Long Term Care Policy Update

July 2014

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LeadingAge NY

Policy Update

July 2014

- Federal (Medicare) Developments
- Managed Care – If you have not started, its already too late!
- State Budget
- Medicaid Rate Issues

Policy Update

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CCRC Cabinet Update

The 10th anniversary CCRC Summer Summit

LeadingAge NY advocacy was successful in obtaining an indefinite delay to the June 30 deadline for CCRCs to submit their marketing incentives. The issue remains controversial and we continue to advocate for a resolution to the issue with both DOH and DFS.

LeadingAge NY was successful in posting an editorial about the fact that New York is lagging behind the rest of the nation in terms of CCRC development, due mostly to overly burdensome regulations and regulatory barriers. The basic theme is of the editorial was to stop exporting NY seniors to neighboring states that offer more CCRC options.

The Cabinet is developing a strategy around direct admissions, with an updated analysis of the role of direct admissions in CCRCs.

Our Continuing Care at Home legislation has passed both the Senate and Assembly and we are now working with the Governor's office to ensure their support.

Our CCRC legislative education day was held on June 2. One of the speaker presentations provided a very astute and insightful analysis of why NY is lagging so far behind other states in CCRC development and could form the basis of CCRC revitalization legislation.

Policy Update

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- Medicare 3-Day Stay
- Entitlement Cuts
- Debt Ceiling Debate
- Prospects for a Budget

Policy Update

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- Medicare Part A Rates and Programmatic Changes
- Medicare Part B Rates
- Therapy Caps
- "Improvement Standard"

Policy Update

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DMEPOS Competitive Bidding

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

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

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CMS Electronic Prescribing Incentive Program

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

MLN Matters # SE1206

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New Timely Filing Requirements

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

MLN MM7080

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State Receives Final Approval of $8 Billion Medicaid Waiver

On April 14, 2014, Governor Cuomo announced that the federal government has officially signed off on New York's Medicaid waiver, which will allow the State to reinvest, over the next five years, $8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms. According to the press release, the $8 billion reinvestment will be allocated as follows:

$6.42 Billion for the Delivery System Reform Incentive Payment (DSRIP) Program – including DSRIP Planning Grants, DSRIP Provider Incentive Payments, and DSRIP administrative costs;

$500 Million for the Interim Access Assurance Fund – temporary, time-limited funding to ensure current trusted and viable Medicaid safety net providers can fully participate in the DSRIP transformation without disruption; and

$1.08 Billion for other Medicaid Redesign purposes – funding to support Health Home development, and investments in long term care, workforce and enhanced behavioral health services.

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State Delays FIDA Enrollment

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

Policy Update

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<u>Managed Care Transition</u>

Nursing Home Transition work group convened by the Department of Health (DOH) has finalize policies that will govern the transition of the nursing home benefit and population into managed care. Subject to federal approval, Medicaid enrollees in downstate areas in need of permanent care in a nursing home will be required to join a managed care plan starting in August of 2014.

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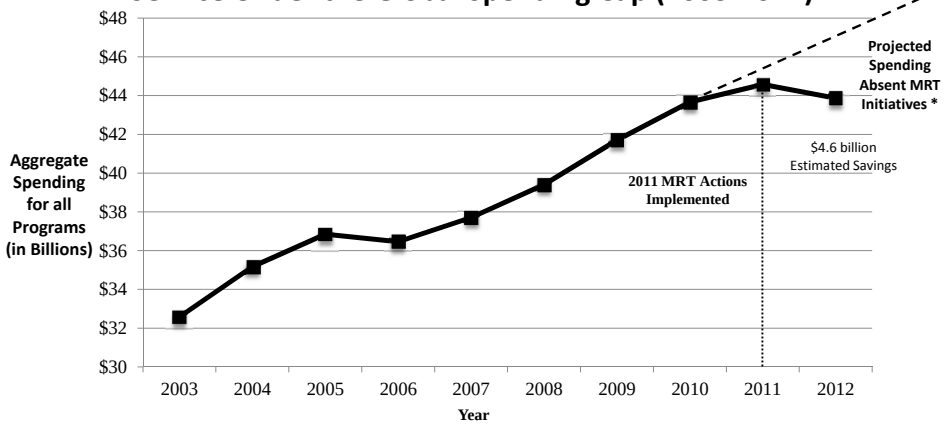
Managed Care Transition

For upstate counties, this requirement will be phased-in starting in January 2015. 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.

