LeadingAge NY
CFO Council Meeting
Policy/Reimbursement Update

April 2015

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Reimbursement Update

Agenda:

- Medicaid FFS Rate Issues
- Key Medicare Issues
- Transition to Medicaid Managed Care
- Executive Compensation
- 2015 State Budget
- A Little More on Managed Care

Medicaid FFS Rate Issues

- 1/1/15 Medicaid Rate
- 5% CMI Constraint / MDS Audits
- 2012 & 2013 Cash Receipts Assessment Reconciliation
- 2013 & 2014 Nursing Home Quality Initiative
- 2% ATB Cut Restoration
- Universal Settlement
- Global Cap

Medicaid FFS Rate Issues

1/1/15 Medicaid Rate Updates

- Current Medicaid rates being paid are 1/1/15 rates with Jan. 2014 CMI
- Retro adjustments to update to 1/1/15 rates with Jan 2014 CMI were made in Medicaid rates cycle 1959 (along with 2012 assessment reconciliation)
- The Medicaid rates that nursing homes are currently receiving will eventually be reconciled retro to 1/1/15 to reflect 1/1/15 rate with July 2014 CMI
- Individual facility 6 month CMI growth is capped at 5 percent until OMIG completes all audits it intends to do for that roster submission

Medicaid FFS Rate Issues

www.leadingageny.org/topics/data/templates/

Nursing Home Pricing Rate Calculation Template and CMI Scenario Modeler

CASE MIX	CMI	CMI Adj %	Bariatric ($17)	Dementia ($8)	TBI ($36)	Special Pop. Add-on
January 2011 CMI and Special Population Counts	0.89	0.9807	13	6	0	$ 2.89
Enter Scenario CMI and Special Population Counts (if desired)	1.06	1.1680	14	7	0	$ 3.16

◉ Use January 2011 CMI

○ Use Scenario CMI

LeadingAge New York

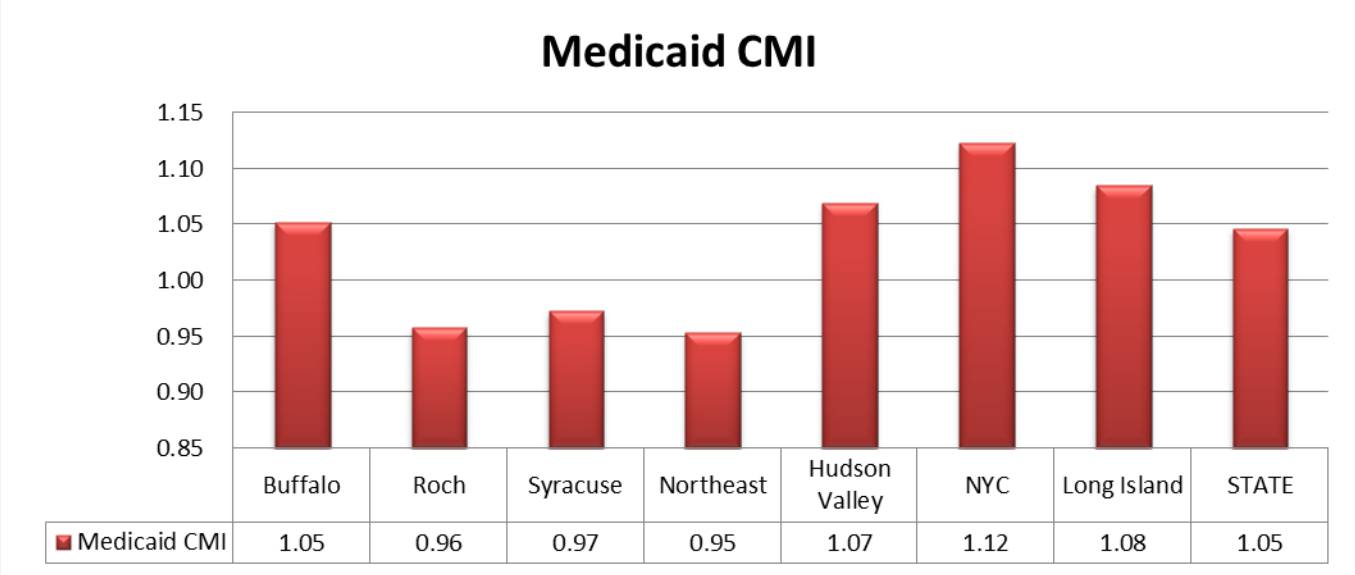
		YEAR 1		YEAR 2		YEAR 3		YEAR 4		YEAR 5		YEAR 6	
		2012 Medicaid Rate (Part B Ineligible)	Medicaid Rate for Part B Eligible Patients	Medicaid Rate (Part B Ineligible)	Medicaid Rate for Part B Eligible Patients	Medicaid Rate (Part B Ineligible)	Medicaid Rate for Part B Eligible Patients	2015 Medicaid Rate (Part B Ineligible)	Medicaid Rate for Part B Eligible Patients	Medicaid Rate (Part B Ineligible)	Medicaid Rate for Part B Eligible Patients	Medicaid Rate (Part B Ineligible)	Medicaid Rate for Part B Eligible Patients
	Nursing Home Price Calculation												
1	Facility Specific Non Comp Price	10.71	10.71	10.71	10.71	10.71	10.71	10.71	10.71	10.71	10.71	10.71	10.71
2	Statewide Direct Price	102.54	101.12	108.38	106.88	113.00	111.43	114.32	112.73	114.85	113.25	115.37	113.76
3	WEF Adjustment	0.7912	0.7912	0.7912	0.7912	0.7912	0.7912	0.7912	0.7912	0.7912	0.7912	0.7912	0.7912
4	Facility Case Mix Adjustment	0.9807	0.9807	0.9807	0.9807	0.9807	0.9807	0.9807	0.9807	0.9807	0.9807	0.9807	0.9807
5	WEF and Case Mix Adjusted Price	79.57	78.46	84.10	82.93	87.68	86.47	88.71	87.47	89.11	87.88	89.52	88.27
6	Statewide Indirect Price	50.82	50.82	53.71	53.71	56.00	56.00	56.66	56.66	56.92	56.92	57.18	57.18
7	WEF Adjustment	0.8884	0.8884	0.8884	0.8884	0.8884	0.8884	0.8884	0.8884	0.8884	0.8884	0.8884	0.8884
8	WEF Adjusted Indirect Price	45.15	45.15	47.72	47.72	49.75	49.75	50.33	50.33	50.57	50.57	50.79	50.79
9	Total Operating Component	135.42	134.32	142.53	141.36	148.15	146.93	149.75	★ 148.52	150.39	149.15	151.02	149.78
10	Dementia, Bariatric, and TBI per diem add-ons	2.89	2.89	2.89	2.89	2.89	2.89	2.89	2.89	2.89	2.89	2.89	2.89
11	Transition Adjustment	10.93	10.93	2.78	2.78	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
12	Quality Adjustment	-	-	-	-	-	-	-	-	-	-	-	-
13	Total Price *(Excluding Capital)*	149.25	148.14	148.20	147.03	151.04	149.82	152.64	151.41	153.28	152.04	153.91	152.67

