

Road Map to Managed Care- No Turning Back



**THURSDAY, MARCH 26TH
HEALTHCARE FINANCIAL MANAGEMENT
ASSOCIATION**

**PRESENTED BY:
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PRESENTATION TOPICS

2

- Medicare Update
- Federal Background – The Affordable Care Act
- State Initiative – Medicaid Redesign
- Medicaid Redesign
- Managed Care & Plans: Defining Features
- Network
- Medicaid Waiver and DSRIP
- Critical Issues for Discussion

Medicare Issues

SNF PPS RULE

3

EXCEPT FOR A SLIGHT CHANGE IN THE CALCULATION OF THE NET MARKET BASKET INCREASE (MBI), THE FINAL RULE IS CONSISTENT WITH THE ORIGINAL [NOTICE OF PROPOSED RULEMAKING](#).

CMS IS IMPLEMENTING A 2.5 PERCENT MBI MINUS A 0.5 PERCENT MULTIFACTOR PRODUCTIVITY ADJUSTMENT FOR A NET INCREASE OF 2.0 PERCENT IN SNF PPS RATES (THE PROPOSED RULE ORIGINALLY CONTAINED A 2.4 PERCENT MBI MINUS 0.4 FOR THE SAME NET 2.0 PERCENT INCREASE).

Medicare Issues

SNF PPS RULE

4

**CALCULATION OF MBFE BASED ON FY 2013 DATA.
FORECASTED MBI MINUS ACTUAL INCREASE
EQUALS DIFFERENCE**

2.5 %

(0.3)

2.2 %

**0.3 < 0.5 THRESHOLD THEREFORE -0- MBFE FOR
FY 2015**

SOURCE: CMS SNF PPS FINAL RULE FOR FY 2015

Medicare Issues

MEDICARE PART A AND SEQUESTRATION

5

WITH THE NET 2.0 PERCENT MBI OVERALL MEDICARE PART A PAYMENTS ARE SET TO INCREASE BY APPROXIMATELY \$750 MILLION NATIONWIDE. HOWEVER, PROVIDERS SHOULD ALWAYS KEEP IN MIND AND BUDGET FOR THE ONGOING IMPACT OF “SEQUESTRATION.” MEDICARE PROVIDER PAYMENTS WERE CUT BY 2 PERCENT BEGINNING APRIL 1, 2013 AS PART OF THE SPENDING REDUCTIONS REQUIRED BY THE BUDGET CONTROL ACT OF 2011 (I.E., SEQUESTRATION). THIS MEANS THAT WHILE THE SCHEDULE OF PAYMENT RATES IS NOT DIRECTLY IMPACTED, OVERALL MEDICARE PAYMENTS TO PROVIDERS WILL CONTINUE TO BE REDUCED BY 2 PERCENT. H.J. RES. 59, THE BIPARTISAN BUDGET ACT OF 2013 SIGNED INTO LAW THIS PAST DECEMBER FURTHER EXTENDED SEQUESTRATION THROUGH 2023.

Medicare Issues

LEADINGAGE RATE TOOL

6

AS ALWAYS, [LEADINGAGE](#) IS PROVIDING MEMBERS WITH THEIR SNF PPS RATE CALCULATOR. THIS IS AN EXCEL™ SPREADSHEET THAT PROVIDES THE MEDICARE PART A RATES PER COUNTY, AND IS AVAILABLE WITH MEMBER LOG-IN BY [CLICKING HERE](#).

THE SPREADSHEET ALLOWS MEMBERS TO INSERT THEIR ESTIMATED MEDICARE DAYS PER MINIMUM DATA SET (MDS) RESOURCE UTILIZATION GROUP (RUG IV) CATEGORY AND PROJECT MEDICARE REVENUE AND ALSO PROVIDES THE RATE ADJUSTMENTS UNDER SEQUESTRATION. IF ANY MEMBER HAS DIFFICULTY ACCESSING THE TOOL, PLEASE LET ME KNOW I WILL BE HAPPY TO ASSIST.

