Reimbursement Update

LeadingAge New York
Annual Conference
May 24, 2017
Saratoga Springs, NY

Karen Lipson,
Executive VP for Innovation Strategies

Darius Kirstein,
Director of Financial Policy & Analysis

LeadingAge New York

Agenda

Landscape Scan

Medicare Update
• Medicare Rates
• VBP & Reporting Initiatives
• Part A Methodology Reform

Alternative Payment Arrangements
• VBP Review- Why and How
• Status and Challenges

Medicaid Update
• Medicaid Rates
• Other Medicaid Funding Issues
Considerations

- State Medicaid Global Cap
- Minimum Wage & Other Wage Mandates
- Managed Care Pressures
- Continuation of NH Benchmark Rate
- VBP Impact Approaching
- Federal Funding
- Federal Medicaid Reform

Landscape

Federal Receipts as Percent of State Revenue

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>FEDERAL $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$37.51B</td>
</tr>
<tr>
<td>Essential Plan</td>
<td>$3.75B</td>
</tr>
<tr>
<td>Temporary &amp; Disability Assistance</td>
<td>$3.65B</td>
</tr>
<tr>
<td>K-12 School Aid</td>
<td>$2.73B</td>
</tr>
<tr>
<td>Public Health</td>
<td>$2.32B</td>
</tr>
<tr>
<td>Capital projects (largely transportation) &amp;</td>
<td>$2.16B</td>
</tr>
<tr>
<td>aid service</td>
<td></td>
</tr>
<tr>
<td>Homeland Security &amp; related</td>
<td>$1.13B</td>
</tr>
<tr>
<td>Children's Services</td>
<td>$1.01B</td>
</tr>
<tr>
<td>Special education programs</td>
<td>$839M</td>
</tr>
</tbody>
</table>


Source: Fiscal Policy Institute New York State Economic and Fiscal Outlook 2017-2018
Potential Impact of American Health Care Act

- Multi-billion direct state budget impact
- 2.7 million individuals in NY at risk of losing coverage
- Medicaid funding reform

1-2-3 Punch:

- The bill would phase out the provision of ACA that gave states federal money to expand their Medicaid programs to serve people who earn up to 138 percent of the poverty level (est. $2 billion impact on NYS)
- The state would have to find $2.3 billion annually that the counties now contribute to Medicaid
- Per-capita caps would limit federal spending on Medicaid pushing more costs onto the state

*Bill would cut $880 billion from the Medicaid program nationally over the next decade, according to the most recent CBO estimate.*

---

Per Capita Caps

- The bill would set the initial target amounts for each state to match the level of per capita Medicaid spending in the state in 2016
- Through 2019, those target amounts would grow at the same rate as the Consumer Price Index for Medical Care for All Urban Consumers (CPI-M)
- Starting in 2020, the target amounts for aged enrollees and people with disabilities would grow at CPI-M plus 1 percentage point, while the other target amounts would continue to grow at the rate of the CPI-M (i.e., 2016 spending increased for inflation)
- Cap would become effective in 2020

*(Numbers in table for demonstration purposes only)*

<table>
<thead>
<tr>
<th>Beneficiary Category</th>
<th>Enrollment</th>
<th>Per Capita Target Amount</th>
<th>Contribution to Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged</td>
<td>125,000</td>
<td>$20,000</td>
<td>$2.5 billion</td>
</tr>
<tr>
<td>People with disabilities</td>
<td>200,000</td>
<td>$30,000</td>
<td>$6.0 billion</td>
</tr>
<tr>
<td>Children</td>
<td>600,000</td>
<td>$4,600</td>
<td>$2.4 billion</td>
</tr>
<tr>
<td>Adults made eligible by ACA</td>
<td>250,000</td>
<td>$6,600</td>
<td>$1.5 billion</td>
</tr>
<tr>
<td>Other adults</td>
<td>300,000</td>
<td>$6,500</td>
<td>$2.0 billion</td>
</tr>
</tbody>
</table>

**Spending Cap for State = Sum of Five Category Subtotals = $14.4 billion**

Source: Center for Health Policy at Brookings
Budget State-Share Distribution (approximate)

Medicaid Global Cap
- limits growth in state Medicaid spending to the ten-year rolling average increase in the Medical Consumer Price Index (CPI).
- Grants "super-powers" to Commissioner of Health to reduce spending if Medicaid expenditures exceed projections
- 2016-17 was 6th year of cap
- Drug spending cap added in 2017-18 State Budget

SFY 2016-17 Global Cap Results

Medicaid Enrollment Summary FY 2017

Source: March 2017 State Fiscal Year End Global Cap Report
Orthopedic surgeon for nearly 20 years before coming to Congress. Represented the northern Atlanta suburbs in the House of Representatives since 2005.

Has advocated converting Medicaid into block grants to states.

Supports shifting Medicare from a “defined benefit” to a “defined contribution” with the government providing older or disabled Americans financial help to buy private insurance.

Outspoken critic of the innovation center, especially as it has experimented with shifting Medicare payments from fee-for-service to a value-based model.

Founded Indianapolis-based health policy consulting firm SVC Inc. in 2001. The company has worked with several states (Indiana, Iowa, Kentucky, Maine, Michigan, Ohio and Tennessee) to set up Medicaid programs under the Affordable Care Act.

Credited with designing the Healthy Indiana Plan, an insurance program for low-income Indiana resident that was created under then-Gov. Mike Pence.

Bachelor’s degree in life sciences from the University of Maryland and master’s degree in public health from Johns Hopkins University.
Medicare

SNF PPS Proposed Rule for FFY 2018
Part A Rate (Oct. 1, 2017-Sep. 30, 2018)

Note that resolution of Medicare Part B funding issues requires a one percent increase in Part A rates for FFY 2018 for post-acute providers including skilled nursing facilities, in place of the market basket calculation.

Which would have been a...

