Reimbursement Update

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

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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

Federal Receipts as Percent of State Revenue

<table>
<thead>
<tr>
<th>Program</th>
<th>Federal $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$23,560</td>
</tr>
<tr>
<td>Essential</td>
<td>$3,758</td>
</tr>
<tr>
<td>Temporary &amp; Disability Assistance</td>
<td>$3,658</td>
</tr>
<tr>
<td>K-12 School Aid</td>
<td>$2,729</td>
</tr>
<tr>
<td>Public Health</td>
<td>$2,326</td>
</tr>
<tr>
<td>Capital projects (largely transportation &amp; debt service)</td>
<td>$2,160</td>
</tr>
<tr>
<td>Homeland Security &amp; related</td>
<td>$1,136</td>
</tr>
<tr>
<td>Children's Services</td>
<td>$1,018</td>
</tr>
<tr>
<td>Special education programs</td>
<td>$420M</td>
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</table>

Source: Fiscal Policy Institute New York State Economic and Fiscal Outlook 2017-2018 (continues...)
Landscape

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._

Landscape

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>
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<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>$4,000</td>
<td>$2.4 billion</td>
</tr>
<tr>
<td>Adults made eligible by ACA</td>
<td>250,000</td>
<td>$6,000</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
Landscape

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
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.

Secretary of Health & Human Services, Dr. Tom Price

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 long-term care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health and hospice providers 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 FY 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
  - 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
Medicare

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
<table>
<thead>
<tr>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NOTICE OF COMING PROPOSAL: REPLACE RUG-IV with RCS-1</strong></td>
</tr>
<tr>
<td>• CMS is considering a major overhaul to the nursing home Medicare Part A rate setting methodology.</td>
</tr>
<tr>
<td>• Published an Advance Notice of Proposed Rulemaking (ANPRM) which lays out a proposal to replace RUG-IV with a new case mix methodology, Resident Classification System, Version 1 (RCS-1).</td>
</tr>
<tr>
<td>• 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</td>
</tr>
<tr>
<td>• RUG-IV has been criticized for being too heavily oriented towards therapy, for incentivizing therapy volume and for insufficiently recognizing non-therapy costs</td>
</tr>
<tr>
<td>• 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</td>
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</tbody>
</table>
Medicare

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>
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</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>

Medicare

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 a 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)

<table>
<thead>
<tr>
<th>Clinical Category</th>
<th>Function Score</th>
<th>Moderate/Severe Cognitive Impairment</th>
<th>Case-Mix Group</th>
<th>Case-Mix Index</th>
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<tbody>
<tr>
<td>Major Joint Replacement or Spinal Surgery</td>
<td>16-18</td>
<td>No</td>
<td>TA</td>
<td>1.82</td>
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<tr>
<td></td>
<td>16-18</td>
<td>Yes</td>
<td>TH</td>
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<td></td>
<td>8-13</td>
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<td>TC</td>
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<td>TD</td>
<td>1.85</td>
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<td></td>
<td>0.7</td>
<td>Yes</td>
<td>TF</td>
<td>1.36</td>
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<tr>
<td>Other Orthopedic</td>
<td>16-18</td>
<td>No</td>
<td>TH</td>
<td>1.55</td>
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<tr>
<td></td>
<td>8-13</td>
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<td>TI</td>
<td>1.56</td>
</tr>
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<td></td>
<td>8-13</td>
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<td>TJ</td>
<td>1.39</td>
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<tr>
<td></td>
<td>0.7</td>
<td>No</td>
<td>TK</td>
<td>1.38</td>
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<td></td>
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<td>TL</td>
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<td>Acute Neurologic</td>
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<td>TM</td>
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<td>TK</td>
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<tr>
<td>Non-Orthopedic Surgery</td>
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<td>TX</td>
<td>1.57</td>
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<td>16-18</td>
<td>Yes</td>
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<td>1.43</td>
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<td>0.7</td>
<td>Yes</td>
<td>TI</td>
<td>0.82</td>
</tr>
</tbody>
</table>

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 Diem Amount</td>
<td>$108.91</td>
<td>$76.12</td>
<td>$125.76</td>
<td>$24.14</td>
<td>$90.35</td>
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<table>
<thead>
<tr>
<th>Component</th>
<th>Case-Mix Adjusted Rate (before variable adjustment)</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>
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<tbody>
<tr>
<td>PT/OT</td>
<td>$174.93</td>
<td>1.0</td>
<td>$174.93</td>
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<td>$146.94</td>
</tr>
<tr>
<td>SLP</td>
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<td>$46.11</td>
<td>na</td>
<td>$46.11</td>
</tr>
<tr>
<td>Nursing</td>
<td>$131.18</td>
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<td>$131.18</td>
<td>na</td>
<td>$131.18</td>
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<tr>
<td>NTA</td>
<td>$153.76</td>
<td>3.0</td>
<td>$461.28</td>
<td>1.0</td>
<td>$153.76</td>
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<tr>
<td>Non-Case Mix</td>
<td>$90.35</td>
<td>na</td>
<td>$90.35</td>
<td>na</td>
<td>$90.35</td>
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<tr>
<td>TOTAL</td>
<td>$596.92</td>
<td></td>
<td>$902.65</td>
<td></td>
<td>$668.94</td>
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</table>