Medicare Issues

SNF PPS RULE

7

ADMINISTRATIVE PRESUMPTION (NO CHANGE IN FINAL RULE)

CMS IS CONTINUING THE ADMINISTRATIVE PRESUMPTION OF COVERAGE FOR INDIVIDUALS SCORING IN ONE OF THE UPPER 52 RUG IV (OUT OF 66) CATEGORIES ON THE INITIAL 5-DAY AND SUBSEQUENT MEDICARE REQUIRED ASSESSMENTS. THE ADMINISTRATIVE PRESUMPTION AUTOMATICALLY CLASSIFIES THESE INDIVIDUALS AS MEETING THE SKILLED LEVEL OF CARE NEEDED FOR MEDICARE PART A COVERAGE UNDER THE FOLLOWING CATEGORIES:

**REHABILITATION PLUS EXTENSIVE SERVICES.
ULTRA HIGH REHABILITATION.
VERY HIGH REHABILITATION.
HIGH REHABILITATION.
MEDIUM REHABILITATION.
LOW REHABILITATION.
EXTENSIVE SERVICES.
SPECIAL CARE HIGH.
SPECIAL CARE LOW.
CLINICALLY COMPLEX.**

AN INDIVIDUAL SCORING IN ONE OF THE LOWER 14 RUG IV CATEGORIES IN NOT AUTOMATICALLY ASSUMED TO MEET THE SKILLED LEVEL OF CARE AND MUST BE EVALUATED ON AN INDIVIDUAL BASIS IN ORDER TO TRIGGER PART A COVERAGE.

Medicare Issues

SNF PPS RULE

8

ADDITIONAL RESEARCH AND STAKEHOLDER INPUT

CMS HAS CONTRACTED WITH ACUMEN, LLC AND THE BROOKINGS INSTITUTION TO IDENTIFY **POTENTIAL ALTERNATIVES TO THE EXISTING METHODOLOGY USED TO PAY FOR THERAPY SERVICES** UNDER THE SNF PPS. UNDER THE CURRENT MODEL, THE THERAPY PAYMENT RATE COMPONENT OF THE SNF PPS IS BASED SOLELY ON THE AMOUNT OF THERAPY PROVIDED TO A PATIENT DURING THE 7-DAY LOOK-BACK PERIOD, REGARDLESS OF THE SPECIFIC PATIENT CHARACTERISTICS. THE AMOUNT OF THERAPY RECEIVED IS USED TO CLASSIFY THE RESIDENT INTO A RUG CATEGORY, WHICH THEN DETERMINES THE PER DIEM PAYMENT FOR THAT RESIDENT. PHASE 1 OF THIS PROJECT WAS COMPLETED IN SEPT. 2013. **CMS IS REPORTING** ON THE MOST PROMISING AND VIABLE OPTIONS TO BE PURSUED IN PHASE 2. CMS WILL CONVENE A TECHNICAL EXPERT PANEL DURING PHASE 2 TO DISCUSS AVAILABLE ALTERNATIVES AND PRESENT INITIAL DATA ANALYSES. COMMENTS ON THIS PROJECT MAY BE SENT TO **SNETHERAPYPAYMENTS@CMS.HHS.GOV**. INFORMATION CAN ALSO BE FOUND ON THE **[PROJECT WEBSITE](#)**.

Medicare Issues

SNF PPS RULE- GEOGRAPHY

9

CMS IS IMPLEMENTING A REVISED SYSTEM OF DELINEATING THE CORE BASED STATISTICAL AREAS (CBSAS) USED TO DETERMINE THE MEDICARE WAGE INDEX IN A GEOGRAPHIC REGION. UNLIKE PRIOR YEARS, IT IS IMPORTANT THAT YOU CHECK YOUR WAGE INDEX BY SPECIFIC COUNTY.

THERE ARE INSTANCES IN WHICH AN INDIVIDUAL COUNTY IN A CBSA WILL HAVE A DIFFERENT WAGE INDEX FROM THE GENERAL INDEX FOR THE OVERALL CBSA (NOTE: JEFFERSON, YATES, ORANGE, PUTNAM, AND DUTCHESS COUNTIES). ALSO, BOTH JEFFERSON AND YATES COUNTIES MOVED FROM “RURAL” TO “URBAN” WITH A RESULTING NET POSITIVE IMPACT ON THE WAGE INDICES FOR THESE AREAS.