- 2.3 percent market basket increase
  - 2.7 percent less .4 percentage point “productivity” adjustment
  - No forecasting error adjustment
  - Wage Index update will cause some regions to see an increase slightly higher than 1%, others slightly lower

Medicare

Part B

- Medicare Physician Fee Schedule (MPFS) determines Medicare Part B rates paid to physicians and other practitioners, along with the ancillary rates paid to nursing homes and home care providers for ancillary services
- “Sustainable Growth Formula” repealed (no more “doc fix”)
- 0.5 percent annual increases through 2019
  - extended the current Medicare therapy caps exceptions process for another two years, through December 31, 2017

2 percent sequestration cut continues on all Medicare payments
Medicare

Quality Reporting Program (SNF QRP)

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) mandated a quality reporting program for SNF
- Goal: comparable measures and reporting across settings
- Beginning with FY 2018 (which starts Oct. 2017), SNFs that fail to comply will have their market basket percentage updates reduced by two percentage points
- Initial QRP measure scores will be based on October 1-December 31, 2016 assessments
- From existing MDS (including 2016 changes) and Medicare claims
- 80% of assessments must have data items required to calculate measures
- MDS data and any corrections must be submitted by June 1, 2017

Medicare

SNF QRP: MDS-Based Measures for use in FFY 2018

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>Data Collection Timeframe</th>
<th>Data Submission Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)</td>
<td>10/01/16-12/31/16</td>
<td>May 15, 2017</td>
</tr>
<tr>
<td>Percent of Patients or Residents with Pressure Ulcers that are New or Worsened</td>
<td>10/01/16-12/31/16</td>
<td>May 15, 2017</td>
</tr>
<tr>
<td>Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function</td>
<td>10/01/16-12/31/16</td>
<td>May 15, 2017</td>
</tr>
</tbody>
</table>

The measures above will be made public in October, 2017
Medicare

**Quality Reporting Program (QRP)**

Three additional claims-based measures added in last year’s SNF PPS Rule (for use in QRP for FFY 2018):

- **Discharge to Community**: assesses successful discharge to the community from a SNF setting, with successful discharge to the community including no unplanned re-hospitalizations and no death in the 31 days following discharge from the SNF. (2018)

- **Medicare Spending per Beneficiary**: holds SNF providers accountable for the Medicare payments within an "episode of care", which includes the period during which a patient is directly under the SNF’s care, as well as a defined period after the end of the SNF treatment, which may be reflective of and influenced by the services furnished by the SNF. (2018)

- **Potentially Preventable Readmission**: assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries in the 30 days post-SNF discharge. (2018)

*The 3 measures above will be publicly reported starting October, 2017*

- One additional MDS measure added last year: Drug Regimen Review (for use starting in 2020). This proposed measure assesses whether PAC providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified.

---

Medicare

**NEWLY PROPOSED Additions to Quality Reporting Program (QRP)**

For QRP starting in FFY 2020, CMS is proposing:

- to replace the current pressure ulcer measure with an updated version

- to adopt four new outcome-based measures that address functional status and align with Inpatient Rehabilitation Facility (IRF) QRP starting in FY 2020:
  - Change in Self-Care Score for Medical Rehabilitation Patients
  - Change in Mobility Score for Medical Rehabilitation Patients
  - Discharge Self-Care Score for Medical Rehabilitation Patients
  - Discharge Mobility Score for Medical Rehabilitation Patients

*WILL REQUIRE SIGNIFICANT MDS MODIFICATIONS*
Medicare

Medicare SNF Value-Based Purchasing Program (SNF VBP)

The Protecting Access to Medicare Act of 2014 (PAMA) requires that VBP apply to SNF payments beginning in October 2018

- Two percent withhold of SNF Part A payments
- Partially earned back based on a SNF’s re-hospitalization rate and level of improvement (50-70%)
- CMS tasked with:
  - specifying a risk adjusted re-hospitalization measure
  - calculating a score for each SNF
  - providing the measure and score reports to SNFs for review and make it available to the public

Medicare

SNF VBP Measures

- The 2016 final rule adopted the SNF 30-Day All-Cause Readmission Measure, (SNFRM) for use in the SNF VBP Program
- risk-standardized rate of all-cause, unplanned, hospital readmissions for SNF Medicare beneficiaries within 30 days of their prior proximal short-stay acute hospital discharge
- Legislation requires CMS to specify a more refined hospitalization measure as soon as practicable
- In the 2017 final rule CMS specifies a SNF 30-day Potentially Preventable Readmission Measure (SNFPPRM) as the refined measure

CMS will use the All-Cause Readmission Measure to start the program and shift to Potentially Preventable Readmission Measure in a future year (TBD)
**SNF VBP**

- Initial measure focuses on *all-cause* unplanned hospital readmissions
- Refined measure focuses on hospital readmissions that are *potentially preventable*. For readmissions during a SNF stay, “preventable” is defined as “avoidable with sufficient medical monitoring and appropriate treatment.”
- Calculated using a full year’s worth of data
- Claims-based so no additional reporting
- Risk adjusted
- Considers performance and improvement

- *In the 2017 rule CMS details the measurement time period for the first year:*
  - CY 2015 is baseline period for calculating performance standards for FFY 2019 SNF VBP (i.e., Oct 2018)
  - CY 2017 would be the measured performance period for FFY 2019 SNF VBP

**NEWLY PROPOSED: SNF VBP Details in SNF PPS Rule**

- Propose moving from Calendar Year to FFY timing for measurements
- Oct. 2019 VBP Rate Adjustments
  - Based on Oct. 2017 – Sep 2018 performance
  - Oct. 2015 - Sep. 2016 is baseline period for measuring improvement
- Considering whether to include Social Risk Factors (income, education, race/ethnicity, employment, disability, etc.)
- Will propose date for the change to more refined measure in future rulemaking
- Will add SNF VBP performance to Nursing Home Compare no later than Oct. 1, 2017
- Methodology to determine earn-back amount
NEWLY PROPOSED: Earn-Back Methodology

1. Estimate Medicare spending on SNF services for the FY 2019 payment year;

2. Estimate the total amount of reductions to SNFs’ adjusted Federal per diem rates for that year, as required by statute;

3. Calculate the amount realized under the payback percentage proposal (60% proposed);

4. Order SNFs by their performance scores;

5. Assign a value-based incentive payment multiplier to each SNF that corresponds to a point on the logistic exchange function that corresponds to its SNF performance score.

