will be required to attest to the accuracy of their correction request
- Rates will be subject to OMIG audit
- Goal is to eliminate appeals and expedite corrections

Medicaid Budgeting Considerations

Capital Funding

- $1.2 billion in Capital Restructuring Financing Program (CRFP) funding was reauthorized in the 2015-15 State Budget
- DOH has not yet provided any information on accessing this or other non-directed capital funding included in the State Budget
- Deadline to apply for DSRIP-related capital funding was extended

Medicaid Budgeting Considerations

Vital Access Provider Program

- $567 million (inclusive of federal funds) for the VAP program with $245 million allocated for financially distressed safety net hospitals
- $10 million is set aside for providers serving rural areas and isolated geographic regions
- The 2015-16 State Budget added eligibility criteria for applicants for the VAP program: (1) financial condition (2) meeting unmet health care (3) producing savings (4) the quality of the application (5) geographic isolation and (6) providing services to an underserved area in relation to other providers
- Applications being accepted but not being acted on at this time
- A number of awardees experiencing delayed funding due to federal approval delays

Medicaid Budgeting Considerations

NH Transition to Managed Care

All counties in the state have transitioned to mandatory Medicaid managed long term care. New permanent nursing home residents are required to enroll in a Managed Long Term Care plan (MLTC) (mainstream Medicaid managed care if they are not eligible for Medicare). Permanent residents are grandfathered into fee-for-service Medicaid unless discharged and readmitted.

- Unless a home negotiates an alternative arrangement with a managed care plan, plans must pay the benchmark fee-for-service (FFS) rate during a three year transition period
- Benchmark rate includes:
  - Assessment reimbursement
  - All current adjustments to the Medicaid FFS rate
  - Plans are required to retroactively adjust provider payments to mirror FFS retroactive adjustments (if benchmark rate is being used)
- DOH confident that CMS will agree to capital rate protection beyond three years
- State interested in having providers and plans move towards value based payment arrangements
- Nursing home residents grandfathered into Medicaid FFS may enroll into managed care starting October, 2015 if they so choose

Medicaid Budgeting Considerations

NH Transition to Managed Care

- Although financial impact will vary, some homes experience increased administrative costs and cash flow delays related to transition to managed care
- To minimize rejected claims and delays it is crucial for homes to be familiar with each plan's billing manual and procedures
- DOH information resources include a July 2015 Webinar, policy guidance document and four sets of Frequently Asked Questions (FAQs) available on the DOH Care Management Expansion web page

Consumers, family members and representative have the right to file a complaint with any of the following:

- MMC Complaint line 800-206-8125
- MLTC Complaint line 866-712-7197

Medicaid Budgeting Considerations

FIDA (Fully Integrated Dual Advantage)

- Demonstration program aimed at modeling integrated Medicaid/Medicare managed long term care in New York City, Long Island and Westchester County
- *Beginning January 2015:* Adult NH residents (and community residents in need of 120 days of community-based LTC) in Bronx, Kings, Nassau, New York, Queens, and Richmond counties were able to voluntarily enroll in a FIDA plan
- *Beginning April 2015:* Permanently-placed adult residents in Bronx, Kings, Nassau, New York, Queens, and Richmond counties started being passively enrolled into FIDA plans. Residents that opt out of FIDA remain in MLTCP or FFS if permanently placed prior to January 2015
- **The FIDA roll out for Region II – Westchester and Suffolk - is on hold (March 1 effective date was cancelled) due to lack of network adequacy and there is no new target date**
- Enrollment to date below 10,000 and well below state's expectation

Medicaid Budgeting Considerations

Global Cap

State Medicaid spending is limited to amounts established by the Medicaid global spending cap. Should the state determine that Medicaid spending is trending above the cap, it has the authority to make across the board or targeted cuts to ensure spending remains below the cap. No such cuts have been required in the first four years of the cap's existence.