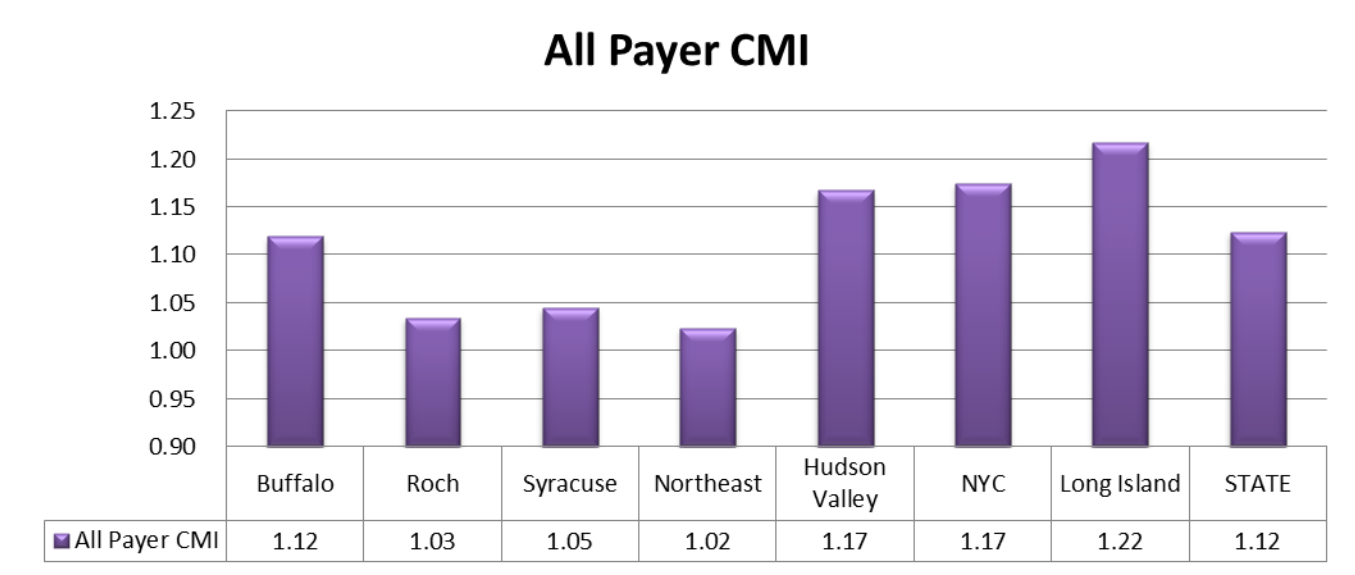
Medicaid FFS Rate Issues

CMI Issues: Audits, Caps and Rosters

- Individual facility 6 month CMI growth is still capped at 5 percent for each roster submission period starting with Jan. 2013
- DOH is preparing to release the 5 percent cap for Jan. 2013 and reissue July 2012 and Jan. 2013 rates reflecting OMIG audit findings in May
- $14 million impact
- CMI and special population add-ons (BMI and dementia) remain only opportunity for homes to impact their Medicaid operating rate
- OMIG most common MDS audit findings revolve around:
  - ADL Coded Inaccurately
  - Physicians visits not counted properly
  - Therapy not recorded properly
- LeadingAge NY clinical staff working with DOH to clarify OMIG standards
- Awaiting clarification on MDS Section S (Medicaid MC vs MLTC)
- January 2015 Census Rosters due by April 17

January 2014 CMI





Medicaid FFS Rate Issues

Cash Receipts Assessment Reconciliation

- 2012 reconciliation complete
- Calculation sheets posted on HCS
- Rate adjustment made in Medicaid Payment Cycle 1959
- Error and correction of 2012 reconciliation rolling into subsequent years
- Update to assessment reimbursement per-diem expected on 1/1/16 (based on 2013 reconciled amount)
- Add-ons listed along with rate components on benchmark rate information posted on the DOH Medicaid reimbursement web page

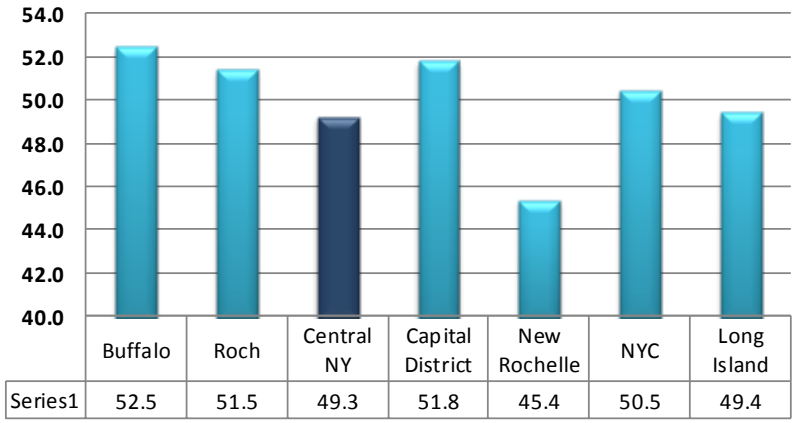
Medicaid FFS Rate Issues

Nursing Home Quality Initiative (NHQI)

- For 2014, the overall point distributions in the NHQI were revised to decrease the weight given to Potentially Avoidable Hospitalizations (PAH) from 20 to 10 points.
- Starting 2014 homes receive points for improvement as well as high scores.
- The three Quality Measures (QMs) for vaccinations were 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 was revised to reflect the primary diagnosis in the hospital discharge record rather than the previously-used admitting diagnosis.
- An adjustment is now applied to the Five-Star survey rating to reflect regional variations in survey results.
- 2014 facility score sheets have been posted to the HCS and made available to the public.
- CMS has approved the 2014 NHQI and DOH is in the process of calculating rate adjustment amounts
- Quality workgroup scheduled to meet in May
- 2013 NHQI rate adjustments still on the verge of being made

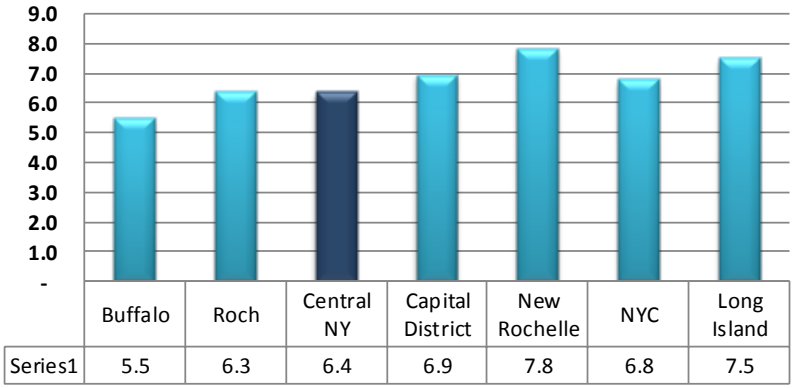
Selected Average 2014 Quality Pool Scores

Average Total Score



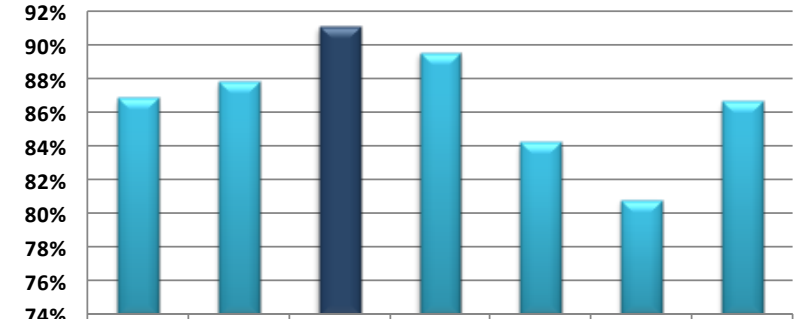
	Buffalo	Roch	Central NY	Capital District	New Rochelle	NYC	Long Island
Series1	52.5	51.5	49.3	51.8	45.4	50.5	49.4

Potentially Avoidable Hospitalizations per 10k Long-stay Days



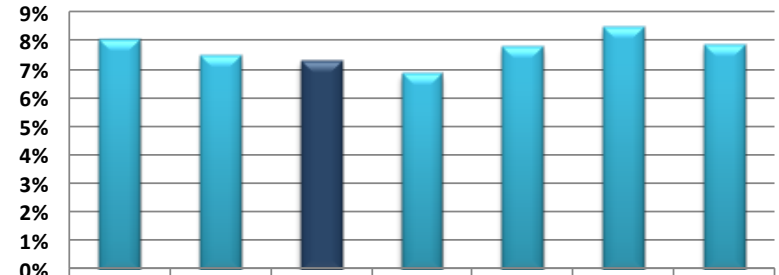
	Buffalo	Roch	Central NY	Capital District	New Rochelle	NYC	Long Island
Series1	5.5	6.3	6.4	6.9	7.8	6.8	7.5

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

Medicaid FFS Rate Issues

Two-percent Cut Restoration: Still waiting for CMS approval of the restoration of the two percent across-the-board cut to Medicaid rates retroactive to April 1, 2014. State maintained its authority to continue alternative cost containment arrangements (e.g., assessment taxes, etc.) that were made in lieu of the two percent cut.