Medicare Advantage Penetration (May 2017)

- Medicare VBP focused on Medicare FFS Population
- Nationwide Medicare Advantage penetration is 33.8%
- Ranges nationwide from single digits in Alaska, Wyoming, Vermont to 57% in Minnesota
- New York ranks 10th with 38.8%; Third in overall enrollees behind CA & FL
CMS is considering a major overhaul to the nursing home Medicare Part A rate setting methodology. Advance Notice of Proposed Rulemaking (ANPRM) lays out a proposal to replace RUG-IV with a new case mix methodology, Resident Classification System, Version 1 (RCS-1). The agency is seeking comments on the model which it intends to formally propose as part of the Skilled Nursing Facility Prospective Payment System (SNF PPS) Rule for FFY 2019.

RUG-IV has been criticized for being too heavily oriented towards therapy, for incentivizing therapy volume and for insufficiently recognizing non-therapy costs. CMS is seeking to remove service-based metrics (e.g., therapy minutes) from the rate setting methodology and derive payments from objective resident characteristics that are predictive of therapy and other service needs.
Notice of Coming Proposal: RCS-1 Structure

Establishes four base rates, each case mix adjusted separately based on most relevant characteristics

Urban RUG-IV

<table>
<thead>
<tr>
<th>Rate Component</th>
<th>Nursing - Case-Mix</th>
<th>Therapy - Case-Mix</th>
<th>Therapy - Non-Case-Mix</th>
<th>Non-Case-Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Diem Amount</td>
<td>$177.16</td>
<td>$133.44</td>
<td>$17.58</td>
<td>$90.42</td>
</tr>
</tbody>
</table>

Urban RCS-1

<table>
<thead>
<tr>
<th>Rate Component</th>
<th>Nursing</th>
<th>NTA</th>
<th>PT/OT</th>
<th>SLP</th>
<th>Non-Case-Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Diem Amount</td>
<td>$100.91</td>
<td>$76.12</td>
<td>$126.76</td>
<td>$24.14</td>
<td>$90.35</td>
</tr>
</tbody>
</table>

Source: Advance Notice of Proposed Rulemaking [CMS-1686-ANPRM]

Notice of Coming Proposal: RCS-1 Structure

- A **PT/OT** base rate adjusted by one of 30 PT/OT case mix groups (based on clinical category, functional score and cognitive impairment) to yield a PT/OT component
- A **Speech/Language Pathology (SLP)** base rate adjusted by one of 18 SLP case mix groups (based on clinical reason for SNF stay, swallowing disorder/mechanically altered diet, SLP-related comorbidity or cognitive impairment) to yield a SLP component
- A **Nursing** base rate adjusted by one of 43 nursing case mix groups (i.e., non-rehab RUGs) used in the current methodology (but with an updated case mix index) to yield a nursing component
- A **Non-Therapy Ancillary (NTA)** base rate adjusted by one of six NTA categories (based on specific conditions and need for extensive services) to yield an NTA component
- A non-case-mix component that would remain as it currently is in the new methodology.
NOTICE OF COMING PROPOSAL: RCS-1 Structure- PT/OT Component Scoring (30 Groups)

PT/OT Component Example:

Step 1: Determine Clinical Category

Step 2: Calculate ADL Score

Step 3: Determine Cognitive Impairment Level

Step 4: Based on combination of these three determine PT/OT case mix group

Variable Per-Diem Adjustment

- Rate would change as the stay progressed
- Adjustments would be made to PT/OT and Non-Therapy Ancillary components

Assessments

- CMS is contemplating requiring just a 5-day, significant change and discharge MDS assessment under SCR-1
Medicare

Rate Adjustment Example using RCS-1 Model

<table>
<thead>
<tr>
<th>Rate Component</th>
<th>Nursing</th>
<th>NTA</th>
<th>PT/OT</th>
<th>SLP</th>
<th>Non-Case-Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Item Amount</td>
<td>$100.91</td>
<td>$76.12</td>
<td>$126.76</td>
<td>$24.14</td>
<td>$90.35</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Component</th>
<th>Day 1 Variable Adjustment</th>
<th>Day 1 Rate (with variable adjustment)</th>
<th>Day 60 Variable Adjustment</th>
<th>Day 60 Rate (with variable adjustment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT/OT</td>
<td>$134.93</td>
<td>$134.93</td>
<td>$146.94</td>
<td>$146.94</td>
</tr>
<tr>
<td>SLP</td>
<td>$46.11</td>
<td>$46.11</td>
<td>$46.11</td>
<td>$46.11</td>
</tr>
<tr>
<td>Nursing</td>
<td>$131.18</td>
<td>$131.18</td>
<td>$131.18</td>
<td>$131.18</td>
</tr>
<tr>
<td>NTA</td>
<td>$153.76</td>
<td>$461.24</td>
<td>$153.76</td>
<td>$153.76</td>
</tr>
<tr>
<td>Non-Case Mix</td>
<td>$90.35</td>
<td>$90.35</td>
<td>$90.35</td>
<td>$90.35</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$596.33</strong></td>
<td><strong>$903.85</strong></td>
<td><strong>$568.34</strong></td>
<td><strong>$568.34</strong></td>
</tr>
</tbody>
</table>

Source: Advance Notice of Proposed Rulemaking [CMS-1686-APNPRM]