- Extended through March 31, 2017
- Limits growth in DOH State Funds Medicaid spending to the 10-year rolling average of the medical component of the Consumer Price Index
- Increases from $17.1 billion in SFY 2014-15 to $17.9 billion in SFY 2015-16 to $18.7 billion in SFY 2016-17
- The Accounts Receivable ending balance for SFY 2014-15 was $280 million; the State expects to recoup $170 million of this amount by March 2016
- Total Medicaid enrollment is up to nearly 6.2 million New Yorkers, with 4.7 million (75 percent) enrolled in Medicaid managed care
- An estimated 6,600 Medicaid nursing home beneficiaries are expected to transition to Medicaid managed care in SFY 2015-16
- As of July 2015, state Medicaid spending was $4 million (0.1 percent) below projections

Medicaid Budgeting Considerations

Value-Based Payment (VBP) Arrangements

The Centers for Medicare & Medicaid Services (CMS) approved New York State's Value Based Payment (VBP) Roadmap, a groundbreaking document laying out the State's plan to move Medicaid payments from traditional fee-for-service (FFS) methods to alternative payment arrangements such as bundling, risk sharing and capitation. Meanwhile, the Department of Health (DOH) has convened a series of subcommittees to work out the operational details of implementing VBP in contracts between providers and Medicaid managed care plans.

- Under the State's Delivery System Reform Incentive Payment (DSRIP) program, by the end of year five, 80-90 percent of payments to providers by Medicaid managed care plans must be made through a value based methodology other than fee-for-service
- The State's Fully-Integrated Duals Advantage (FIDA) Program requires the implementation of non-fee-for-service provider reimbursement methodologies
- Medicare is moving towards more VBP arrangements as well and DOH is working on ways to coordinate Medicaid with Medicare VBP initiatives
- LeadingAge NY has formed a Task Force on Alternative Payment Arrangements and participates on DOH VBP workgroups

Medicaid Budgeting Considerations

Delivery System Reform Incentive Payment Program (DSRIP)

DSRIP is the main mechanism by which New York State will implement the Medicaid Redesign Team (MRT) Waiver Amendment. DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program and encouraging provider partnering and integration with the primary goal of reducing avoidable hospital use by 25% over 5 years. Up to $6.42 billion dollars are allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health.

While hospitals are the lead partners in Performing Provider Systems (PPS) and some systems may not have their focus on post-acute care yet, this may change as systems recognize the central role post acute and long term care services play in reducing hospitalizations.

Information on individual DSRIP PPS projects is available on the DOH DSRIP web page and news on DSRIP developments is provided through LeadingAge NY DSRIP Weekly Updates.

Medicaid Budgeting Considerations

Advanced Training Initiative

DOH is implementing the nursing home Advanced Training Initiative (ATI), a program aimed at teaching direct caregivers to detect early changes in a resident's status that could lead to health declines and/or hospitalization. The program is funded at $46 million in State Fiscal Year (SFY) 2015-16, with another $46 million slated for SFY 2016-17. Homes eligible for the current year have been determined and notified.

- In the ATI program, nursing homes may partner with designated training organizations to offer training to certified nurse aides and other front-line workers. Homes were encouraged, although not required, to partner with one of the training partners listed on the application and select from a list of established training programs. (LeadingAge NY is one of three listed training partners.)
- Awards were allocated based on each qualifying facility's reported 2014 Medicaid days in relation to the total 2014 Medicaid days reported for all qualifying facilities
- Homes with a nursing and therapy staff retention rate above the statewide median were notified that they were eligible to apply. Hospital-based homes and homes that received Vital Access Provider (VAP) grants were excluded
- DOH's goal is to be able to begin making payments beginning in Dec. 2015. For that to occur, the Centers for Medicare & Medicaid Services approval will need to be received to obtain federal matching funding
- Criteria to participate in next year's funding opportunity may or may not resemble this year's program

Medicaid Budgeting Considerations

Mortgage Refinancing Shared Savings

- Legislation authorizes DOH to share fifty percent of savings accruing from a mortgage refinancing transaction with the refinancing facility
- Refinancing transactions that close after April 1, 2015 are eligible
- DOH seeking CMS approval

Medicaid Budgeting Considerations

Energy Efficiency

- State Budget authorizes DOH to conduct energy efficiency audits of nursing homes to develop cost/benefit analyses of potential modifications for each facility
- The audits and reviews would serve as the basis of an energy efficiency program that DOH would develop through regulation
- DOH and NYSERDA are engaged in discussions with energy audit firms to conduct up to 50 level 2 energy audits expected to be completed by December 2015
- Facilities will not incur any costs associated with the performance of an energy audit
- Initial phase of targeted facilities to be based on higher energy users
- DOH is compiling a list of candidate homes