Medicare Issues

MEDICARE PART B

10

SUSTAINABLE GROWTH FORMULA (SGR): FOR SEVERAL YEARS NOW, THE FACT THAT ANNUAL PAYMENT ADJUSTMENTS HAVE BEEN TIED TO THE SGR FORMULA HAS CREATED THE UNFORTUNATE CIRCUMSTANCE OF PROJECTING EVER INCREASING NEGATIVE RATE ADJUSTMENTS THAT REQUIRE CONGRESS TO ACT TO OVERRIDE.

Medicare Issues

MEDICARE PART B

11

LEADINGAGE NEW YORK PROVIDED MEMBERS WITH [A DETAILED ANALYSIS](#) OF THE “DOC FIX” MEASURE PASSED BY CONGRESS ([H.R. 2 THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015](#)). AMONG OTHER THINGS, THIS MEASURE REPEALS THE CURRENT SUSTAINABLE GROWTH RATE (SGR) FORMULA BASED METHODOLOGY FOR DETERMINING ANNUAL UPDATES TO THE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS). THE MPFS DETERMINES MEDICARE PART B RATES PAID TO PHYSICIANS AND OTHER PRACTITIONERS, ALONG WITH THE ANCILLARY RATES PAID TO NURSING HOMES AND HOME CARE PROVIDERS FOR ANCILLARY SERVICES.

Medicare Issues

MEDICARE PART B

12

APRIL 1 MPFS RATES - THE IMMEDIATE IMPACT ON PAYMENTS WILL BE TO ELIMINATE THE SCHEDULED 21.2 PERCENT REDUCTION IN PART B RATES AND KEEP RATES AT THEIR CURRENT LEVELS THROUGH JUNE 2015. THERE WOULD BE A 0.5 PERCENT MINIMUM INCREASE EFFECTIVE JULY 2015 THROUGH 2019.

Medicare Issues

MEDICARE PART B

13

A “MERIT-BASED INCENTIVE PAYMENT SYSTEM” (MIPS) QUALITY PROGRAM WOULD IMPLEMENT SOME FEATURES OF MEDICARE’S CURRENT QUALITY PROGRAMS, INCLUDING THE PHYSICIAN QUALITY REPORTING SYSTEM (PQRS), MEANINGFUL USE (MU), AND VALUE BASED PAYMENT MODIFIER (VBM) PROGRAMS.

Medicare Issues

MEDICARE PART B

14

INCOME-RELATED PREMIUM ADJUSTMENT (EFFECTIVE 2018) PROVIDES FOR AN INCREASE IN THE PERCENTAGE THAT BENEFICIARIES PAY TOWARD THEIR PART B AND D PREMIUMS IN TWO INCOME BRACKETS (ROUGHLY 2 PERCENT OF BENEFICIARIES): FOR INDIVIDUALS WITH INCOME BETWEEN \$133.5-160K (\$267-\$320K FOR A COUPLE), THE PERCENT OF PREMIUM PAID INCREASES FROM 50 PERCENT TO 65 PERCENT. FOR THOSE WITH INCOME BETWEEN \$160-214K (\$320-\$428K FOR A COUPLE), THE PERCENT INCREASES FROM 65 PERCENT TO 75 PERCENT.

Medicare Issues

MEDICARE PART B

15

ONE PERCENT MARKET BASKET UPDATE FOR POST-ACUTE PROVIDERS REPLACES THE MARKET BASKET UPDATE IN 2018 WITH A ONE PERCENT UPDATE FOR LONG-TERM CARE HOSPITALS, SKILLED NURSING FACILITIES, INPATIENT REHABILITATION FACILITIES, HOME HEALTH PROVIDERS AND HOSPICE PROVIDERS.

Medicare Issues

MEDICARE PART B

16

MEDICARE THERAPY CAPS

THE DOC FIX LEGISLATION EXTENDS THE CURRENT MEDICARE THERAPY CAPS EXCEPTIONS PROCESS FOR ANOTHER TWO YEARS, THROUGH DECEMBER 31, 2017. WE WILL CONTINUE TO WORK WITH CONGRESS ON A BIPARTISAN BASIS TO RESOLVE THIS ISSUE.