Medicare

Current Case-Mix Adjusted Payment

- Therapy Base Rate
- Therapy CMR
- Non-Case-Mix Therapy Base Rate
- Nursing Base Rate
- Nursing CMR
- Non-Case-Mix Base Rate

Recommended Case-Mix Adjusted Payment

- PT/OT
- PT/OT Base Rate
- PT/OT CMR
- NTA
- NTA Base Rate
- NTA CMR

Source: Skilled Nursing Facilities Payment Models Research Technical Report, April 2017
Medicare

**Estimated Impact of Moving to RCS-1**

<table>
<thead>
<tr>
<th>Resident Characteristics</th>
<th>% of Stays</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;60 years</td>
<td>9.6%</td>
<td>5.4%</td>
</tr>
<tr>
<td>65-74 years</td>
<td>21.3%</td>
<td>2.7%</td>
</tr>
<tr>
<td>75-84 years</td>
<td>34.0%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>85-89 years</td>
<td>19.3%</td>
<td>-2.3%</td>
</tr>
<tr>
<td>90+ years</td>
<td>15.7%</td>
<td>-2.8%</td>
</tr>
<tr>
<td>Medicare/Medicaid Dual Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dually enrolled</td>
<td>35.2%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Not dually enrolled</td>
<td>64.8%</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Number of Utilization Days = 1-15 days</td>
<td>33.3%</td>
<td>15.9%</td>
</tr>
<tr>
<td>16-30 days</td>
<td>33.3%</td>
<td>0.6%</td>
</tr>
<tr>
<td>31+ days</td>
<td>33.3%</td>
<td>-2.5%</td>
</tr>
<tr>
<td>Number of Utilization Days = 100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>97.4%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Yes</td>
<td>2.6%</td>
<td>-2.7%</td>
</tr>
<tr>
<td>CFS Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Intact</td>
<td>54.3%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Mildly Impaired</td>
<td>22.8%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Moderately Impaired</td>
<td>18.2%</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Severely Impaired</td>
<td>4.6%</td>
<td>6.3%</td>
</tr>
<tr>
<td>IV Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>97.4%</td>
<td>-2.6%</td>
</tr>
<tr>
<td>Yes</td>
<td>2.6%</td>
<td>22.9%</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>65.0%</td>
<td>-2.8%</td>
</tr>
<tr>
<td>Yes</td>
<td>35.0%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Wound Infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>97.8%</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Yes</td>
<td>2.2%</td>
<td>17.9%</td>
</tr>
</tbody>
</table>

**Resident Characteristics**

<table>
<thead>
<tr>
<th>Most Common Therapy Level</th>
<th>% of Stays</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>RV</td>
<td>54.0%</td>
<td>-9.1%</td>
</tr>
<tr>
<td>RVH</td>
<td>22.7%</td>
<td>9.3%</td>
</tr>
<tr>
<td>RVH</td>
<td>7.7%</td>
<td>24.4%</td>
</tr>
<tr>
<td>RM</td>
<td>3.7%</td>
<td>36.6%</td>
</tr>
<tr>
<td>RI</td>
<td>0.1%</td>
<td>49.3%</td>
</tr>
<tr>
<td>Non-Rehabilitation</td>
<td>11.7%</td>
<td>44.5%</td>
</tr>
<tr>
<td>Physical Therapy Use</td>
<td>7.9%</td>
<td>24.2%</td>
</tr>
<tr>
<td>Yes</td>
<td>92.1%</td>
<td>-3.0%</td>
</tr>
<tr>
<td>Occupational Therapy Use</td>
<td>8.6%</td>
<td>24.8%</td>
</tr>
<tr>
<td>Yes</td>
<td>91.4%</td>
<td>-3.2%</td>
</tr>
<tr>
<td>Speech Language Pathology Use</td>
<td>58.4%</td>
<td>3.2%</td>
</tr>
<tr>
<td>No</td>
<td>41.6%</td>
<td>-3.1%</td>
</tr>
<tr>
<td>Yes</td>
<td>58.6%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Therapy Utilization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PT xOT x SLT</td>
<td>39.9%</td>
<td>20.2%</td>
</tr>
<tr>
<td>PT xOT Only</td>
<td>50.4%</td>
<td>7.2%</td>
</tr>
<tr>
<td>PT xSLT Only</td>
<td>0.6%</td>
<td>22.9%</td>
</tr>
<tr>
<td>OT xSLT Only</td>
<td>0.6%</td>
<td>25.6%</td>
</tr>
<tr>
<td>PT Only</td>
<td>1.9%</td>
<td>34.5%</td>
</tr>
<tr>
<td>OT Only</td>
<td>0.6%</td>
<td>31.6%</td>
</tr>
<tr>
<td>SLT Only</td>
<td>0.6%</td>
<td>39.2%</td>
</tr>
<tr>
<td>Non-Therapy</td>
<td>5.5%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

Source: Advance Notice of Proposed Rulemaking [CMS-1686-ANPRM]

---

Medicare

**Top Medicare RUG Utilization in 2016 FY in New York State**

<table>
<thead>
<tr>
<th>RUG</th>
<th>% of RUG Days to Total Days</th>
<th>Average Length of Stay by RUG</th>
</tr>
</thead>
<tbody>
<tr>
<td>RUB</td>
<td>31.8%</td>
<td>26.3</td>
</tr>
<tr>
<td>RUC</td>
<td>23.1%</td>
<td>29.4</td>
</tr>
<tr>
<td>RVB</td>
<td>7.4%</td>
<td>16.4</td>
</tr>
<tr>
<td>RVC</td>
<td>7.2%</td>
<td>19.1</td>
</tr>
<tr>
<td>RUA</td>
<td>7.0%</td>
<td>18.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td><strong>76.9%</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: PEPPER
Medicare

Comprehensive Care for Joint Replacement (CJR)

- Requires hospitals in selected regions to accept Medicare bundled payments for hip and knee replacement surgeries (DRGs 469 and 470) since April 2016
- Hospitals in Erie, Niagara, Dutchess, Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, and Westchester Counties are subject to the requirement
- Hospital responsible for the quality and costs of care for the entire episode from the time of the surgery through 90 days after discharge. Hospitals, physicians, and post-acute care providers bill Medicare on a fee-for-services basis
- CMS reconciles payments to target prices (with benefit and penalty caps)
- Requires hospitals to collaborate with nursing homes, home health agencies, and other post-acute partners.

