ALP Reimbursement in a Managed Care Environment

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Agenda

• Provide an overview of discussions to date
• Lessons learned from past transitions
• Identify key outstanding issues and questions
• Input and feedback from you
Discussions to Date

- LeadingAge NY (including member representation) has been involved in DOH Workgroup regarding ALP preparation for managed care transition
- Subgroup was developed to focus on reimbursement and finance issues, which met in January

ALP Reimbursement Under Managed Care

- Currently, ALPs are reimbursed per Resource Utilization Group (RUG) category and region. There are 16 RUG categories and regions.
- Current rates can be found here: https://www.health.ny.gov/facilities/long_term_care/reimbursement/alp/
- Managed care organizations (MCOs) and managed long term care (MLTC) plans expressed concern about potential complexity and variability of current structure. They are asking for a simpler mechanism.
MLTC Rate Setting

- The state’s actuarial firm (Mercer) and DOH develop regional rates based on historical community-based service utilization patterns and costs
- Four regions (NYC-LI-Westch; Hudson Valley; Upstate Metro Areas; Rest of State)
- Admin reimbursement is capped and various adjustments are made
- Regional rates are adjusted using plan-specific risk scores
- A separate rate is calculated for plan members residing in a nursing home which is then blended with the community member rate to arrive at a final rate
- Plan receives this per-member, per-month (“PMPM”) rate to provide all the Medicaid services a member may need

Simplifying Reimbursement: Options

- Single rate for ALP services:
  - Develop a single rate, based on an average of the ALP population
  - While this allows for administrative simplicity for the ALP and the plan, it does not incentivize the ALP to care for a higher needs population.
- Case Mix:
  - Each ALP has an acuity adjusted rate based on the case mix of the population similar to nursing home reimbursement
  - While this may result in reimbursement that is more reflective of the acuity of the population being served in any given facility, the process is very complex, and there is concern about recreating problems that exist in nursing home process (administrative burden, OMIG audit process, etc.) in the ALP.
The Data Slide: Commonly Used RUGs & Selected RUG Rates

### MOST COMMON ALP RUGs

<table>
<thead>
<tr>
<th>RUG</th>
<th>Volume</th>
<th>NYC Rate</th>
<th>SYR Rate</th>
<th>ELMIRA Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>48.8%</td>
<td>$73.75</td>
<td>$55.14</td>
<td>$51.60</td>
</tr>
<tr>
<td>PB</td>
<td>22.3%</td>
<td>$95.64</td>
<td>$69.57</td>
<td>$65.28</td>
</tr>
<tr>
<td>PC</td>
<td>10.6%</td>
<td>106.98</td>
<td>77.01</td>
<td>72.28</td>
</tr>
<tr>
<td>CA</td>
<td>8.9%</td>
<td>$88.16</td>
<td>$64.79</td>
<td>$60.80</td>
</tr>
<tr>
<td>BB</td>
<td>3.0%</td>
<td>$106.98</td>
<td>$77.01</td>
<td>$72.28</td>
</tr>
<tr>
<td>CB</td>
<td>2.8%</td>
<td>$115.44</td>
<td>$82.72</td>
<td>$77.51</td>
</tr>
</tbody>
</table>

### 30 DAYS x ALP RATE

<table>
<thead>
<tr>
<th>RUG</th>
<th>NYC Rate</th>
<th>SYR Rate</th>
<th>ELMIRA Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>$2,213</td>
<td>$1,654</td>
<td>$1,548</td>
</tr>
<tr>
<td>PB</td>
<td>$2,869</td>
<td>$2,087</td>
<td>$1,958</td>
</tr>
<tr>
<td>PC</td>
<td>$3,209</td>
<td>$2,310</td>
<td>$2,168</td>
</tr>
<tr>
<td>CA</td>
<td>$2,645</td>
<td>$1,944</td>
<td>$1,824</td>
</tr>
<tr>
<td>BB</td>
<td>$3,209</td>
<td>$2,310</td>
<td>$2,168</td>
</tr>
<tr>
<td>CB</td>
<td>$3,463</td>
<td>$2,482</td>
<td>$2,325</td>
</tr>
</tbody>
</table>

Note: RUG rates are for 2017; volume is from Jul. 2013 - Jun. 2014
Source: LeadingAge NY Analysis of Medicaid claims data

### Options continued

- While there are 16 RUG categories and regions, the ALP resident population tends to fall within one of 5-6 RUG groups.
- Can we narrow reimbursement categories to reflect the 5-6 groups?
- Do we need to reduce the categories to fewer than 5-6, and if so, what does that look like?
- Is there a need to reduce the number of regions, and if so, how do we collapse without bring rates down in a region?
- UAS-NY data requested from DOH to further analyze.
- Member feedback
Network Adequacy