NY Total Medicaid Spending Statewide for All Categories of Service Under the Global Spending Cap (2003-2012)



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
# of Recipients	4,266,535	4,593,566	4,732,563	4,729,166	4,621,909	4,656,354	4,910,511	5,211,511	5,396,521	5,578,143
Cost per Recipient	$7,635	$7,658	$7,787	$7,710	$8,158	$8,464	$8,493	$8,379	$8,261	$7,864

*Projected Spending Absent MRT Initiatives was derived by using the average annual growth rate between 2003 and 2010 of 4.28%.

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Medicaid Spending SFY 2013 (dollars in millions)			
Category of Service	Estimated	Actual	Variance Over / (Under)
Total Fee For Service	$11,601	$11,308	($293)
Inpatient	$3,148	$3,075	($73)
Outpatient/Emergency Room	$590	$543	($47)
Clinic	$647	$598	($49)
Nursing Homes	$3,434	$3,417	($17)
Other Long Term Care	$1,794	$1,782	($12)
Non-Institutional	$1,988	$1,893	($95)
Medicaid Managed Care	$9,751	$9,797	$46
Family Health Plus	$968	$957	($11)
Medicaid Administration Costs	$569	$529	($40)
Medicaid Audits	($323)	($303)	$20
All Other	$648	$728	$80
Local Funding Offset	($7,302)	($7,302)	$0
SUBTOTAL	$15,912	$15,714	($198)
Prepayment of 2013-14 Expenses	$0	$196	$196
TOTAL	$15,912	$15,910	($2)

Source: DOH Annual Global Cap Report

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Managed Care Transition

Managed Care Organizations (MCOs) will be required to pay a nursing home provider the current fee-for-service rate for three years, instead of the two years originally proposed. However, a plan and provider may negotiate an alternative rate acceptable to both parties. The three year period will start in July 2014 downstate and on Jan. 1, 2015 upstate. DOH will reassess whether there is a need for a longer transition after one year. This provision is included in the governor's 2014-15 state budget proposal, which also specifies that the fee-for-service rate requirement does not apply to short-term Medicaid residents.

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Managed Care Transition

Contracts between providers and MCOs will be required to include due process rights for the provider and must allow the provider to remedy any identified problems prior to imposition of penalties or termination of the agreement. If an agreement should be terminated for reasons other than imminent patient harm or a finding of fraud, the MCO must continue the member's placement in the nursing home as an out of network placement and pay Medicaid fee-for-service rates.

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Managed Care Transition

While a separate rate cell will be used for enrollees of mainstream Medicaid Managed Care plans requiring permanent nursing home placement, a blended rate cell will be used for this population when the Managed Long Term Care (MLTC) plan premium is calculated. This change was made to allow the proposal to go forward.

MCOs will be required to make bed hold payments for Medicaid residents based on the same rules (i.e., day limitations and 95 percent occupancy threshold) and rates (50 percent of Medicaid rate for hospitalization bed hold, 95 percent for therapeutic leave bed hold) governing fee-for-service Medicaid bed hold.

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Managed Care Transition

Provisions included in the previous version of the policy document that would have established a mechanism to address MCO cost anomalies of providing nursing home care to their enrollees have been removed. Risk mitigation related to nursing home placements as well as a separate nursing home rate cell for MLTC plans were adamantly opposed by consumer advocates and ultimately removed. DOH has promised to closely monitor the adequacy of the blended rate.