Medicare

Expansion of Comprehensive Care for Joint Replacement (CJR)

- Expansion to 3 additional conditions scheduled for July 1, 2017 delayed to Oct. 1, 2017
- (1) Surgical Hip and Femur Fractures- same geographic area as CJR
- (2) Acute Myocardial Infarction
- (3) Coronary Artery Bypass Graft
  - Cardiac related models in 98 random geographical areas
  - In New York state: Herkimer and Oneida Counties
Medicare

**Payroll Based Journal (PBJ)**

- Nursing homes started collecting data in specified ways in July 2016
- Quarterly data due to CMS 45 days after end of quarter
- Provides CMS with refined staffing data for additional quality measures (staffing levels, turnover, tenure)
- Jan-Mar 2017 quarterly submission was due May 15
- next deadline is Aug 14, 2017
- Recent PBJ Manual updates
- CMS indicates it will use PBJ data in 5-star in 2018
- Nursing Home Compare indicates submission status (two cycles of non-filing will result in suppression of 5-star scores)

**Dates & Deadlines**

- Medicare Cost Report (5 months after FY ends, <10% Medicare may apply for waiver)
- Immunization Reports
- Executive Compensation Report (end of June or Medicaid Cost Report Due Date, whichever later)
- MDS Census Submission for CMI (April & October)
- Capital Component Review
- PBJ Submissions (45 days after quarter ends)
- 2017 Rate Appeals (June 2, 2017)
Medicaid

Medicaid Managed Care
• Rate adequacy/clarity concerns
• Risk adjustment issues
• Rate cells
• NH Benchmark rate
• Marketing ban (MLTC)
• Geographic narrowing
• FIDA Marketing and Region 2 Rollout
• Discussion on integrated (Medicaid/Medicare) models forthcoming

Top Ten Single-Capitation Plans in the State:

<table>
<thead>
<tr>
<th>Single-Capitated MLTC Plans</th>
<th>Feb. 2017 Members</th>
<th>Statewide Market Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIDELIS CARE AT HOME</td>
<td>17,421</td>
<td>10.03%</td>
</tr>
<tr>
<td>GUILDS</td>
<td>15,228</td>
<td>8.77%</td>
</tr>
<tr>
<td>CENTER'S PLAN FOR HEALTHY LIVING</td>
<td>14,711</td>
<td>8.47%</td>
</tr>
<tr>
<td>VNS CHOICE</td>
<td>13,417</td>
<td>7.72%</td>
</tr>
<tr>
<td>SENIOR HEALTH PARTNERS (HealthFirst)</td>
<td>13,217</td>
<td>7.61%</td>
</tr>
<tr>
<td>ELDERPLAN (HomeFirst)</td>
<td>12,175</td>
<td>7.01%</td>
</tr>
<tr>
<td>ELDERSERVE (RiverSpring at Home)</td>
<td>11,113</td>
<td>6.40%</td>
</tr>
<tr>
<td>AGEWELL NEW YORK</td>
<td>7,939</td>
<td>4.57%</td>
</tr>
<tr>
<td>VILLAGE CARE MAX</td>
<td>7,455</td>
<td>4.29%</td>
</tr>
<tr>
<td>SENIOR WHOLE HEALTH</td>
<td>7,162</td>
<td>4.12%</td>
</tr>
</tbody>
</table>

Source: LeadingAge NY Analysis of DOH Medicaid Enrollment Data
Value-Based Payment Update

LeadingAge New York Annual Conference
Karen Lipson
EVP for Innovation Strategies
May 24, 2017

Agenda

• Quick refresher on key trends and policies driving VBP
• New incentives and priorities under VBP
• VBP in Medicare and Medicaid
• Strategic imperatives
KEY TRENDS AND POLICIES DRIVING VBP

Medicare Post-Acute Spending Soars until 2011, with Wide Regional Variation . . .

- Medicare spending on post-acute care has more than doubled since 2000; per capita spending has grown by 90%. (MedPac testimony before House WAM, June 2013)
- IOM concluded that spending on post-acute care around the country accounts for 73% of the regional variation in Medicare spending.
And Begins to Slow after 2011

Medicaid LTC Spending Growth

LTSS spending growing at high rate nationwide, primarily due to HCBS growth.

Eiken, Truven Health Analytics for CMS, Apr. 2016.
Policy Initiatives

Care Management for All
• Managed Care
• Health Homes, PCMH

Delivery System Reform
• DSRIP PPSs

Payment Reform
• Value-Based Payment

Achieve Value by Improving Quality, . . .
... And By Reducing Waste

- Missed Prevention Opportunities
- Inflated Prices
- Unnecessary Services
- Excess Admin
- Poor Transitions
- Poor Medication Management

Aligning Incentives Between Payers and Providers

<table>
<thead>
<tr>
<th>Yesterday’s Incentives</th>
<th>Tomorrow’s Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payers</strong></td>
<td><strong>Payers</strong></td>
</tr>
<tr>
<td>Control utilization</td>
<td>Reduce demand through prevention</td>
</tr>
<tr>
<td>Emphasize lower cost settings and services</td>
<td>Emphasize lower cost settings and services</td>
</tr>
<tr>
<td>Reduce rates</td>
<td>Restructure rates to reward lower costs and higher quality</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td><strong>Providers</strong></td>
</tr>
<tr>
<td>Increase admissions, NH days</td>
<td>Reduce demand through prevention</td>
</tr>
<tr>
<td>Increase services</td>
<td>Emphasize lower cost settings and services</td>
</tr>
<tr>
<td>Increase rates per day or episode</td>
<td>Provide high quality at lower overall cost to earn bonuses and share in savings</td>
</tr>
</tbody>
</table>
New Paradigm: From “Heads in Beds” to “Feet on the Ground”