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. Although no provision to guarantee this was included in the 2015-16 budget, DOH recently reiterated their intent to do so retroactively to April 1, 2014.

Medicaid FFS Rate Issues

Universal Settlement

- 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
- Governor's office and attorneys currently drafting release documents
- Most homes have submitted lists of their appeals and litigation excluded from the settlement
- Homes Nursing homes have until April 24 to notify DOH of OMIG audits eligible for discontinuation
- Failure to identify such audits could result in the finalization of such audits and recoupment even if those audits would otherwise be eligible for discontinuance under the terms of the Settlement.

Medicaid Global Cap

Global Cap

- Through November spending under the Global Cap was $10 million below estimates;
  - ✓ Fee-For-Service and Medicaid Managed Care spending are on target with estimates;
  - ✓ Timing related issues include lower spending in Other State Agencies (-$58 million) offset by lower audit recoveries (+$52 million).
- Health care coverage was provided to an additional 287,000 fragile and low income recipients through November:
  - ✓ Medicaid Managed Care enrollment increased by 403,000 recipients.
  - ✓ Fee for Service enrollment decreased by 116,000 recipients.

Global Cap Spending

Medicaid Spending November 2014 (dollars in millions)			
Category of Service	**Estimated**	**Actual**	**Variance**
Medicaid Managed Care	**$8,058**	**$8,061**	**$3**
Mainstream Managed Care	$5,820	$5,842	$22
Long Term Managed Care	$2,238	$2,219	($19)
Family Health Plus	**$289**	**$314**	**$25**
Total Fee For Service	**$6,312**	**$6,304**	**($8)**
Inpatient	$1,973	$1,977	$4
Outpatient/Emergency Room	$265	$271	$6
Clinic	$379	$368	($11)
Nursing Homes	$2,208	$2,223	$15
Other Long Term Care	$477	$473	($4)
Non-Institutional	$1,010	$992	($18)
Medicaid Administration Costs	**$292**	**$318**	**$26**
OHIP Budget / State Operations	**$111**	**$100**	**($11)**
Medicaid Audits	**($270)**	**($218)**	**$52**
All Other	**$1,620**	**$1,523**	**($97)**
Local Funding Offset	**($4,966)**	**($4,966)**	**$0**
TOTAL	**$11,446**	**$11,436**	**($10)**

Medicare Issues

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).

Medicare Issues

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

Medicare Issues

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.

Medicare Issues

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.

Medicare Issues

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 in 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.

Medicare Issues

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. Information can also be found on the project website.

Medicare Issues

SNF PPS Rule- Geography

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. 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). Also, both Jefferson and Yates counties moved from “Rural” to “Urban” with a resulting net positive impact on the wage indices for these areas.

Medicare Issues

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.

Medicare Issues

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.

Medicare Issues

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.

Medicare Issues

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.

Medicare Issues

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.

Medicare Issues

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.

Medicare Issues

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.

Medicare Issues

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.

Medicare Issues

Effective Oct. 1, 2015, the Centers for Medicare and Medicaid Services (CMS) intends to begin collecting nursing home staffing data through the new Payroll-Based Journal (PBJ) reporting system. CMS set up a 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.

Medicare Issues

Beginning Jan. 1, 2015, CMS began applying a VM to physician payments under the Medicare Physician Fee Schedule for physicians in groups with 100 or more EPs based on the 2013 performance period. The program will continue to be phased in according to the following schedule:

In 2016, the payment adjustments will apply to physicians in groups of 10 or more EPs based on 2014 performance;

2017, the payment adjustments will apply to physician solo practitioners and physicians in groups of 2 or more EPs based on 2015 performance; and

2018, the payment adjustments will also apply to non-physician EPs who are solo practitioners or are in groups of 2 or more EPs.

Medicare Issues

New Timely Filing Requirements

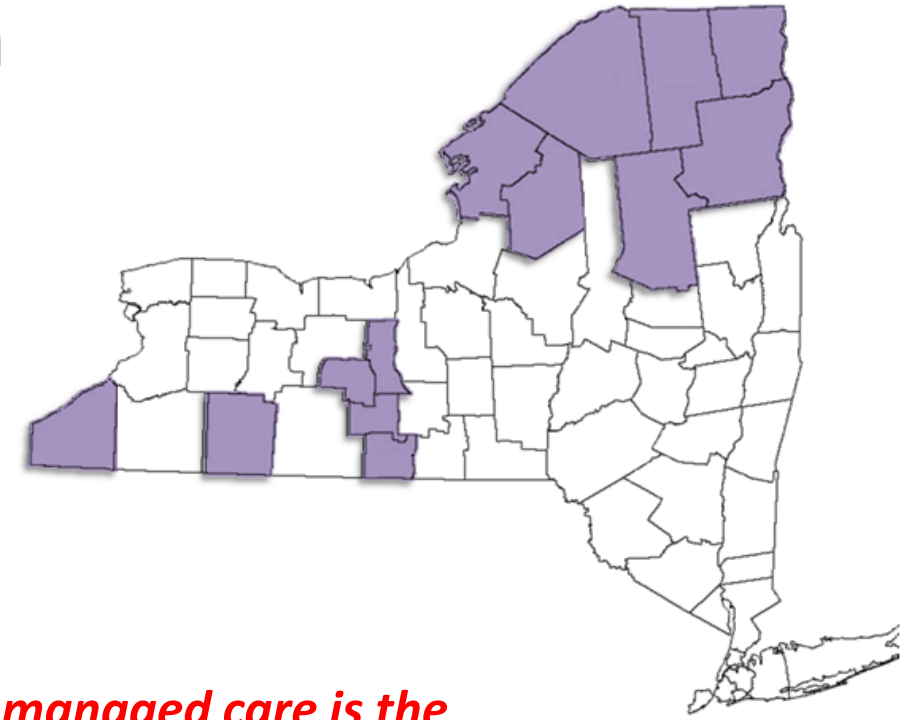
- For **institutional claims** that include span dates of service (i.e., a "From" and "Through" date span on the claim), the "**Through" date on the claim will be used to determine the date of service for claims filing timeliness.**
- For **professional claims (CMS-1500 Form and 837P**) submitted by 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

Transition to Managed Long Term Care (Community Medicaid, as of 3/2015)

MLTC Upstate Transition

Counties left to complete the transition, upon approval by CMS, are the Southern Tier counties of **Allegany, Chautauqua, Chemung, Schuyler, Seneca,** and **Yates;** and the North Country counties of **Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis,** and **St. Lawrence**.



Source: NYS DOH

Other hot development in managed care is the coming carve-in of behavioral health

NH Transition to Managed Care

Transition to Managed Care for Nursing Home Residents

- New permanent nursing home residents required to enroll into managed care
- Started Feb 1 for NYC
- Started April 1 for Westchester and Long Island
- Beginning July 1 Upstate

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 houses a regularly updated timeline outlining the transition to managed care for all LTC populations.

NH Transition to Managed Care

Nursing Home Transition Phase-In Schedule	
Month	**County**
February 1, 2015 **Phase 1**	New York City – Bronx, Kings, New York, Queens and Richmond
April 1, 2015 **Phase 2**	Nassau, Suffolk and Westchester
July 1, 2015 **Phase 3**	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, St. Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, Yates
October 1, 2015	Voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid.

Source: NYS DOH

NH Transition to Managed Care

Three Year Rate Protection

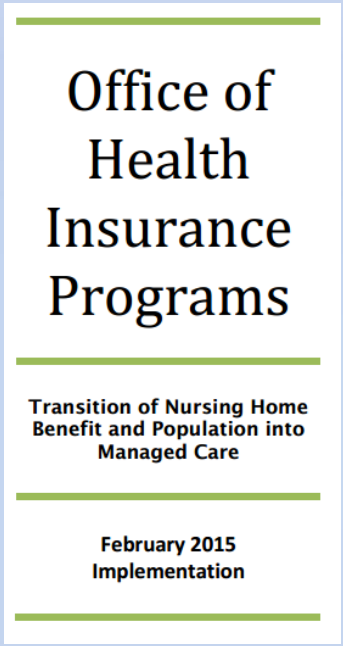
Managed Care Organizations (MCOs) will be required to pay a nursing home provider the DOH-calculated fee-for-service (FFS) rate for three years. However, a plan and provider may negotiate an alternative rate acceptable to both parties. DOH will reassess whether there is a need for a longer transition after one year. The FFS rate includes cash receipts assessment reimbursement amount and plans are required to pay bed-hold.