Medicare

Current Case-Mix Adjusted Payment

- Therapy Base Rate
- Therapy CM
- Non-Case-Mix Therapy Base Rate

- Nursing Base Rate
- Nursing CM

Recommended Case-Mix Adjusted Payment

- PT/OT
- SLP Base Rate
- NTA Base Rate
- Non-Case-Mix Base Rate

- PT/OT CM
- SLP CM
- NTA CM
- Non-Case-Mix CM

- PT/OT Adjustment Factor
- SLP Adjustment Factor
- NTA Adjustment Factor
### 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;65 years</td>
<td>9.6%</td>
<td>-5.4%</td>
</tr>
<tr>
<td>65-74 years</td>
<td>23.3%</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>29.3%</td>
<td>-2.0%</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>Dual enrolled</td>
<td>35.2%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Not dually enrolled</td>
<td>64.8%</td>
<td>-1.9%</td>
</tr>
<tr>
<td>Number of Utilization Days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-15 days</td>
<td>33.3%</td>
<td>0.9%</td>
</tr>
<tr>
<td>16-30 days</td>
<td>21.6%</td>
<td>0.8%</td>
</tr>
<tr>
<td>31+ days</td>
<td>35.1%</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 Impaired</td>
<td>54.3%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Mildly Impaired</td>
<td>22.8%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Moderately Impaired</td>
<td>38.2%</td>
<td>-1.8%</td>
</tr>
<tr>
<td>Severely Impaired</td>
<td>4.6%</td>
<td>6.1%</td>
</tr>
<tr>
<td>IV Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>91.4%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Yes</td>
<td>8.6%</td>
<td>22.5%</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>3.0%</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>17.0%</td>
</tr>
</tbody>
</table>

### 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

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 PB 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

- Discussion on integrated care forthcoming
- Geographic narrowing
- Rate cells
- Benchmark rate
- Marketing ban

Current MLTC Statewide Enrollment*

Total Enrollees in MLTC: 189,364 (As of 8/1/2017)

<table>
<thead>
<tr>
<th>Month</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>406,990</td>
<td>408,982</td>
<td>416,821</td>
<td>414,680</td>
<td>411,594</td>
</tr>
<tr>
<td>At Risk</td>
<td>6,891</td>
<td>4,902</td>
<td>4,957</td>
<td>4,957</td>
<td>5,585</td>
</tr>
<tr>
<td>OASAP</td>
<td>4,392</td>
<td>4,389</td>
<td>4,411</td>
<td>4,411</td>
<td>4,648</td>
</tr>
<tr>
<td>OMAC</td>
<td>137,246</td>
<td>139,408</td>
<td>143,288</td>
<td>142,512</td>
<td>141,764</td>
</tr>
<tr>
<td>YOYO</td>
<td>6,779</td>
<td>6,779</td>
<td>6,779</td>
<td>6,779</td>
<td>6,779</td>
</tr>
</tbody>
</table>

*Total enrollee count includes 1/1/2017 - 8/1/2017
### Medicaid

#### 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>GUILDMET</td>
<td>15,228</td>
<td>8.77%</td>
</tr>
<tr>
<td>CENTERS 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>

---

### 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, . . .

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

. . . And By Reducing Waste
### 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
- FHA plans submit alternative payment plans: January 2016
- PPS-MCOs submit VBP growth plans: April 1, 2016
- 50% of MCO payments = at least shared savings VBP: Goal of >35% (15% for MLTCs) = 2-sided risk

- 2015
  - 80-90% of MCO payments = at least shared savings VBP
  - Goal of >35% (15% for MLTCs) = 2-sided risk

- 2016
  - 80-90% of MCO payments = at least shared savings VBP
  - Goal of >35% (15% for MLTCs) = 2-sided risk

- 2017
  - >50% of Medicare FFS payments linked to quality = shared savings, 2-sided risk, population-based

- 2018
  - >50% of Medicare FFS payments linked to quality = shared savings, 2-sided risk, population-based

- 2019
  - >65% of MCO payments = shared savings or higher risk
  - Goal of ≥50% of MCO payments = 2-sided risk VBP (MMCs only)

MEDITCARE 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)

<table>
<thead>
<tr>
<th>Year</th>
<th>All Medicare FFS</th>
<th>FFS linked to quality</th>
<th>Alternative payment models</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>30%</td>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

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**

- 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)

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 capititated 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

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 0: 14.6%
- VBP Level 2: 28.8%
- 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

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

*Existing MLTC QM. Additional measures under consideration.