VALUE-BASED PAYMENT TIMELINE (revised 5/31/2016)

- DSRIP DY 1 Begins: April 1, 2015
- CMS approves VBP Roadmap: Summer, 2015
- PPS-MCOs submit VBP growth plans: April 1, 2016
- FIDA plans submit alternative payment plans: January, 2016
- CMMS approves VBP Roadmap: Summer, 2016
- Medicare VBP
- Medicaid VBP
- FIDA VBP
- Medicare FFY payments tied to quality - 40% = shared savings, 2-sided risk, population-based
- 60% of Medicare FFY payments tied to quality - 50% = shared savings, 2-sided risk, population-based
- 80-90% of MCO payments = at least shared savings VBP or higher risk
- Goal of >50% of MCO payments = 2-sided risk VBP
- 80% of Medicare FFY payments linked to quality - >30% = shared savings, 2-sided risk, population-based
- 90% of Medicare FFY payments linked to quality - >50% = shared savings, 2-sided risk, population-based
- 90% of Medicare FFY payments linked to quality - >50% = shared savings or higher risk
MEDICARE VALUE-BASED PAYMENT

Medicare’s Value-Based Payment Plan

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)

2016
- 50%
- 85%
- All Medicare FFS

2018
- 59%
- 99%
- All Medicare FFS
Medicare VBP Initiatives Affecting LTPAC

- **Hospital VBP**
  - Medicare Spending Per Beneficiary (MSPB) Measure
  - Readmissions Reduction Program

- **SNF VBP**
  - Readmissions reduction measure
  - Medicare Spending Per Beneficiary quality measure

- **Bundled Payments**

- **Shared Savings Program/Accountable Care Organizations**
  - Shared savings is based on total per capita Medicare Part A and B spending, including post-acute care.

Medicare Accountable Care Organizations

- 20% of Medicare FFS Beneficiaries in NYS are Attributed to 27 ACOs

![Participation in Medicare’s ACO, FFS, and MA Programs 2014](source_image.png)
Bundled Payments for Care Improvement

- Actual expenditures for 90-day episode reconciled against a target price. Model 2 includes inpatient stay plus post-acute care and all related services.
- Waiver of 3-day hospital stay rule if majority of partner SNFs rated 3 stars or higher by Nursing Home Compare.

MEDICAID VALUE-BASED PAYMENT: SUSTAINABILITY FOR NYS DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM (DSRIP)
New York’s Value-Based Roadmap

- By Apr. 1, 2020, **80-90%** of all payments by MCOs to providers must be in VBP arrangements.

- **4 “Integrated Service Models:”**
  - Total Care for General (attributed) Population
  - Integrated Primary Care Bundle
  - Maternity Care Bundle
  - Total Care for a Special Needs Subpopulation
    - HIV/AIDS
    - Behavioral health with comorbidities
    - People with multiple morbidities and disabilities
    - Frail elderly

VBP Arrangements

- **4 Types of Payment with Different Levels of Risk:**
  - **MLTC Level 1 (MMC Level 0):** FFS with a pay-for-performance element tied to avoidable hospital use and other quality metrics*
  - **MMC Level 1:** FFS with upside-only shared savings (when outcome scores are sufficient)
  - **Level 2:** FFS with 2-sided risk sharing (upside available when outcome scores sufficient; downside reduced when outcome scores high)
  - **Level 3:** PMPM capitated payment for total care for subpopulation (with outcome-based component)

* The State has agreed to count these types of arrangements between MLTC plans and providers as Level 1.
Results of DOH Survey on VBP Penetration

MLTC
- FFS/Other: 94.1%
- VBP Level 0: 2.6%
- VBP Level 2: 3.3%

MAP
- VBP Level 2: 44.3%
- VBP Level 1: 4.8%
- VBP Level 0: 4.3%
- FFS Other: 46.6%

Source: NYS DOH, VBP Resource Library, July 2016

Results of DOH Survey on VBP Penetration

Mainstream Managed Care
- VBP Level 1: 3.3%
- VBP Level 2: 26.8%
- VBP Level 3: 2.9%
- FFS Other: 52.4%

Source: NYS DOH, VBP Resource Library, July 2016
Penalties for Failure to Meet State VBP Targets

- If VBP targets are not met, plans must pay penalties that range from 1% to 1.5% of the difference between the targets and the actual VBP percentages.
- Plans may pass on penalties to providers that refuse to enter into VBP arrangements.

MLTC VBP Approved Quality Measures

| Percentage of members who did not have an emergency room visit in the last 90 days* | Percentage of members who remained stable or demonstrated improvement in pain intensity* |
| Percentage of members who did not have falls resulting in medical intervention in the last 90 days* | Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care score* |
| Percentage of members who did not experience uncontrolled pain* | Percentage of members who remained stable or demonstrated improvement in urinary continence* |
| Percentage of members who were not lonely and not distressed* | Percentage of members who remained stable or demonstrated improvement in shortness of breath* |
| Percentage of members who received an influenza vaccination in the last year* | Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection* |

*Existing MLTC QM. Additional measures under consideration.
Completely Hypothetical Bundle Example

The Challenge

Medicare and Medicaid Provide Inconsistent Incentives
Medicaid VBP Presents Challenges for LTPAC Providers

- Potential opportunities for LTPAC providers to share in savings **BUT**
- The people we serve are dual eligible; and
- Most of the savings available would be derived from reductions in avoidable hospital use and would accrue to *Medicare*; and
- When we reduce hospital use, personal care hours, nursing home days, and ADHC days increase, driving *Medicaid* spending growth.