Medicaid Budgeting Considerations

Young Adult Special Populations Demonstration

- Legislation requires DOH to establish up to three demonstration programs to provide more appropriate settings and services for young adults who have severe and chronic health problems or multiple disabling conditions which may include developmental disabilities
- Of the demonstrations: (1) at least one must target individuals 21 to 35 years of age who are aging out of pediatric acute care hospitals or pediatric nursing homes; and (2) at least one must target individuals 21 to 35 years of age with developmental disabilities that are aging out of pediatric acute care hospitals, pediatric nursing homes or homes serving developmentally disabled children
- The program may provide start-up funds, capital investment funding and enhanced rates
- Eligible provider applicants must have demonstrated expertise in caring for the targeted population and a record of providing quality care
- DOH has developed a work plan; no solicitations have been issued yet

Medicaid Budgeting Considerations

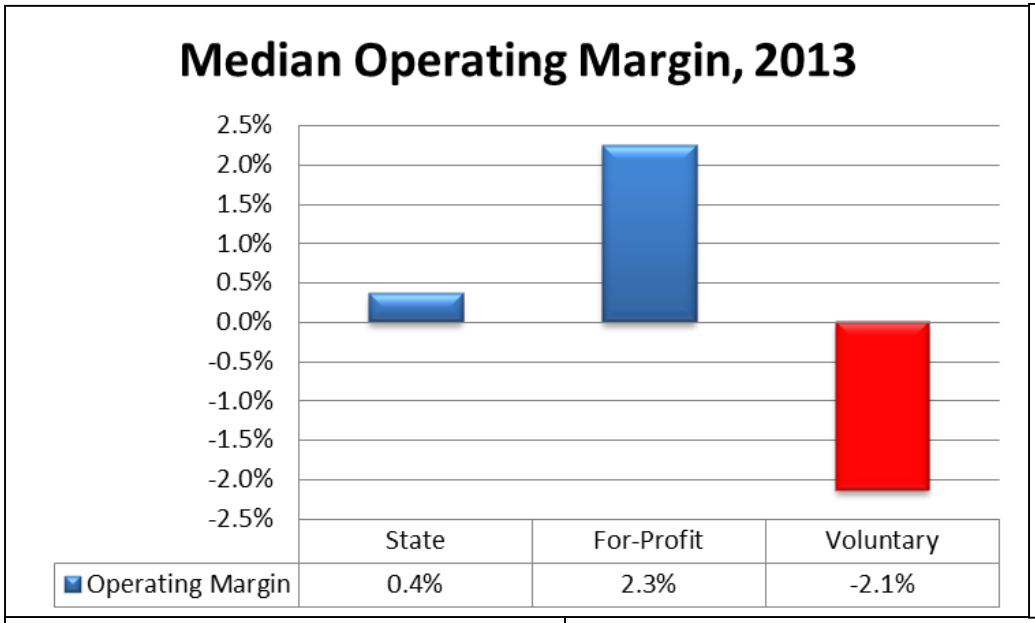
Care for Individuals with Neurodegenerative Diseases

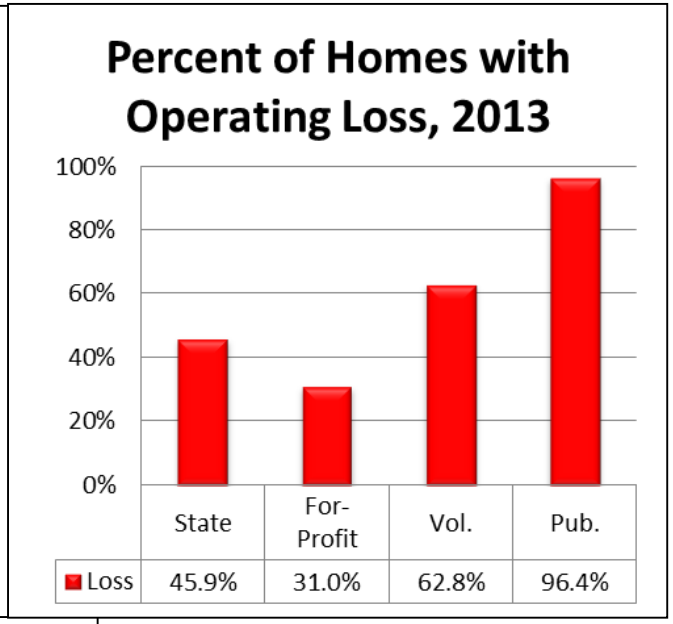
- Aimed at improving care for nursing home residents with Huntington Disease as well as Parkinsons and ALS
- DOH has convened a workgroup with multiple sub-groups
- Sub-groups have made recommendations on care and reimbursement
- State is currently leaning towards a specialty unit model