Medicare Issues

MEDICARE PART B

17

TO WATCH IN THE FUTURE, THE PHYSICIAN PAYMENT REFORM IS NOT FULLY FUNDED AND CONCERN HAS BEEN RAISED AS TO HOW THIS WILL BE ADDRESSED.

Medicare Issues

18

EFFECTIVE OCT. 1, 2015, THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) INTENDS TO BEGIN COLLECTING NURSING HOME STAFFING DATA THROUGH THE NEW PAYROLL-BASED JOURNAL (PBJ) REPORTING SYSTEM. CMS SET UP A [PBJ WEB PAGE](#) AND POSTED A [DRAFT MANUAL](#) AND [VENDOR SOFTWARE SPECIFICATIONS](#). THE INITIAL OCT. 1 START DATE IS FOR THOSE FACILITIES SEEKING TO PARTICIPATE IN THE DATA SUBMISSION ON A VOLUNTARY BASIS IN ANTICIPATION OF A MANDATORY START DATE OF JULY 1, 2016.

Medicare Issues

BEGINNING JAN. 1, 2015, CMS BEGAN APPLYING A VM TO PHYSICIAN PAYMENTS UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE FOR PHYSICIANS IN GROUPS WITH 100 OR MORE EPS BASED ON THE 2013 PERFORMANCE PERIOD. THE PROGRAM WILL CONTINUE TO BE PHASED IN ACCORDING TO THE FOLLOWING SCHEDULE:

IN 2016, THE PAYMENT ADJUSTMENTS WILL APPLY TO PHYSICIANS IN GROUPS OF 10 OR MORE EPS BASED ON 2014 PERFORMANCE;
2017, THE PAYMENT ADJUSTMENTS WILL APPLY TO PHYSICIAN SOLO PRACTITIONERS AND PHYSICIANS IN GROUPS OF 2 OR MORE EPS BASED ON 2015 PERFORMANCE; AND
2018, THE PAYMENT ADJUSTMENTS WILL ALSO APPLY TO NON-PHYSICIAN EPS WHO ARE SOLO PRACTITIONERS OR ARE IN GROUPS OF 2 OR MORE EPS.

Medicare Issues

NEW TIMELY FILING REQUIREMENTS

20

- **FOR INSTITUTIONAL CLAIMS THAT INCLUDE SPAN DATES OF SERVICE (I.E., A “FROM” AND “THROUGH” DATE SPAN ON THE CLAIM), THE “THROUGH” DATE ON THE CLAIM WILL BE USED TO DETERMINE THE DATE OF SERVICE FOR CLAIMS FILING TIMELINESS.**
- **FOR PROFESSIONAL CLAIMS (CMS-1500 FORM AND 837P) SUBMITTED BY PHYSICIANS AND OTHER SUPPLIERS THAT INCLUDE SPAN DATES OF SERVICE, THE LINE ITEM “FROM” DATE WILL BE USED TO DETERMINE THE DATE OF SERVICE AND FILING TIMELINESS. (THIS INCLUDES SUPPLIES AND RENTAL ITEMS).**

[MLN MM7080](#)

The most important slide of all time:

21

- ACO = Accountable Care Organization – a product of the Affordable Care Act
- BHO = Behavioral Health Organization / Utilization Management focus
- BIP = Balance Incentive Program
- DISCO = Developmental Disability Individual Service Care Organization
- DSRIP = Delivery System Reform Incentive Payment
- FFS = Fee for Service
- FIDA = Fully Integrated Duals Advantage
- HARP = Health and Recovery Plan (set of behavioral services available from an MCO)
- Health Homes = Care Coordination / Management on a regional basis with integration of provider networks
- LOL – Laugh Out Loud
- MAP (Medicaid Advantage Plus) = combination of Medicaid managed long term care plan and Medicare Advantage plan
- MCO = Managed Care Organization a.k.a. Health Plan
- Medicaid Advantage = Medicaid managed care for dual eligible not in need of LTC
- Medicare Advantage = Medicare managed care
- MLTC = Managed Long-Term Care Plan
- MMCP = Mainstream Medicaid Managed Care Plan
- PACE Program = Program for All-Inclusive Care for the Elderly
- VAP = Vital Access Provider

Federal Background – Affordable Care Act

- Policy and law makers on both sides of the aisle acknowledge that traditional FFS is no longer sustainable for the social safety net health care programs, i.e., Medicare, Medicaid and CHIP.