New Models Demand New Metrics and Strategies

<table>
<thead>
<tr>
<th>Today</th>
<th>Tomorrow</th>
</tr>
</thead>
<tbody>
<tr>
<td># of residents and days</td>
<td># of Covered Lives</td>
</tr>
<tr>
<td>Survey performance</td>
<td>Avoidable hospitalizations, outcome measures</td>
</tr>
<tr>
<td>Professional standards</td>
<td>Evidence-based practices, clinical efficiencies, utilization management</td>
</tr>
<tr>
<td>Case mix</td>
<td>Population health, predictive analytics</td>
</tr>
<tr>
<td>Cost per registrant</td>
<td>Total cost of care in comparison with benchmark</td>
</tr>
<tr>
<td>EHR adoption</td>
<td>Bi-directional health information exchange</td>
</tr>
</tbody>
</table>
Organizational Building Blocks for VBP

Population Health Management

Collaborations • Performance Measurement • Technology • Consumer Engagement

Keys to Success in New Payment Environment

• Scale
  – To increase the number of people served
  – To invest in IT infrastructure, data and analytics
  – To distribute fixed costs
  – To mitigate risk

• Efficiency
  – Clinical: Lowest appropriate level of care
  – Operational: Business processes
  – Financial: Contract, claims submission/payment management

• Clinical integration and excellence
Medicaid

Adult Day Health Care
• Capital is only FFS rate component that changes
• Off-site program lease reimbursement
• Unbundled services option

Medicaid Assisted Living Program (ALP)
• Managed care transition date unknown (unlikely this year)
• DOH transition workgroup
• Some discussion of rate update but no $ to do so
Medicaid

Home Care

• CHHA Medicare Final Rule decreased rates by 0.7 percent for CY 2017
  • changed outlier payment methodology
  • implemented Negative Pressure Wound Therapy (NPWT) reimbursement
  • finalizes changes to Value Based Purchasing (HHVBP) Model (select states, not NY)
  • makes updates to the Quality Reporting Program
  • CMS considering potential major case mix methodology refinements

• LHCSA workforce mandates and related funding concerns for LHCSA (FLSA, minimum wage)

• Consumer Directed Personal Assistance Program (CDPAP) workers now included under wage parity requirements downstate

Medicaid

Projecting Your Nursing Home Medicaid Operating Rate

• 2016 was the last year of the 5-year phase-in of the pricing methodology for nursing homes. In 2017 no stop-loss/stop-gain provisions apply.
• The 2017 operating component increased by roughly $0.75 over 2016 due to the rate phase-in.
• The largest potential driver of change to the operating rate is the case mix adjustment and the special population add-ons.
• Operating rates for discrete specialty units are frozen at 2009 rates and remain unchanged.
• Base year costs from 2007 (no trend factor since 2007)
• Wage adjustments based on 2009 data.
• Possibility of eventual base year update.
• Benchmark rate for extended until the end of 2020.
### Medicaid

#### Medicaid FFS Rates (and Benchmark Rates) are Predictable

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Rate for Part B Eligible Patients</td>
<td>Medicaid Rate for Part B Eligible Patients</td>
<td>Medicaid Rate for Part B Eligible Patients</td>
<td>Medicaid Rate for Part B Eligible Patients</td>
</tr>
<tr>
<td>Statewide Direct Price</td>
<td>$123.35</td>
<td>$123.91</td>
<td>$113.25</td>
</tr>
<tr>
<td>Statewide Indirect Price</td>
<td>$64.23</td>
<td>$64.52</td>
<td>$56.92</td>
</tr>
<tr>
<td>Transition Adjustment</td>
<td>10% stop gain/loss</td>
<td>no stop gain/loss</td>
<td>10% stop gain/loss</td>
</tr>
</tbody>
</table>

### Benchmark Rate:

- Medicaid FFS rates (and benchmark rates) are predictable.

- Medicaid FFS rates for free-standing home with fewer than 300 beds.

<table>
<thead>
<tr>
<th>2017 Medicaid Rate Calculation</th>
<th>Medicaid Rate for Part B Eligible Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Direct Price</td>
<td>$113.37</td>
</tr>
<tr>
<td>WEF Adjustment</td>
<td>0.8098</td>
</tr>
<tr>
<td>Facility Case Mix Adjustment</td>
<td>1.0358</td>
</tr>
<tr>
<td>WEF and Case Mix Adjusted Price</td>
<td>90.77</td>
</tr>
<tr>
<td>Statewide Indirect Price</td>
<td>$57.18</td>
</tr>
<tr>
<td>WEF Adjustment</td>
<td>0.9096</td>
</tr>
<tr>
<td>WEF Adjusted Indirect Price</td>
<td>$52.01</td>
</tr>
<tr>
<td>Facility Specific Non Comp Price</td>
<td>10.00</td>
</tr>
<tr>
<td>Total Operating Component</td>
<td>161.70</td>
</tr>
<tr>
<td>Capital Per Diem</td>
<td>30.00</td>
</tr>
<tr>
<td>TOTAL RATE</td>
<td>188.28</td>
</tr>
</tbody>
</table>

### CMI Considerations

- CMI picture dates last Wednesday in January and the last Wednesday in July.
- Submission window: 3 weeks starting Sep. 11, 2017.
- 5 percent CMI growth constraint (pending audit) continues.
- Homes should file an MDS with CMS for any resident that may be listed on their case mix census roster, even if not required by regulations.
- All managed long term care residents, including those that integrate Medicaid and Medicare such as PACE, FIDA and MAP, are counted in the Medicaid CMI calculation.
- Complete MDS accurately to capture special populations eligible for add-on (Dementia and Bariatric).
Medicaid