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.

NH Transition to Managed Care - Resources

www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm

Transition of Nursing Home Populations and Benefits into Medicaid Managed Care Recorded Webinar and Slides (Jan. 22, 2015)



Three sets of Frequently Asked Questions (Released in January, March and April 2015)

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

NH Transition FAQ Greatest Hits

Q: Will NHs continue to bill Medicare Part B for rehabilitation services, or bill the MLTC plan instead?

A: Billing policies have not changed under this transition. Plans are responsible for maximizing other insurance coverage, and Medicaid is the payer of last resort.

NH Transition FAQ Greatest Hits

Q: Please clarify the term "quarterly" regarding claims submission. Will NH bill the MCOs every three months?

A: NHs will bill plans according to an agreed upon schedule and in accordance with the contractual arrangement between the plan and provider. However, in workgroup discussions, plans indicated a willingness to process claims bi-weekly.

NH Transition FAQ Greatest Hits

Q: Considering the benchmark rate does not include levels, how should plans reimburse rehabilitative services after a hospital admission?

A: The benchmark is based directly on the promulgated nursing facility rate. These rates include an average Medicaid only case mix for the facility based upon a census submitted by the facility. This average rate is paid to nursing facilities for six months and then revised based upon the next census. The nursing facility rate is not adjusted on a patient specific basis.

NH Transition FAQ Greatest Hits

Q: How should Nursing Homes bill for retroactive rate adjustments for Case Mix Index (CMI)?

A: The Department is creating a schedule to allow the initial case mix rates to be issued during the month in which the rate is active, eliminating the need for retro billing. In addition, the Department is examining all rate schedules in an effort to issue statewide rate packages twice per year.

NH Transition FAQ Greatest Hits

Q: Do managed care plans receive additional reimbursement from the State for contracting with a facility with a high property in its rate?

A: There is a Nursing Home Price Mitigation Pool to provide additional funding to high cost Nursing Homes.

NH Transition FAQ Greatest Hits

Q: What are the requirements for the sharing of care plan information between the MCO and the Nursing Home for an enrollee?

A: The NH remains responsible for care provided, and the plan authorizes the care plan based upon medical necessity criteria. MCO may make a determination regarding the medical necessity of patient care. If agreement cannot be reached, plans and providers must utilize the Complaints and Appeals process to arrive at a determination.

NH Transition FAQ Greatest Hits

Q: If a patient is enrolled in Hospice, who is responsible for billing the plan, Hospice provider or the NH?

A: The hospice provider will bill the MCO for room and board provided to patients residing in the nursing home and pass this amount to the nursing home.

NH Transition FAQ Greatest Hits

Q: If a consumer is admitted to a nursing home for a short term stay following an inpatient hospital stay, is an eligibility determination by the LDSS, including a 60 month look back, required?

A: No, plans are required to cover short term stays. There are no changes to the eligibility rules that districts will use to determine eligibility for Medicaid coverage of long-term nursing home care (permanent placement); including when the 60-month transfer of assets look-back period applies or the application of a transfer of assets penalty period.

NH Transition FAQ Greatest Hits

Q: Can a mainstream MMC enrollee be disenrolled for non-payment of NAMI? If so, what are the parameters for disenrollment? If not, what are the guidelines?

A: Consumers may not be disenrolled for non-payment of NAMI.

Q: Is the Plan delegation of NAMI collection to a NH a contractual matter? Is the NH allowed to refuse this delegation?

A: NAMI delegation is a contractual arrangement between plans and providers. Nursing homes are not required to accept delegation of this task by a plan. It is recommended that plans discuss the collection of the NAMI and any communications nursing homes have developed for collection purposes with a nursing home. The Department does not have required forms or letters for this use.

NH Transition FAQ Greatest Hits

Q: How common is delegation of Net Available Monthly Income (NAMI) collection by plans to NHs statewide?

A: NAMI delegation is a contractual arrangement between plans and providers. DOH does not have access to this specific data.

Q: Will budgets be provided to the NH facility to document the NAMI amount to be collected?

A: The plans will receive a copy of the enrollee's eligibility notice specifying the NAMI amount due. If the plan delegates the NAMI collection to the NH, the plan is responsible for advising the NH of the amount to be collected.

NH Transition FAQ Greatest Hits

Q: What assessment tool will be utilized to determine level of care?

A: All mandated assessments and evaluation criteria will continue under MMC and MLTC enrollment. For example, nursing homes receiving Medicaid or Medicare payment will continue to utilize the Minimum Data Set (MDS) to assess all consumers upon admission to the Nursing Home and periodically after admission. Care Assessment Areas (CAAs) will also continue to be required to formulate the individual's care plan.

NH Transition FAQ Greatest Hits

Q: MCOs or MLTCs grant retro authorization if the NH does not obtain prior authorization?

A: It is anticipated that admission and the billing cycle begin after authorization is obtained. There may be extenuating situations where retro-authorization may be needed in order to address a specific member. However, all non-emergent transitions in care should be authorized by the plan as part of the discharge planning process. This would be part of the provider's contract negotiation process with the plan.

NH Transition FAQ Greatest Hits

Q: Many MCOs appear to be contracting with the larger NH facilities to meet network requirements. What can smaller nursing homes do to obtain contracts with plans?

A: DOH encourages nursing homes to contract with multiple plans whose service area includes the NH if possible. Based on the information we have on contracting, the majority of NH facilities have contracts with MCOs. For example, the most recent information shows that only 3 of the 43 NHs in the Bronx do not have a contract, 5 of the 40 in Brooklyn don't have a contract, 1 of the 18 New York NHs don't have a contract and four of the 55 NHs in Queens do not have at least one contract with a MMCP. As a result, this does not appear to be an issue as it relates to access. The DOH will continue to monitor.

NH Transition FAQ Greatest Hits

Q: What happens when a MCO says an enrollee who is a NH resident no longer needs LTC, but the resident has no community address to which to be discharged? Does the plan continue payment until discharge?

A: In the absence of a safe and adequate discharge, the enrollee must remain in the nursing home, and the plan will continue to be responsible for the nursing home payments until a safe discharge can be arranged.

NH Transition FAQ Greatest Hits

Q: Will nursing home be required to ensure that individual health providers who provide care at their facility have participating network agreements with the same plans as the nursing home? If not, what are the disclosure requirements of the nursing home and the provider?

A: Nursing homes should clearly identify non-salaried providers who treat members in the NH. The Department strongly encourages any non-salaried provider to contract with the plan to avoid denials in the future.

NH Transition to Managed Care

Plan Selection and Enrollment

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

Source: NYS DOH

NH Transition to Managed Care

Transitions: Hospital to Nursing Home

- Hospital Role:
  - Checks eligibility; Notifies MCO of stay and possible need for LTC
  - Assembles discharge planning team
  - Arranges meetings with enrollee, family and team
  - Conducts PASRR, PRI
  - Obtains information from MCO participating NHs on placement openings that meet enrollee needs
  - Physician makes recommendation for transition and care plan based on:
    - Clinical needs of enrollee
    - Functional criteria
    - Availability of services in the community
  - Communicates recommendation, care plan (specific enrollee needs) and supporting documentation to MCO for authorization

Source: NYS DOH

NH Transition to Managed Care

Transitions: Hospital to Nursing Home

- Nursing Home Role:
  - Responds to request for placement openings that meet enrollees needs
  - Communicates with Hospital and MCO on care plan development
  - Obtains authorization for stay prior to admission
  - Conducts mandatory assessments

Source: NYS DOH

NH Transition to Managed Care

Transitions: Hospital to Nursing Home

- MCO Role:
  - Provides plan liaison; reaches out to hospital when notified of stay
  - Has knowledge if enrollee already in receipt of LTSS
  - Member of discharge planning team, ensures:
    - person centered care planning
    - enrollee choice, enrollee education about care options
    - decisions not based on financial incentives for hospital, plan or nursing home
  - Provides list of participating nursing homes/community providers
  - Assists in matching needs of enrollee to available providers or securing out of network
  - Assists in compiling documentation for authorization review