- Network adequacy provision:
  - must provide consumer choice in each county, providing two or more options to the consumer;
  - 11 counties do not have an ALP, and some have one or two ALPs

- Number of options on plan and ALP side have implications for negotiations

Network Adequacy: the Nursing Home Transition Experience

- Fear of being shut out
- Being in a network is no guarantee of volume
- Network narrowing concerns
- Minimum NH requirement: **Network Adequacy:**
  8: Kings, Queens, Bronx, Suffolk, Nassau, Westchester, Erie, Monroe
  5: New York, Richmond
  4: Oneida, Dutchess, Onondaga, Albany
  3 in eight counties, all other counties 2 (where available)
Rate Protection

• DOH has suggested rate protection for a period of 1-2 years

• Plan could not pay below benchmark rate for that period of time

Rate Protection: the Nursing Home Transition Experience

• 3-year transition
• Benchmark rate:
  – Most current Medicaid rate
  – With capital, quality pool, other add-ons
  – Requires plans to mirror retro adjustments in FFS
  – DOH publishes benchmark list (issues)
  – Bed hold
  – Re-asses need to continue longer than 3 yrs
• Plan & provider may negotiate different rate
• Out of network arrangements subject to benchmark rate
• High cost pool
• Uncertainties of VBP
New ALP Cost Report in the Future?

• Analysis of cost, as well as the minimum wage rate adjustment process, has highlighted the need for a more refined cost reporting mechanism.
• Current ACF financial report does not separate costs
  – for different categories of licensure, such as ACF vs. ALP beds under one roof
  – SSI-covered services (room and board) versus ALP Medicaid covered services
• DOH plans to develop a new ALP-specific cost report
• LeadingAge NY is exploring how to possibly modify existing reports to fit the needs of the ALP
  – Consideration will need to be given to how ALPs with non-ALP beds in their building will parse out their costs in a consistent way.
• Member input will be needed

DME and Supplies

Background:
• The ALP Medicaid payment covers the provision of medical supplies and equipment not requiring prior approval.
• DME providers may only submit claims for a Medicaid eligible ALP participant for DME items requiring prior approval.
• See Medicaid Update DME Clarification, March 2007
  http://www.leadingageny.org/?LinkServID=8513A743-DF57-FD1C-BF4FEFEC8A55CD35
  – Procedure codes that require prior approval are underlined in the DME fee schedule, available at http://www.emedny.org/ProviderManuals/DME/PDFS/DME_Fee_Schedule_2006.pdf
DME and Supplies

- Confusion about what ALP is responsible for
  - Different terms contribute to confusion
  - The process for approval, authorization, etc. for DME and supplies can change, which impacts inclusion in the ALP rate
  - Confusion about what is considered DME and supplies; for ex. hearing aids
- Thus, ALP providers should consult DME fee schedule when there is a question
- We are working to change the process moving forward to eliminate these variables and confusion.
  - ALP would be responsible for most day to day items that residents need
  - High cost items/customized DME to be excluded

Minimum Wage

- ALP 2017 published rate adjustments based on minimum wage survey
- Challenging process given no true “cost report”
- Minimum wage mandate has a five-year phase-in period, and the dollar amount will grow
  - Need to ensure data is accurate to inform budget allocation
  - LeadingAge NY will work with other stakeholders to better clarify data collection effort in the future
- Advocacy regarding sufficiency of funds; concerns about:
  - Overall sufficiency
  - Did not support non Medicaid providers
  - Pressure to increase other wages
- A lot of outstanding questions remain; awaiting DOH meeting to further discuss.
- How do this work when managed care/MLTC is the payer?
Other Lessons from Nursing Home Transition to Managed Care

- Upstate had benefit of lessons learned downstate
- Impact was gradual (grandfather clause)
- Variety in billing requirements, codes an issue, clean claims a challenge
- Cash flow implications, potential occupancy impact
- Concerns about inadequate funding / delays in rate updates
- Assessments and more assessments
- Guidance not always communicated/clear so important that provider know available resources
- Key NH transition documents:
- Valuable resources at: [www.omh.ny.gov/omhweb/bho/mctac.html](http://www.omh.ny.gov/omhweb/bho/mctac.html)

The Good News is.....

- We have a seat at the table
- LeadingAge NY membership-opportunity to learn from each other
- Opportunity to learn from past transitions
- You are going to help us figure this out!
Questions??? What Do You Think?

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