CMI Data 2015-2016

<table>
<thead>
<tr>
<th>Month</th>
<th>PROP</th>
<th>PUB</th>
<th>VOL</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-15</td>
<td>1.22</td>
<td>0.99</td>
<td>1.08</td>
<td>1.15</td>
</tr>
<tr>
<td>Jul-15</td>
<td>1.24</td>
<td>1.01</td>
<td>1.11</td>
<td>1.18</td>
</tr>
<tr>
<td>Jan-16</td>
<td>1.26</td>
<td>0.97</td>
<td>1.12</td>
<td>1.19</td>
</tr>
<tr>
<td>Jul-16</td>
<td>1.26</td>
<td>1.00</td>
<td>1.12</td>
<td>1.19</td>
</tr>
</tbody>
</table>

Source: LeadingAge NY Analysis of DOH Roster Submission Data

Medicaid

2018 Medicaid Rate-Setting Timetable

- DOH is seeking to move rate setting process forward to ensure rates are ready on their effective date
- OMIG no longer responsible for MDS audits
- DOH fast-track approach
- Capital attestations for all ($30M appeals cap)

*DOH just issued patch to correct 2016 Medicaid Cost Report*

*Some members receiving processed appeals letters- 30 day response*
Retroactive Adjustments

Areas of outstanding nursing home rate adjustments include:

- 2013 through 2016 Nursing Home Quality Initiative adjustments (up & down)
- A one percent increase in the operating rate retroactive to 4/1/14 to reflect reinvestment of the .08 percent assessment that is scheduled to continue
- The release of the CMI constraint on homes whose CMI changed by more than five percent (2015 forward)
- Reissuance of rates reflecting OMIG MDS audit findings for homes that had MDS audits (2015 forward)
- Carve-out of transportation costs from nursing home Medicaid rate
- Cash Receipts Assessment reconciliation (2016 next)
- Hospitalization bedhold elimination: enacted, implementation pending promulgation of regulations

2016 Occupancy

- Source: Weekly bed availability report submissions to DOH

<table>
<thead>
<tr>
<th>2016 Median Occupancy</th>
<th>Vol</th>
<th>Pub</th>
<th>Prop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95.1%</td>
<td>94.4%</td>
<td>94.3%</td>
</tr>
</tbody>
</table>

Percent of Homes with Occupancy Above 95% in 2016

Source: LeadingAge NY Analysis of Weekly Bed Availability Data
Medicaid

Universal Settlement

• Up to $850 million over a five-year period
• Roughly $350 million derived from the 0.8 percent cash receipts assessment
• Homes agree to drop nearly all pending lawsuits and rate appeals for rates in effect prior to Jan. 1, 2012
• Outstanding Medicaid liabilities offsets:
  • Up to 100 percent of distributions
• Payment Schedule:
  • First payment (SFY 2015-16) made in March 2016
  • Second payment (SFY 2016-17) made in July 2016
  • Third payment (SFY 2017-18) to trustees by March 31, 2018
  • Fourth payment (SFY 2018-19) to trustees by March 31, 2019
  • Final payment (SFY 2019-20) to trustees by March 31, 2020

• State confirmed third payment is reflected in state’s spending plan for SFY 2016-17

Medicaid

Two-percent Cut Restoration

• The cash receipts assessment continues at 6.8 percent (6 percent reimbursable 0.8 percent not reimbursable)
• DOH intends to supplement Medicaid rates by $70 million annually retroactive to 4/1/14 to reinvest funds collected by the 0.8 percent assessment
• Timing unclear and DOH has not been willing to provide anything in writing

In Sep. 2015 the State filed a Medicaid State Plan Amendment (SPA) with the Centers for Medicare and Medicaid Services (CMS) to make the reinvestment, is responding to several additional questions from CMS, and is drafting regulations.
### Medicaid

#### Minimum Wage
- State Budget includes funds intended to cover some of the costs of the increase for health care providers
- Funding included in provider Medicaid rates as of Jan 1, 2017 and will be updated annually
- DOH may adjust the Medicaid Global Cap to account for the impact of the minimum wage increases
- Impact largest on home/personal care
- DOH to require additional cost reporting which will be basis of reconciliation and future rate adjustments
- State expects use of funds to be documented and those not used for minimum wage to be returned

As of Dec. 31, 2016:
- $9.70 Upstate (then +$0.70 each yr.)
- $10 LI/Westchester (then + $1 each yr.)
- $11 NYC (then up $2 each yr.)

Fast food workers:
- $12.00 NYC / $10.75 Rest of State
- Increasing to $13.50 / $11.75 on Dec 31, 2017

### Medicaid

#### Advanced Training Initiative
- $46 million for SFY 2016-17
- Teach direct caregivers to detect changes in a resident’s status that could lead to health declines and/or hospitalization
- Awardees partner with designated training partners to implement selected program
- Eligibility criteria: retention rate above statewide median (excluding hospital-based homes and VAP recipients)
- Survey has been issued to funding recipients
- Important to document use of funds
- Money appropriated for 2017-18 but needs CMS approval
Nursing Home Quality Initiative (NHQI)

- Rate adjustments on hold (2013, 2014, 2015 & 2016) pending resolution of legal challenge
- DOH issued 2017 NHQI methodology (same as 2016)
- Detailed 2013 through 2016 scores are available to the public
- 2013 and 2014 amounts shown on the benchmark rate listings on the DOH Medicaid rate web page:
  - the 2014 NHQI adjustment amounts are listed on the “January 2015 Nursing Home and Specialty Rates” document
  - 2013 NHQI adjustment amounts appear on the July 2014 benchmark rate lists accessible by clicking on Historical Benchmark Rates
- DOH published an NHQI Honor Roll (in top quintile all three years)

http://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/
Medicaid

Other Initiatives

• Equity withdrawals
• Medicaid Lag
• Shared Refinancing Savings
• Energy Initiative

Thank you!

Darius Kirstein
Director of Financial Policy & Analysis
dkirstein@LeadingAgeNY.org
LeadingAge NY
13 British American Blvd., Suite 2
Latham, NY 12110
Phone: 518-867-8841

Karen Lipson
EVP for Innovation Strategies
klipson@leadingagency.org
www.leadingagency.org
Phone: 518-867-8383