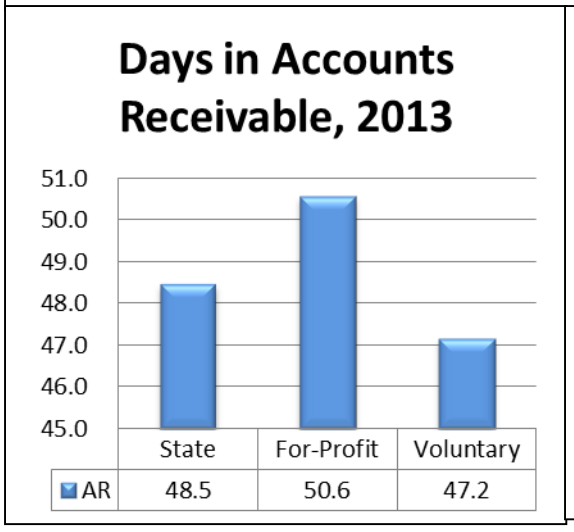
Helpful Data and Benchmarking Tools

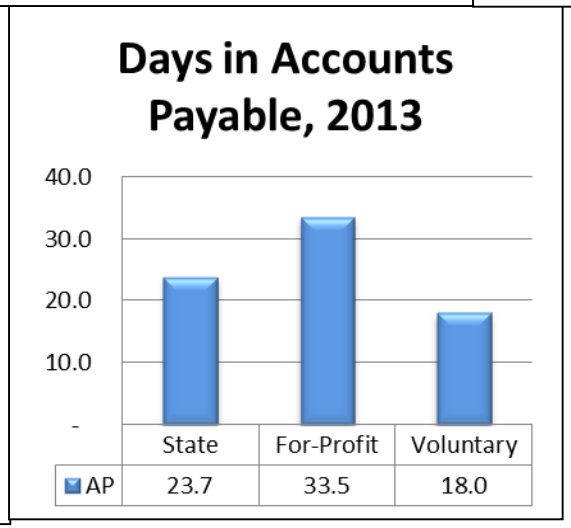
- LeadingAge NY puts available data in comparative format for members to use as benchmarks
- Familiarity with your own and competitor data is more important than ever in a managed care world that is moving towards value based payments
- Visit the LeadingAge NY Data Page to access benchmarking tools available to members
- Contact dkirstein@leadingageny.org if you do not have the latest FASTracker tool that provides cost and staffing benchmarks