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Managed Care Transition

Network adequacy standards remain the same: MCOs are required to contract with eight plans in Kings, Queens, Bronx, Suffolk, Nassau, Westchester, Erie and Monroe counties; five in New York and Richmond counties; four in Oneida, Dutchess, Onondaga and Albany counties; three in Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady and Ulster counties; and two in all other counties (where available).

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Nursing Home Bed Hold Changes

The Bed Hold DAL sets out three varieties of bed reservation days:

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

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

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

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

Policy Update

July 2014

Global Cap Authority: Extends the Medicaid global spending cap for one year to March 31, 2016 along with the authority of the Commissioner of Health and State Budget Director to reduce spending if Medicaid expenditures are exceeding projections. State share Medicaid spending is limited to $17.1 billion in SFY 2014-15 and $17.9 billion in SFY 2015-16. The Legislature added detailed reporting requirements around how the cap is set and tracking of expenditures by service line.

Policy Update

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

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

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

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

Policy Update

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

Policy Update

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

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

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

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

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

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

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

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

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

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

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

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

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

EQUAL Program: Maintains funding at $6.5 million.

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

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

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

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

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

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

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

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

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

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

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CMI Cap: Thanks to strong advocacy from LeadingAge NY, its members and other groups, the Legislature rejected the governor's proposal to cap the growth of each nursing home's case mix index at two percent for any six month period.

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

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

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

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

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

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Policy Update

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

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

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

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

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

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

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

Policy Update

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

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Extension of intergovernmental transfer (IGT) payments: Authorization to make IGT payments of up to $300 million per year to public nursing homes would be extended for three years through March 31, 2017.

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

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Medicaid Rates

Nursing homes checking their Medicaid remittance file for payment cycle 1905 should see adjustments to rates retroactive to Jan. 1, 2013. This update reflects the incorporation of the July 2012 Case Mix Index (CMI) into 2013 and 2014 Medicaid rates. As of Feb. 25th, DOH had not posted rate sheets that would correspond to these updates, but we expect them to be available on the Health Commerce System (HCS) shortly.

Nursing homes that experienced a CMI change greater than five percent from January 2012 to July 2012 have their CMI constrained to a five percent change pending audit. Please note that rates covering the period July 1, 2013 through Dec. 31, 2013 will eventually be updated again to incorporate the January 2013 CMI. Rates for Jan. 1, 2014 through July 30, 2014 will eventually be updated to incorporate the July 2013 CMI.

The Medicaid rates that providers are currently receiving have also been updated to reflect a Jan. 1, 2014 rate calculated using a July 2012 CMI.

The 2013 rate adjustments **do not** reflect the 2013 quality pool adjustment that is still awaiting CMS approval. Initial DOH numbers suggest that the negative rate adjustment to nursing homes that fall into the 4th and 5th quintiles will be about one percent of their 2013 Medicaid operating rate. Nursing homes in the top quintile should see a net positive adjustment totaling roughly 1.1 percent of their operating rate. Nursing homes in the second quintile should see a net positive adjustment of about 0.6 percent of their daily operating rate while the net adjustment for homes in the third quintile should be about 0.1 percent of the rate.

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Medicaid Rates

The calculation of the capital component of nursing home Medicaid rates will remain mostly intact. The RHCF-4 Medicaid cost report will be revised to allow providers to calculate capital reimbursement amounts for their home. Additional edits and safeguards will be incorporated into the software, but homes will be responsible and accountable for the accuracy of their capital calculations. The final reimbursable capital will be determined through audit, which will be done by the Office of the Medicaid Inspector General (OMIG) or its contractor. We support this approach but stressed the need for training, clear instructions, availability of DOH guidance and a timely audit process, to minimize the need for recoveries years later. DOH has pledged to conduct educational sessions and make staff available for facility questions.