Federal Background – The Affordable Care Act

23

- The ACA creates incentives to move away from traditional FFS to new payment arrangements, including managed care, bundled payments, value based purchasing, and accountable care organizations.

Patient Protection & Affordable Care Act

- New office created in CMS to coordinate care of “dual eligibles” to coordinate Medicare and Medicaid coverage, eliminated inefficient or duplicative coverage, and reduce hospitalizations.
- Provides for enhanced federal funding and grant monies for states to implement innovative payment and care management systems.

Priorities:

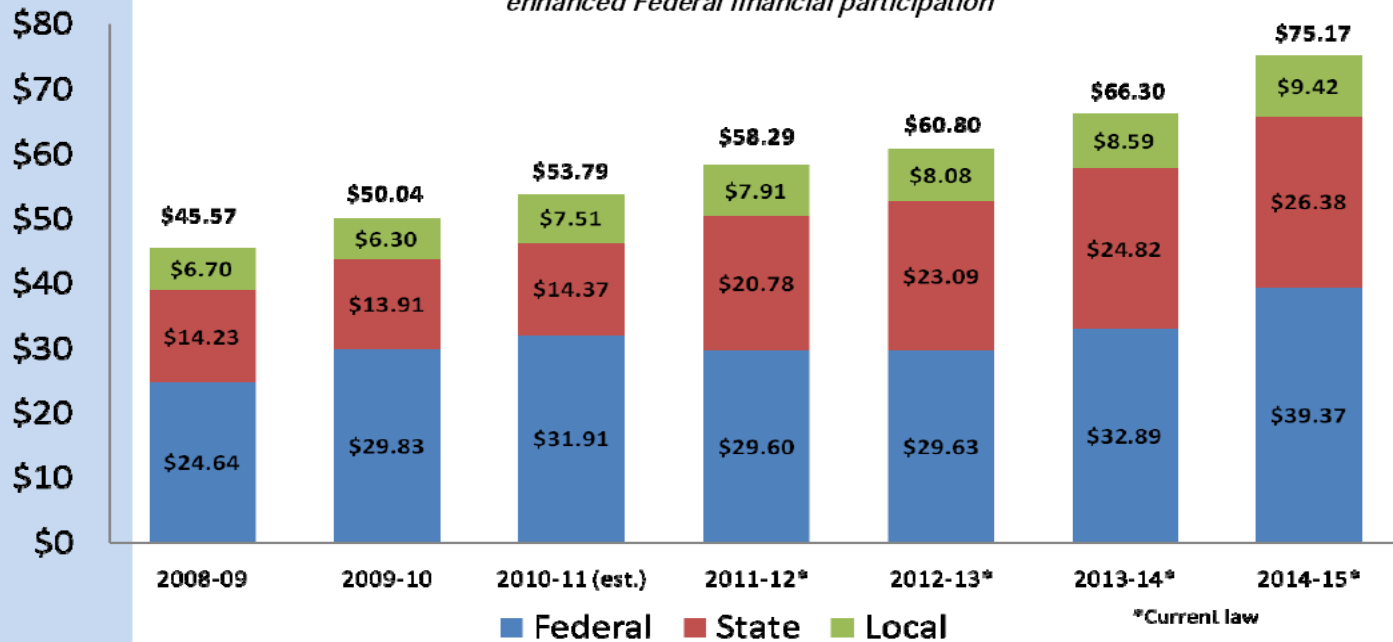
25

- **Reduce Uninsured**
 - Reduce Medicaid eligible
 - Encourage participation in the NY Health Exchange (NY State of Health) for individuals and small businesses
- **Measure and constantly strive to improve patient quality of care and satisfaction**
- **State or join care coordination organizations to improve quality, lower costs, and increase reimbursement**
 - Accountable care organizations
 - Medical homes
 - Health homes
- **Prepare to invest in technology to**
 - Measure quality of care
 - Measure costs
 - Share information with other coordination organizations