Benchmarking Tools- Nursing Home Finances



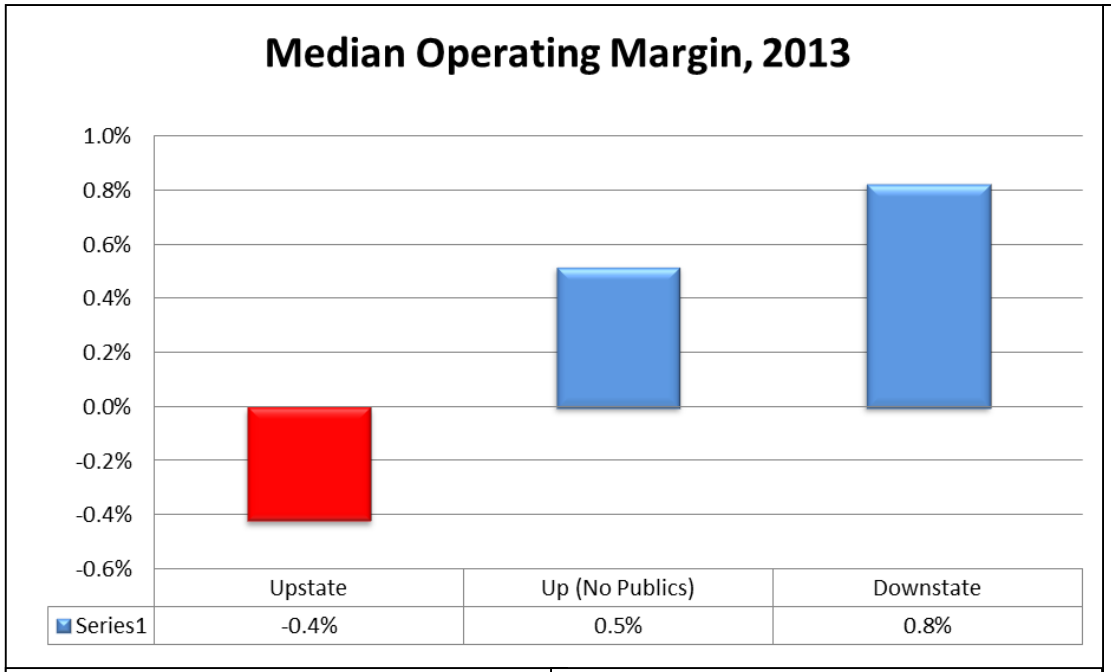


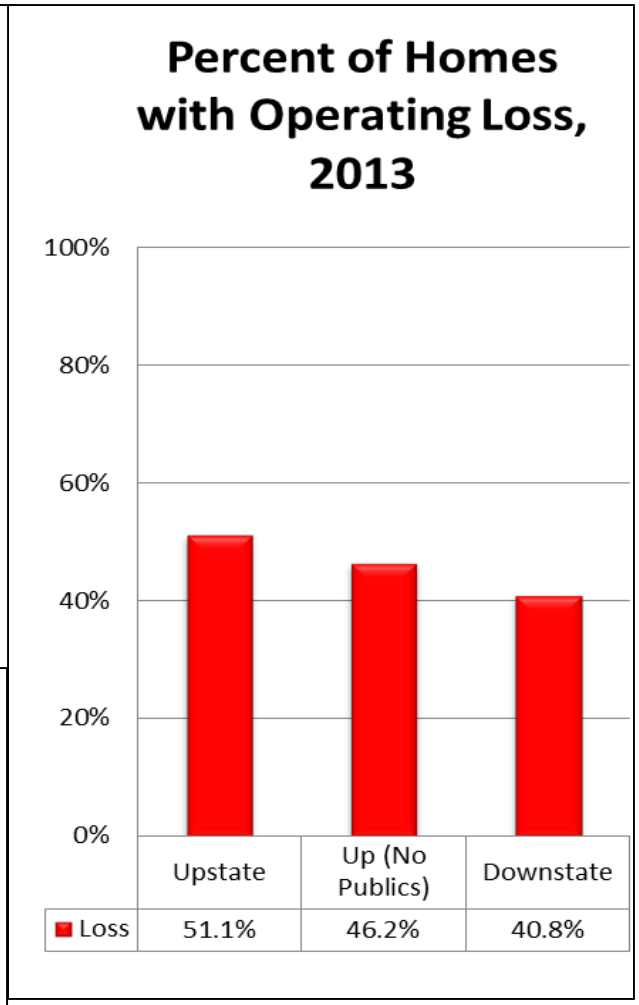


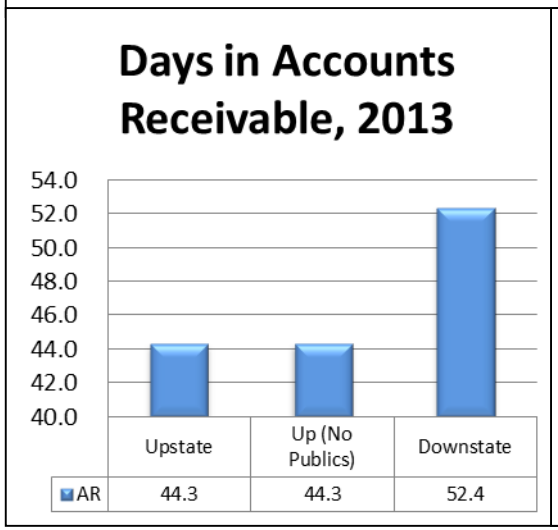


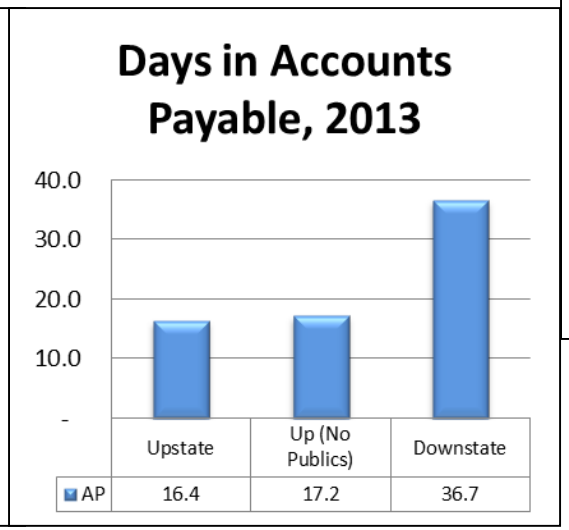
Public home median operating margin was -38.8% in 2013. The median AR for public homes was 41.2 days; AP stood at 8.1 days