Source: NYS DOH

NH Transition to Managed Care

Transitions: Hospital to Nursing Home

- MCO Role (continued):
  - Upon receipt of recommendation for transition
    - Assesses care plan and clinical needs
    - approves or adjusts the care plan to ensure member's needs are met
    - Considers member choice
  - Authorizes care plan and placement in timely manner and before discharge
  - Notifies providers, enrollees of determination
  - Arranges for UAS-NY assessments in NH

Source: NYS DOH

NH Transition to Managed Care

Source: NYS DOH

NH Transition to Managed Care

Transitions: Community to Nursing Home

- MCO Role:
  - Provides NH plan liaison
  - Member of care planning team, ensures:
    - person centered care planning
    - enrollee choice, enrollee education about care options
    - decisions not based on financial incentives
  - Assists in compiling documentation for authorization review
  - Upon receipt of recommendation for transition:
    - Assesses care plan and clinical needs
    - approves or adjusts the care plan to ensure member's needs are met
  - Authorizes care plan and placement in timely manner
  - Notifies providers, enrollees of determination
  - Arranges for UAS-NY assessments in NH

Source: NYS DOH

NH Transition to Managed Care

Benchmark Rates

- The benchmark rate will include all aspects of the Nursing Homes reimbursement for a FFS patient, including but not limited to Operating, Capital, Per Diems, Cash Assessment and Quality.
- The benchmark rate will be updated and published on the DOH Public Website at least twice a year.
  - http://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/
  - Plans and providers should coordinate through the contracting process how to incorporate the benchmark rate into Nursing Home reimbursement.
  - The Department does not object to Plans and providers appending benchmark rate sheets to contracts.

Source: NYS DOH

NH Transition to Managed Care

Plan Billing

- The following illustrates how an ancillary service such as physician services will be handled:
  - Mainstream – Included in premium/benefit
    - Scenario 1 – NH does cover physician benefit (in benchmark), Plan pays NH as part of benchmark rate
    - Scenario 2 – NH does not cover physician benefit (not in benchmark), Plan pays physician
  - MLTC – Not included in premium/benefit
    - Scenario 1 – NH does cover physician benefit (in benchmark), Plan pays NH as part of benchmark rate
    - Scenario 2 – NH does not cover physician benefit (not in benchmark), physician bills FFS
- Therapeutic/ Hospital Leave days where a Nursing Home is required to reserve the bed for the patient the Plan will be required to pay the NH. The cost associated with these days have been included in the base data and are reflected in the premium.

Source: NYS DOH

FIDA

FIDA (Fully Integrated Dual Advantage)

- Model of managed long term care that will integrate Medicaid and Medicare funding and services 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 can voluntarily enroll in FIDA plans.
- *Beginning April 2015:* Permanently-placed adult residents in Bronx, Kings, Nassau, New York, Queens, and Richmond counties will be passively enrolled in a FIDA plan. Residents that opt out of FIDA will 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 is cancelled) due to lack of network adequacy and there is no new target date.**

FIDA

FIDA Enrollment Update*

January 1	February 1	March 1	April 1 (PE)	May 1 (PE)
237	269	243	7,134	8,667

NYMC Calls Received	Total Opt-Outs
49,803	31,801

*As of March 7, 2015

Source: NYS DOH

DSRIP

Q: What is DSRIP?

A: Delivery System Reform Incentive Payment Program (DSRIP). It 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, 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.

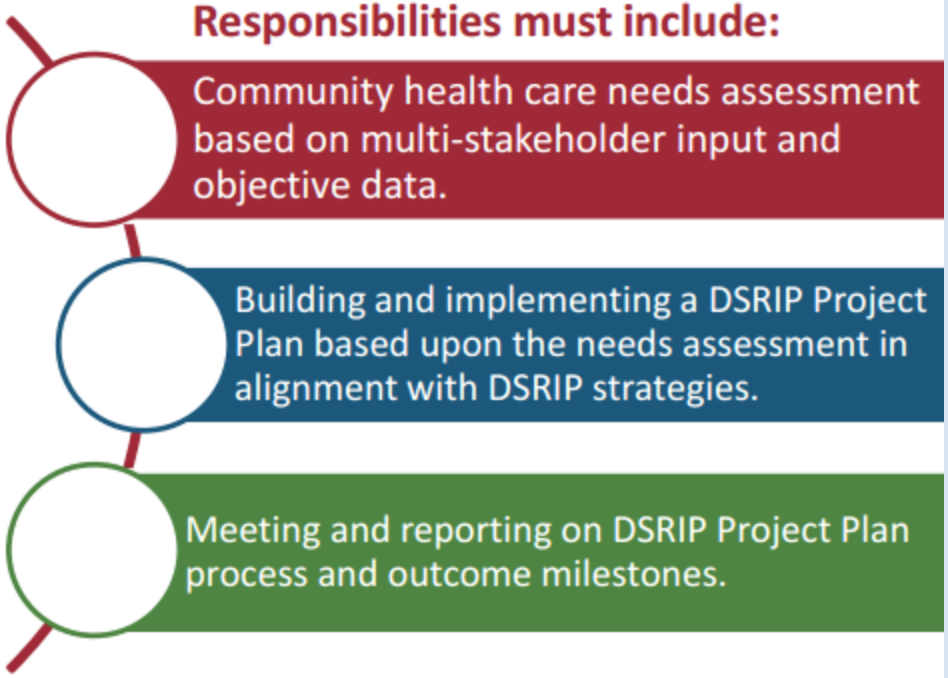
DSRIP

PERFORMING PROVIDER SYSTEMS (PPS): LOCAL PARTNERSHIPS TO TRANSFORM THE DELIVERY SYSTEM

Partners should include:

- *Hospitals*
- *Health Homes*
- *Skilled Nursing Facilities*
- *Clinics & FQHCs*
- *Behavioral Health Providers*
- *Home Care Agencies*
- *Other Key Stakeholders*

Responsibilities must include:



DSRIP

PPS by County

Albany
Albany Medical Center Hospital
Ellis Hospital
Broome
United Health Services Hospitals
Clinton
Adirondack Health Institute
Columbia
Albany Medical Center Hospital
Delaware
Mohawk Valley PPS (Bassett)
United Health Services Hospitals
Westchester Medical Center
Dutchess
Montefiore Hudson Valley Collaborative
Westchester Medical Center
Essex
Adirondack Health Institute
Franklin
Adirondack Health Institute
Fulton
Adirondack Health Institute
Ellis Hospital
Greene
Albany Medical Center Hospital

Hamilton
Adirondack Health Institute
Herkimer
Mohawk Valley PPS (Bassett)
Montgomery
Ellis Hospital
Rensselaer
Ellis Hospital
Saratoga
Adirondack Health Institute
Albany Medical Center Hospital
Ellis Hospital
Schenectady
Ellis Hospital
Schoharie
Mohawk Valley PPS (Bassett)
Warren
Adirondack Health Institute
Albany Medical Center Hospital
Washington
Adirondack Health Institute

Project	Capital Region	
	Albany Medical Center Hospital	Ellis Hospital
Domain 2: System Transformation Projects		
A. Create Integrated Delivery Systems		
2.a.i Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management		
2.a.iii Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services		
2.a.v Create a medical village/alternative housing using existing nursing home infrastructure		
B. Implementation of Care Coordination and Transitional Care Programs		
2.b.iii ED care triage for at-risk populations		
2.b.iv Care transitions intervention model to reduce 30 day readmissions for chronic health conditions		
2.b.viii Hospital-Home Care Collaboration Solutions		
D. Utilizing Patient Activation to Expand Access to Community Based Care for Special Populations		
2.d.i Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care		
Domain 3: Clinical Improvement Projects		
A. Behavioral Health		
3.a.i Integration of primary care and behavioral health services		
3.a.ii Behavioral health community crisis stabilization services		
3.a.iv Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs		
B. Cardiovascular Health—Implementation of Million Hearts Campaign		
3.b.i Evidence-based strategies for disease management in high risk/affected populations (adult only)		
D. Asthma		
3.d.ii Expansion of asthma home-based self-management program		
3.d.iii Implementation of evidence-based medicine guidelines for asthma management		
G. Palliative Care		
3.g.i Integration of palliative care into the PCMH Model		
Domain 4: Population-wide Projects: New York's Prevention Agenda		
A. Promote Mental Health and Prevent Substance Abuse (MHSA)		
4.a.iii Strengthen Mental Health and Substance Abuse Infrastructure across Systems		
B. Prevent Chronic Diseases		
4.b.i. Promote tobacco use cessation, especially among low SES populations and those with poor mental health.		
4.b.ii Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer)		

DSRIP

Attribution:

- Medicaid members will be assigned to a single PPS through a process known as attribution. The NYSDOH will use geography, historical health care usage, and primary care provider assignment to attribute individuals to a specific PPS. Attribution will determine funding amounts and outcome metrics for projects.