In concert with the Transition of Nursing Home Benefit and Population to Managed Care policy document that requires managed care plans to pay nursing home fee-for-service rates, including capital and assessment reimbursement, for three years for permanently placed enrollees, this decision ensures some level of capital reimbursement stability for nursing homes for the transition period.

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Universal Settlement

Under the proposed settlement, a total of $475 million would be provided to nursing homes statewide over five years (an estimated $75 million in 2013 and $100 million annually in 2014-2017) to mitigate losses and accelerate gains resulting from implementation of statewide pricing. In exchange, facilities would be expected to execute legally binding settlement agreements with the state relinquishing their rights to any financial relief from most non-capital rate appeals and lawsuits relating primarily to pre-statewide pricing rates (i.e., prior to 2012). The state's goal remains to get all nursing homes to participate in the settlement.

Based on the state's desire to begin making settlement payments in the current state fiscal year (which ends March 31, 2014), the associations are being asked to provide input on the terms of the agreement and a distribution methodology for the funding by next week. Following consideration of the association input, DOH plans to conduct a webinar in early December to brief all nursing homes in the state on the settlement agreement and the associated Medicaid rate impacts. Facilities would then be asked to execute the agreement within a relatively short timeframe following the webinar. Depending on whether there is sufficient interest among facilities, the state would pursue federal approvals and plan to begin making payments prior to March 31, 2014.

Policy Update

July 2014

Two more managed care issues…

NAMI payments and $50 PNA under managed care.

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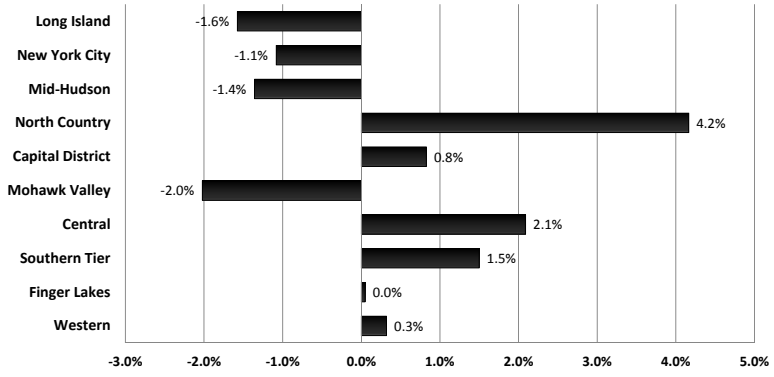
Percent Change in State and County Medicaid Spending: SFY 2011-12 Compared to SFY 2012-13



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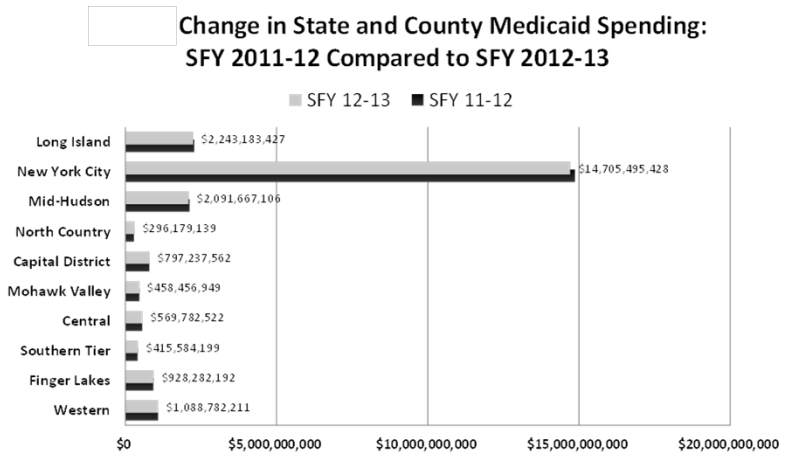