Benchmarking Tools- Nursing Home Finances

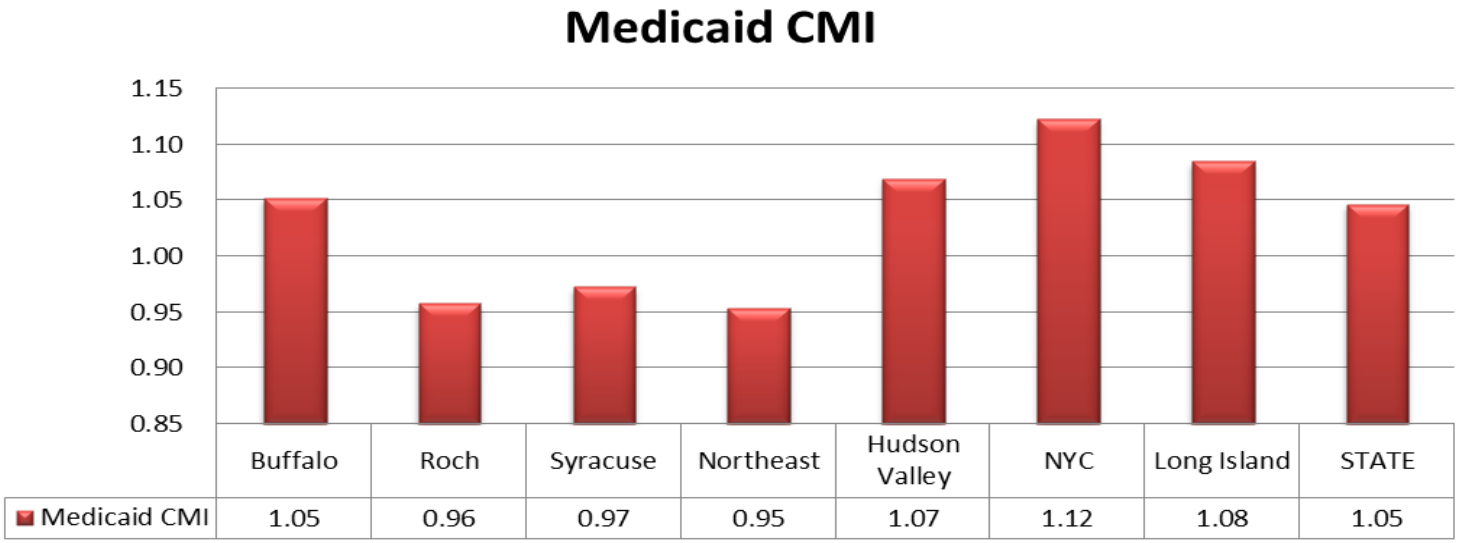


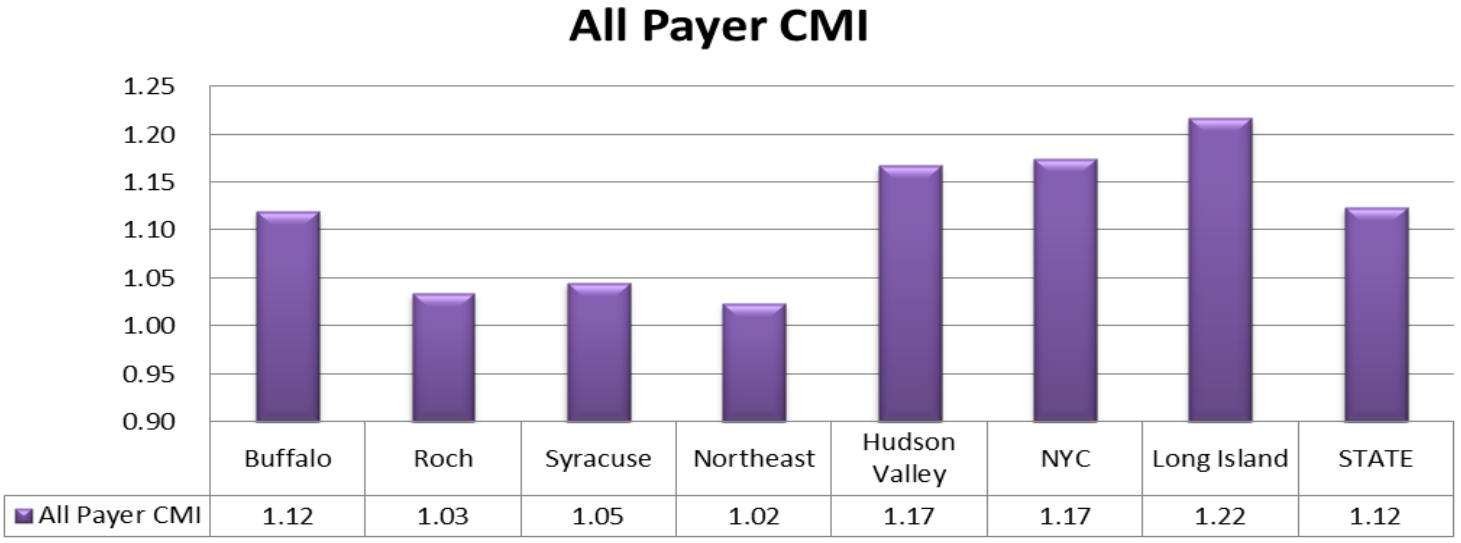






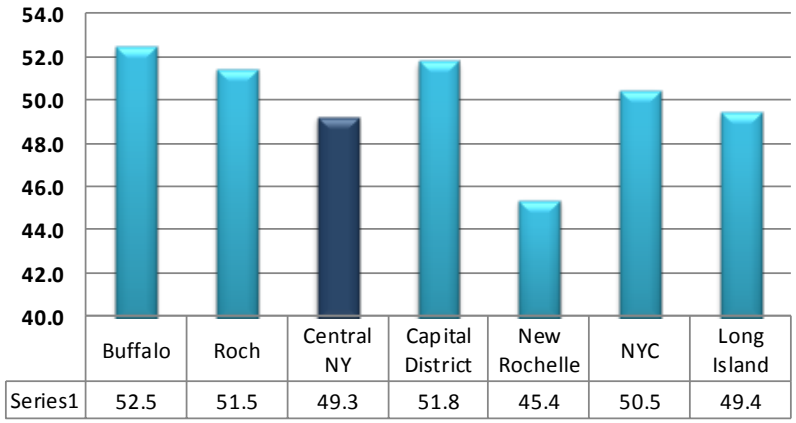
Benchmarking Tools- January 2014 CMI





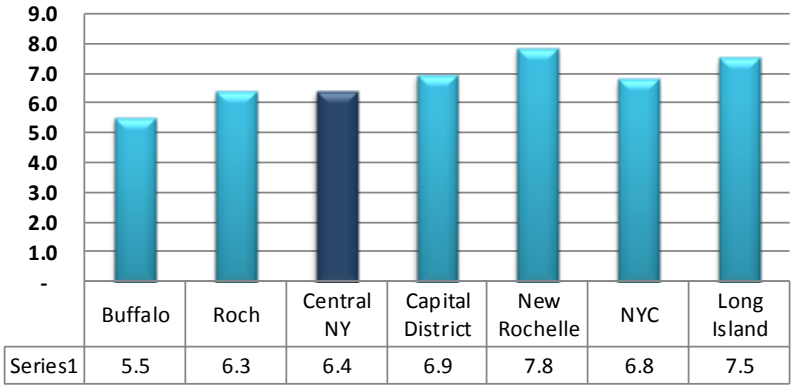