DSRIP

Not Just New York

- DSRIP initiatives are part of broader Section 1115 Waiver programs and provide states with significant funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries.
- Originally, DSRIP initiatives were more narrowly focused on funding for safety net hospitals however, they increasingly are being used to promote a far more sweeping set of payment and delivery system reforms.
- The first DSRIP initiatives were approved and implemented in California, Texas, and Massachusetts in 2010 and 2011, followed by New Jersey, Kansas and Massachusetts in 2012, and most recently New York which was approved in 2014.

Under DSRIP initiatives, funds to providers are tied to meeting performance metrics

Source: Kaiser Family Foundation

New York State Executive Order No. 38

In effect in all counties except Nassau.

Places limits on executive compensation and administrative costs for covered providers.

LeadingAge NY has challenged in court, awaiting decision.

New York State Executive Order No. 38

Determining Covered Provider Status

Administrative Expenses and Program Services Expenses Calculation.

If an entity determines that it is or is projected to be a Covered Provider, then the entity must calculate its administrative and program services expenses to establish compliance with the Administrative Expenses Cap. The Administrative Expenses Cap is as follows:

- For CRPs commencing between July 1, 2013 and June 30, 2014: no more than 25% of Covered Operating Expenses
- For CRPs commencing between July 1, 2014 and June 30, 2015: no more than 20% of Covered Operating Expenses
- For CRPs commencing July 1, 2015 and thereafter: no more than 15% of Covered

New York State Executive Order No. 38

Operating Expenses

If an entity determines that it is a Covered Provider, it must identify "Covered Executives" and calculate their executive compensation in order to ensure compliance with the E.O. 38 limitations on executive compensation. To assist in this, an Executive Compensation Calculation Worksheet was developed.

- The limits apply to Directors, Trustees, Officers and key employees covered executive compensation in excess of $199,000 requires compensation studies and governing body approval the compensation study should meet the standards delineated in the EO #38 Guidance.
- If compensation is above the 75% percentile or there is no governing board approval, then a waiver submission will be required an exception exists for a formal employment contract that began prior to July 1, 2012.

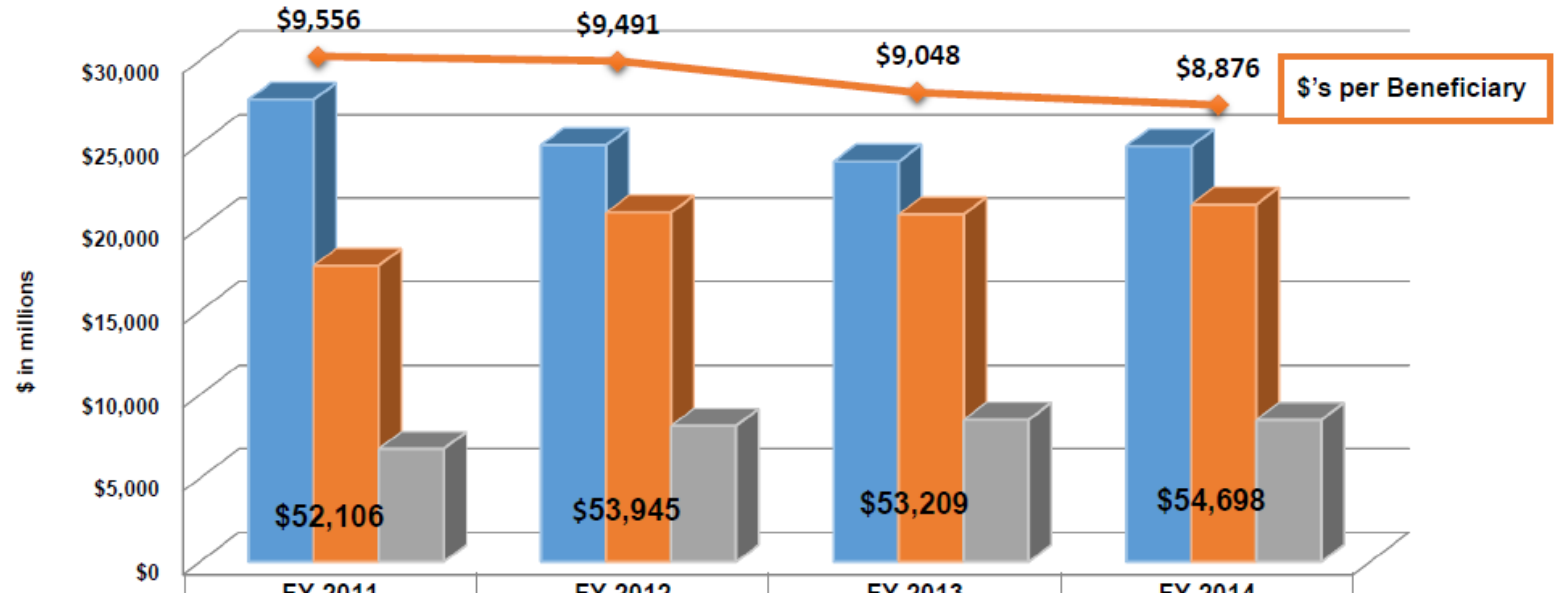
New York State Executive Order No. 38

EO #38 disclosure filings and, if necessary, waiver submissions for year-end December 31, 2014 are due the later of June 29, 2015 or when the organization's NYS cost report is due. Waiver applications for both the Administrative Expenses and Executive Compensation limitations are available through an online waiver application available on the E.O. 38 Website, http://executiveorder38.ny.gov/ .

Final FY 2015-16 State Budget

Medicaid All Funds Spending (FY2011-14)

"Bending" the Cost Curve



	FY 2011	FY 2012	FY 2013	FY 2014
Federal Funds	$27,642	$24,921	$23,940	$24,848
State Funds	$17,714	$20,892	$20,774	$21,368
Local Funds	$6,750	$8,132	$8,495	$8,482

Final FY 2015-16 State Budget

Global Cap

•Extended through March 31, 2017 limiting growth in DOH State Funds Medicaid spending to the 10-year rolling average of the medical component of the Consumer Price Index.

•Increases: $17.1 billion in SFY 2014-15 to $17.9 billion in SFY 2015-16 and $18.7 billion in SFY 2016-17.

Final FY 2015-16 State Budget

Global Cap – Shared Savings

•The global cap shared savings program enacted in 2014 allows for the distribution of 50 percent or more of savings under the cap. is to be distributed proportionally in the first quarter of the calendar year based on the claims and encounters submitted to Medicaid by each provider and plan during the previous three-year period. The remaining savings, up to 50 percent, is to be used to assist financially distressed and critically needed providers as determined by DOH. There were no savings available for distribution during SFY 2014-15.

Final FY 2015-16 State Budget

Global Cap – Local Share

The global cap projection for SFY 2015-16 reflects the third year of the 3-year phase-out of growth in local share Medicaid expenditures enacted in SFY 2013-14. Annual growth in the local share of Medicaid will be capped at zero percent in SFY 2015-16. The final 2015-16 budget also modifies the calculation of the global cap to account for additional State costs or savings that result from implementation of the Basic Health Plan.

Final FY 2015-16 State Budget

Capital Funding

A “dedicated infrastructure investment fund”

$850 million repayment of Medicaid disallowances and overpayments.

$3.05 billion for Upstate Revitalization initiatives and “special infrastructure projects,” including $500 million for the New NY Broadband Initiative and additional capital for health care infrastructure.

$1.4 billion in new capital investments will be made available for infrastructure improvements and additional tools to stabilize health care providers to advance health care transformation goals.