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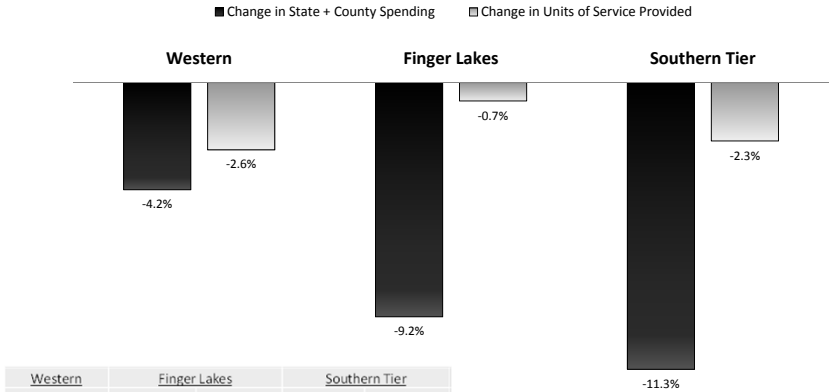
Change in Medicaid Spending & Utilization, SFY 2011-12 to SFY 2012-13: Nursing Homes



Western	Finger Lakes		Southern Tier	
• Allegany	• Genesee	• Seneca	• Broome	• Steuben
• Cattaraugus	• Livingston	• Wayne	• Delaware	• Tioga
• Chautauqua	• Monroe	• Wyoming	• Chemung	• Tompkins
• Erie	• Ontario	• Yates	• Chenango	
• Niagara	• Orleans		• Schuyler	

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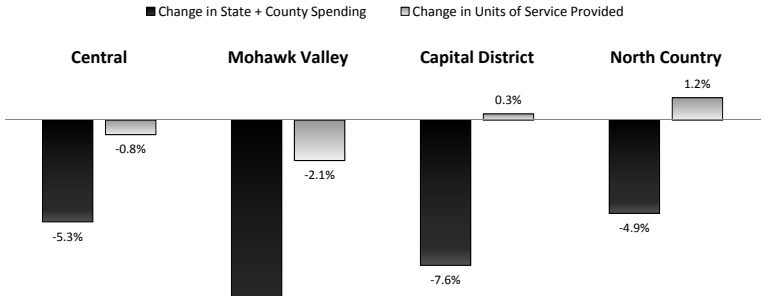
Change in Medicaid Spending & Utilization, SFY 2011-12 to SFY 2012-13: Nursing Homes



Central NY	Mohawk Valley	Capital District		North Country	
• Cayuga	• Fulton	• Albany	• Saratoga	• Clinton	• Hamilton
• Cortland	• Herkimer	• Columbia	• Schenectady	• Essex	• Lewis
• Madison	• Montgomery	• Greene	• Warren	• Franklin	• St. Lawrence
• Onondaga	• Oneida	• Rensselaer	• Washington	• Jefferson	
• Oswego	• Otsego				
	• Schoharie				

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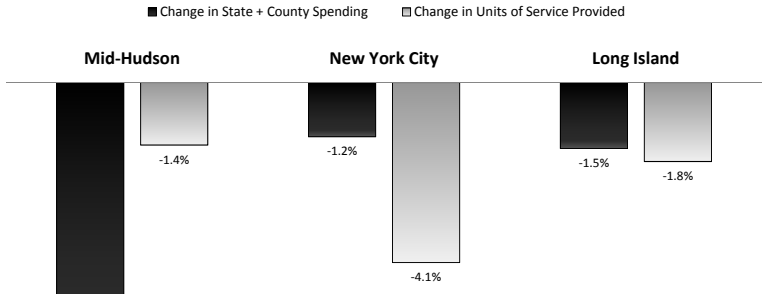
Change in Medicaid Spending & Utilization, SFY 2011-12 to SFY 2012-13: Nursing Homes



Mid Hudson
• Dutchess
• Orange
• Putnam
• Rockland
• Sullivan
• Ulster
• Westchester

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Policy Update

July 2014

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