Benchmarking Tools- 2014 Quality Pool

Average Total Score



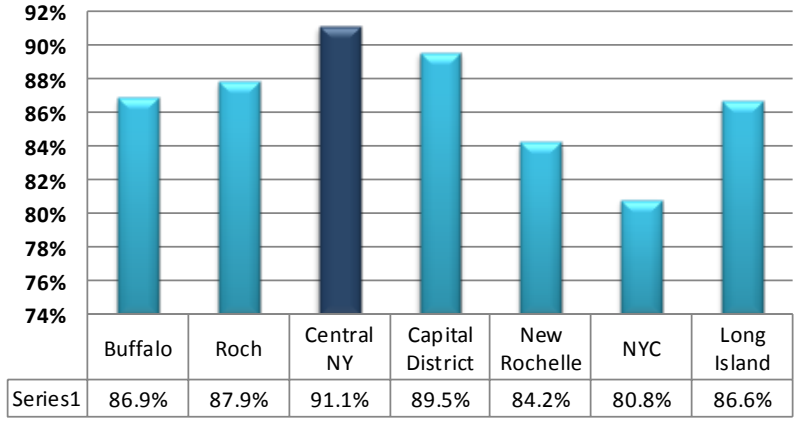
	Buffalo	Roch	Central NY	Capital District	New Rochelle	NYC	Long Island
Series1	52.5	51.5	49.3	51.8	45.4	50.5	49.4