Final FY 2015-16 State Budget

Capital Funding

- $1.2 billion in Capital Restructuring Financing Program (CRFP) funding reauthorized.
- $1.4 billion is to be allocated to:

Kings County Health Care Transformation

Oneida County Health Care Transformation

Essential Health Care Provider Support Program

Other various program

Final FY 2015-16 State Budget

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. “Rural” is defined as a county with fewer than 200,000 people or a town with fewer than 200 people per square mile. Providers eligible for the rural enhanced payment include hospitals, nursing homes, diagnostic and treatment centers, ambulatory surgery centers and clinics.
- The final budget adds 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.
- Increased reporting to legislature.

Background on VAP

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. Comprehensive LeadingAge memo here.
- 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.

Background on VAP

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.
- 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.

Final FY 2015-16 State Budget

Energy Efficiency/Disaster Preparedness

The final budget authorizes DOH to conduct energy efficiency audits and/or emergency preparedness reviews of nursing homes and to develop cost/benefit analyses of potential modifications for each facility. The audits and reviews would serve as the basis of an energy efficiency and/or disaster preparedness program that DOH would develop through regulation. Only homes that participate in the audits or reviews would be eligible to participate in the resulting program and to receive any funding that may be provided as part of the program. Program implementation is contingent on a determination by DOH that the program would be in the best financial interest of the State.

Final FY 2015-16 State Budget

Value-Based Payment (VBP) Arrangements

The final budget legislation rejects the proposed new authority for the Commissioner of Health to authorize VBP arrangements. 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. Similarly, the State's Fully-Integrated Duals Advantage (FIDA) Program requires the implementation of non-fee-for-service provider reimbursement methodologies. DOH intends to submit its VBP "Roadmap" for approval to the Centers for Medicare and Medicaid Services (CMS) by April 15, 2015.

Although the Executive Budget language was not enacted, existing statutory and regulatory provisions appear to allow DOH and the Department of Financial Services to proceed with most elements of the VBP Roadmap.

Final FY 2015-16 State Budget

Medicare-Medicaid "Crossover" Payments

The final budget, accepts in part, the Executive's proposal to limit Medicaid payments for dual eligibles' Medicare Part B coinsurance amounts so that the total Medicare/Medicaid payment to the provider does not exceed the amount that the provider would have received for a Medicaid-only patient. The final budget accepts this cut with respect to dual eligibles in fee-for-service Medicare, but rejects it for dual eligible beneficiaries who are enrolled in Medicare Advantage plans. This cut will take effect on July 15, 2015.

Final FY 2015-16 State Budget

Medicaid Trend Factors

Authorization for previous year's trend (i.e., inflation) factor reductions, specifically reductions and eliminations during 1996-97, was extended for two years through March 31, 2017.

Continuing the pattern of the last several years, trend factor adjustments to Medicaid reimbursements for 2015-17 have been eliminated through March 31, 2017. This trend factor freeze affects hospitals, nursing homes (except for pediatric facilities), Adult Day Health Care (ADHC) programs, Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), personal care providers, Assisted Living Programs (ALPs), hospices and clinics.

Final FY 2015-16 State Budget

Two Percent Across-the-Board Cut

Last year's enacted budget eliminated, effective April 1, 2014, the 2 percent across-the-board cut to all Medicaid service sectors that was in effect since April 1, 2011. However, various provider sectors including nursing homes, ADHC programs, LTHHCPs and ALPs agreed in prior years to alternative savings mechanisms (i.e., increased provider taxes for nursing homes/ADHC/LTHHCPs and reductions in State-only quality funding for ALPs) to the 2 percent Medicaid cut. Existing statute authorizes these alternative mechanisms to be continued on or after April 1, 2014. In the case of nursing home services, collections from the resulting 0.8 percent cash receipts assessment are slated to partially fund the Universal Settlement of Nursing Home Rate Appeals and Litigation.

More information is expected in the near future.

Final FY 2015-16 State Budget

Minimum Wage

The final budget ***rejects*** the Executive's proposal to raise the minimum wage to $11.50 per hour in New York City and to $10.50 per hour in the remainder of the State. As of Dec. 31, 2014, the minimum wage rose to $8.75 per hour and, under existing law, will increase to $9.00 on Dec. 31, 2015.

Final FY 2015-16 State Budget

Medicaid Managed Care Universal Billing Codes

The enacted budget requires that Medicaid payment claims for long term care services, including nursing home services, to Medicaid Managed Care plans, including MLTC plans, use universal billing codes approved by DOH or a nationally accredited organization by Jan. 1, 2016. This addresses the administrative challenge that providers contracting with multiple plans, each with unique billing codes, face. An accompanying provision requires that Medicaid Managed Care Plans, including MLTC plans, pay Medicaid claims via electronic funds transfer by Jan. 1, 2016.

Final FY 2015-16 State Budget

Nursing Home Rate Appeals Cap

The final budget extends for four years, through March 31, 2019, current law that limits the amount of nursing home rate appeals that DOH may process to $80 million per State fiscal year. If the Universal Settlement of Nursing Home Rate Appeals and Litigation goes forward, $50 million of each year's appeals cap will be used to fund the settlement, with the remaining $30 million available for the processing of appeals excluded from the settlement.

Final FY 2015-16 State Budget

Mortgage Refinancing Shared Savings

The final budget authorizes DOH to modify nursing home capital reimbursement rates after April 1, 2015 to share a minimum fifty percent of savings accruing from a mortgage refinancing transaction with the refinancing facility. This provision was discussed by the Nursing Home Capital Work Group and provides a financial incentive for homes to go through the refinancing process while still ensuring that the State benefits from the resulting savings. LeadingAge NY strongly advocated for this initiative which incorporates our proposed language. Further details on the program are expected in the near future.

Final FY 2015-16 State Budget

Young Adult Special Populations Demonstration

The final budget requires DOH to establish up to three demonstration programs to provide more appropriate settings and services, prevent out-of-state placements and allow repatriation to their home communities 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.

Just A Little More on Managed Care

- Fee For Service (FFS) is too costly to sustain
- There are new terms to understand with managed care
- It is critical that the plan and provider are speaking the same language. Subtle differences in terminology can lead to misunderstandings.
- Understand provider manuals not just for the practical information, but to have a sense of how the plan uses terms.
- It is important to understand the different types of plans.
  - Different types of plans will have different benefit packages.
  - Different types of plans generally serve different populations.
  - Policies, contracts, provider manuals will vary even within the same category of plan.