### Completely Hypothetical Bundle Example

![Bar chart](image_url)
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**

---

Questions or Reactions?

Contact information:
Karen Lipson
klipson@leadingageny.org
www.leadingageny.org
Phone: 518-867-8383
Medicaid

Projecting Your 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 FFS Rates (and Benchmark Rates) are Predictable

Benchmark rate= all this plus cash receipts assessment reimbursement amount

Link for Medicaid rate template to model CMI changes: www.leadingagency.org/topics/data/templates/

Link for benchmark rate list: www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/
Medicaid

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

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)
Medicaid

**Retroactive Adjustments Due**

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)

---

**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
- State transfers money to trustees, trustees issue payments:
  - Distributions related to specific litigation sent to attorney of record for distribution to home
  - Other distributions sent directly to home
  - Disputed moneys held in escrow
- Outstanding Medicaid liabilities offsets:
  - Up to 70 percent of first distribution
  - Up to 100 percent of subsequent distributions
  - DOH will refund through the trustees any offsets for liabilities that have been paid
- 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
**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 2011, the State enacted a 0.8 percent increase in the cash receipts assessment on nursing homes in lieu of the two percent across-the-board cut imposed on most other Medicaid providers. While the two percent cut has expired, the 0.8 percent nursing home assessment continues. DOH has indicated that proceeds of the .8 percent assessment will be reinvested in nursing home care: a portion will help fund the Universal Settlement with the rest slated to fund an increase in the Medicaid operating rate.

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. When approved, the provision will fund an increase in nursing home Medicaid operating rates by approximately one percent retroactive to the time that the cut was repealed on April 1, 2014. Expected to be paid as a retro add-on to April 2015 rates and forward.

The math (in rough numbers):
- State collects @$70M through .8 percent assessment
- Reinvests $35M into Universal Settlement (matched by federal funds)
- Reinvests $35M into NH rates (matched by federal funds)

**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
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
- Good idea 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
- 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/
### 2016 Nursing Home Quality Initiative Scoring Quick Reference

**Quality Component**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source and Measurement Period</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of contract agency staff used</td>
<td>2015 Medicaid Cost Report</td>
<td></td>
</tr>
<tr>
<td>Medicaid Lag</td>
<td>2015 Medicaid Cost Report</td>
<td></td>
</tr>
<tr>
<td>Percent of long-stay residents with pressure ulcers</td>
<td>2015 Medicaid Cost Report</td>
<td></td>
</tr>
<tr>
<td>Percent of long-stay residents who received the pneumococcal vaccine</td>
<td>2015 Medicaid Cost Report</td>
<td></td>
</tr>
<tr>
<td>Percent of long-stay residents who received the influenza vaccine</td>
<td>2015 Medicaid Cost Report</td>
<td></td>
</tr>
<tr>
<td>Percent of long-stay residents with depression</td>
<td>2015 Medicaid Cost Report</td>
<td></td>
</tr>
<tr>
<td>Percent of long-stay residents with too much weight</td>
<td>2015 Medicaid Cost Report</td>
<td></td>
</tr>
<tr>
<td>Unsupervised use in patients with dementia</td>
<td>2015 Medicaid Cost Report</td>
<td></td>
</tr>
<tr>
<td>Percent of long-stay residents whose need for help with daily activities has increased</td>
<td>2015 Medicaid Cost Report</td>
<td></td>
</tr>
<tr>
<td>Percent of long-stay residents with a urinary tract infection</td>
<td>2015 Medicaid Cost Report</td>
<td></td>
</tr>
</tbody>
</table>

**Compliance Component**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source and Measurement Period</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Five-Star Quality Rating for Health Inspections (by facility rated)</td>
<td>2015 CMS Health Care Quality Improvement Program</td>
<td></td>
</tr>
<tr>
<td>Percent of long-stay residents with pressure ulcers</td>
<td>2015 CMS Health Care Quality Improvement Program</td>
<td></td>
</tr>
<tr>
<td>Percent of long-stay residents who received the pneumococcal vaccine</td>
<td>2015 CMS Health Care Quality Improvement Program</td>
<td></td>
</tr>
<tr>
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</tbody>
</table>

**Efficiency Component**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source and Measurement Period</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Lag</td>
<td>2015 Medicaid Cost Report</td>
<td></td>
</tr>
<tr>
<td>Percent of long-stay residents with pressure ulcers</td>
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</tbody>
</table>

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### Medicaid

#### Other Initiatives

- Equity withdrawals
- Medicaid Lag
- Shared Refinancing Savings
- Energy Initiative
Thank you!

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