Potentially Avoidable Hospitalizations per 10k Long-stay Days



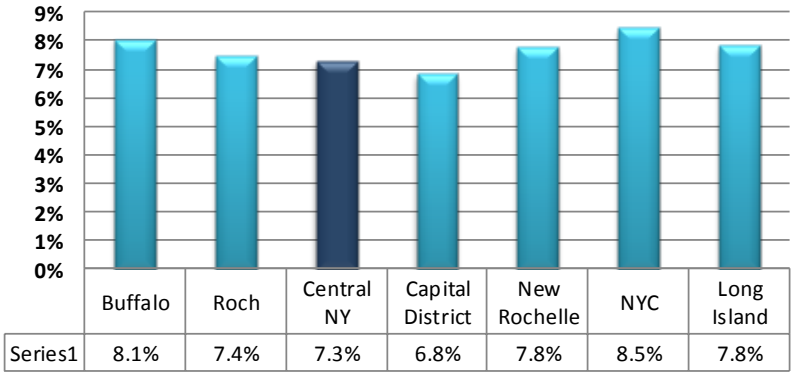
	Buffalo	Roch	Central NY	Capital District	New Rochelle	NYC	Long Island
Series1	5.5	6.3	6.4	6.9	7.8	6.8	7.5

Percent of Employees with Flu Shot



	Buffalo	Roch	Central NY	Capital District	New Rochelle	NYC	Long Island
Series1	86.9%	87.9%	91.1%	89.5%	84.2%	80.8%	86.6%

Long Stay, High-Risk Residents with Pressure Ulcers



	Buffalo	Roch	Central NY	Capital District	New Rochelle	NYC	Long Island
Series1	8.1%	7.4%	7.3%	6.8%	7.8%	8.5%	7.8%

Source: LeadingAge NY analysis of DOH-calculated data

Benchmarking Tools- Turnover

Nursing Staff Turnover Benchmarks

Source: 2013 RHCF Medicaid Cost Reports, Contract Staff Excluded	2013 Median Employee Turnover Rate				
	TOTAL (Nursing, Therapy & Social Work)	RN-LPN-Aide	RN	LPN	AIDE
Buffalo Region	45.2%	46.6%	52.6%	32.5%	51.7%
Rochester Region	37.6%	38.2%	31.3%	35.2%	40.2%
Central NY	37.5%	39.4%	38.5%	34.7%	44.1%
Northeastern NY	30.7%	32.4%	29.1%	34.3%	34.3%
Hudson Valley	28.5%	29.9%	37.1%	29.8%	23.9%
NYC	13.5%	13.2%	18.5%	12.0%	8.8%
Long Island	16.5%	16.4%	22.1%	18.0%	12.3%
Voluntary	28.6%	29.4%	27.8%	25.2%	29.5%
Public	26.2%	27.7%	24.9%	25.1%	24.8%
Proprietary	24.5%	24.4%	33.9%	26.8%	19.8%
Statewide	26.6%	27.7%	28.7%	25.6%	24.9%

Turnover Rate = number of terminations (vountary and non) during the year divided by average number of staff during the year.

Source: LeadingAge NY analysis of 2013 RHCF Report data

Benchmarking Tools- Retention

Nursing Staff Retention Benchmarks

Source: 2013 RHCF Medicaid Cost Reports, Contract Staff Excluded	2013 Median Employee Retention Rate				
	TOTAL (Nursing, Therapy & Social Work)	RN-LPN-Aide	RN	LPN	AIDE
Buffalo Region	73.6%	72.9%	64.3%	76.8%	72.9%
Rochester Region	71.6%	71.2%	70.7%	74.1%	70.9%
Central NY	71.7%	71.0%	72.7%	72.7%	71.0%
Northeastern NY	70.7%	70.2%	73.7%	71.5%	70.6%
Hudson Valley	79.7%	80.6%	77.8%	80.0%	83.8%
NYC	88.3%	89.3%	83.3%	86.6%	93.0%
Long Island	84.2%	83.8%	79.6%	87.1%	86.4%
Voluntary	78.9%	78.8%	80.2%	81.8%	77.7%
Public	81.1%	80.1%	77.2%	83.3%	81.1%
Proprietary	79.4%	80.0%	75.0%	77.8%	82.1%
Statewide	79.3%	79.2%	78.6%	80.0%	81.1%

Source: LeadingAge NY analysis of 2013 RHCF Report data

Note: The retention rate calculation DOH will use for ATI purposes is not yet certain