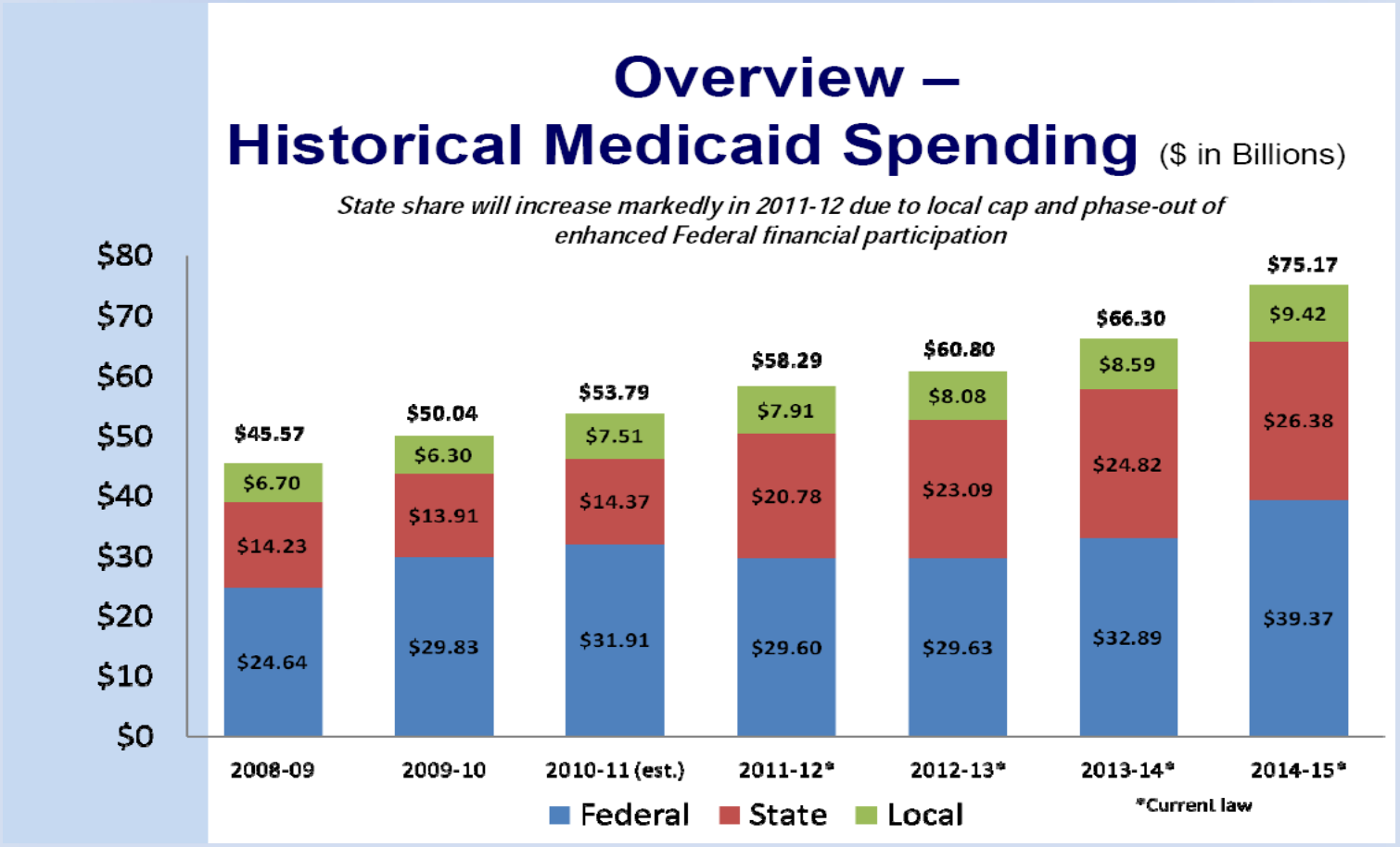
Managed Care Changes Incentives

Party	Issue	Fee-for-Service	Managed Care
Consumer	*Services*	Wide provider choice; minimal limits on services; limited care coordination	Provider choice limited; service limits; focus on care coordination
	Finances	Varying levels of cost sharing	Varying levels of cost sharing and incentives
Health care provider	*Services*	Driven by provider assessment of need, subject to review	Usually determined and authorized by plan
	Finances	State-set reimbursement, volume-driven	Rate negotiated with plan, volume controlled
Payer	*Services*	Scope driven by federal/ state laws, regs and policy	Scope driven by contract with managed care plan
	Finances	Total paid = rate times service utilization	Total paid = PMPM times # of enrollees

The most important slide of all time:

- ACO = Accountable Care Organization – a product of the Affordable Care Act
- BHO = Behavioral Health Organization / Utilization Management focus
- BIP = Balance Incentive 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
- PC = Patrick Cucinelli

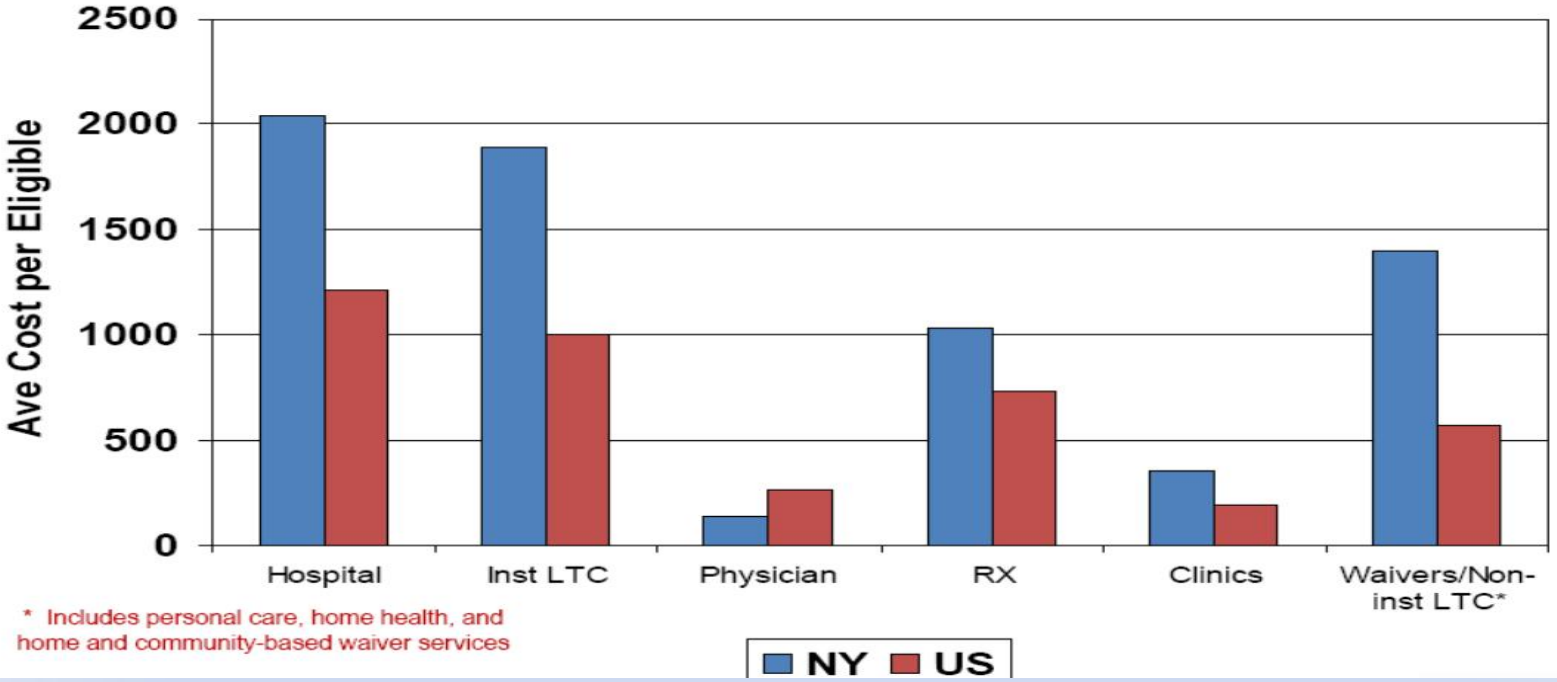
Medicaid Redesign: Comparative Spending



Medicaid Redesign By Service Category

Overview:
Medicaid Spending NYS vs. U.S.

New York is above national average in Medicaid spending in all service categories except for physicians



* Includes personal care, home health, and home and community-based waiver services

Just A Little More on Managed Care

- Understanding how managed care organizations, the DOH, Maximus and the providers interact.
- All referrals will go through Maximus.
- The plans will play a role in selecting providers.
- Enrollees can change plans “midstream.”
- All payments will flow through the plans.
- Opportunity for one off contracts.
- Networks become very important.

Just A Little More on Managed Care

- The NYS DOH has partnered with MAXIMUS to provide all activities related to the CFEEC including initial evaluations to determine if a consumer is eligible for Community Based Long Term Care (CBLTC) for more than 120 days. The CFEEC will be responsible for providing conflict-free determinations by completing the Uniform Assessment System (UAS) for consumers in need of care.
- CFEEC evaluations are conducted in the home (includes hospital or nursing home) by a Registered Nurse for new to service individuals and all other related activities are conducted in writing or by phone.

Just A Little More on Managed Care

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

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

Just A Little More on Managed Care

- In or Out of Network – Impact on Admissions.
- Medicaid Eligibility and Pending
- Changing Enrollment.
- Working with plans assigned care or case worker.
- Pre-Authorizations and Authorizations.
- Plan assessments, care planning, quality assurance and satisfaction surveys.
- Define your process of insurance verification and dis-enrollment from plan

Just A Little More on Managed Care

- Provider and plan disagree? Conflict –Free Evaluation process
- Fair Hearing Rights.
- Know your contracts and billing manuals.
- Cash Flow Impact.

Thank You!

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