Medicaid Redesign: Comparative Spending

Overview – Historical Medicaid Spending (\$ in Billions)

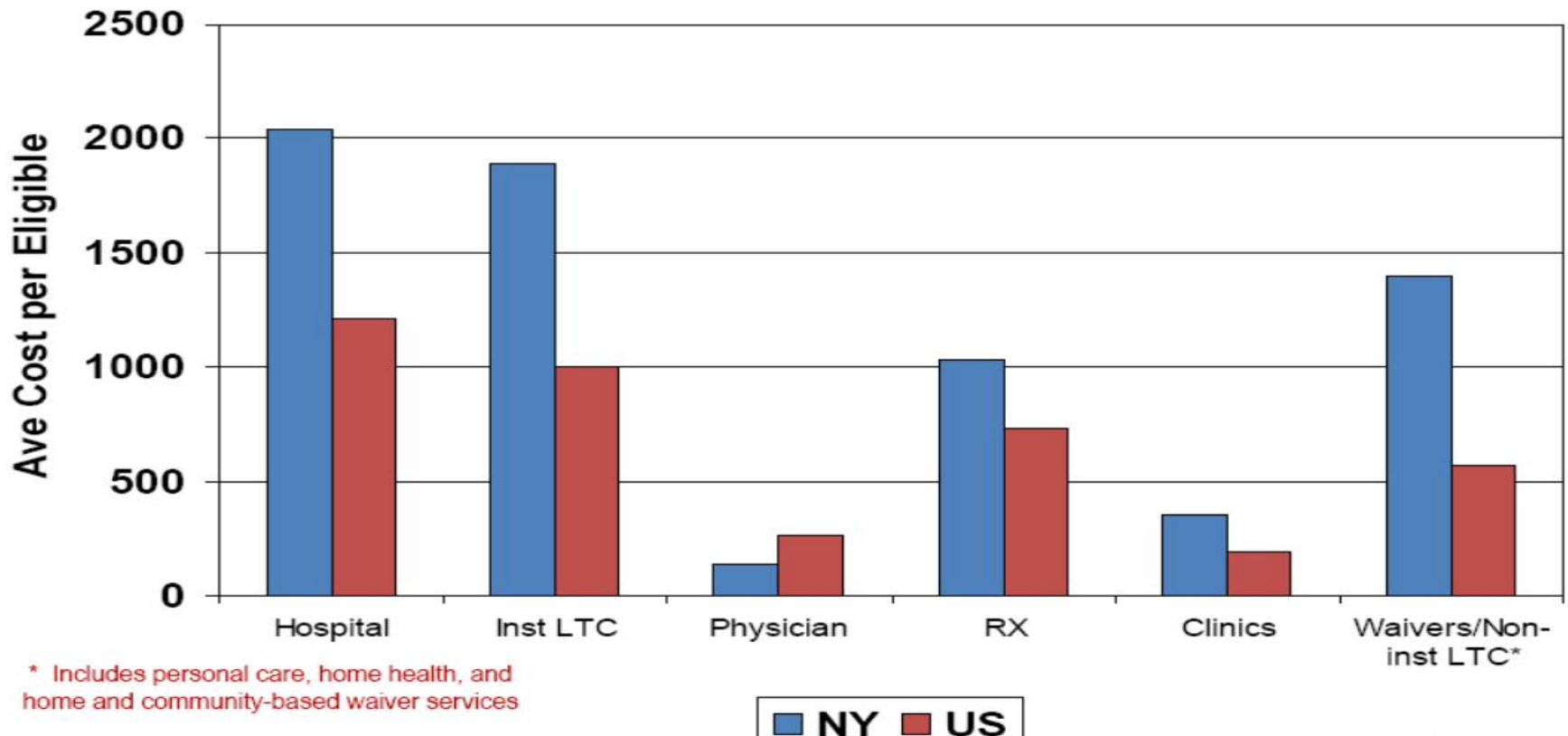
State share will increase markedly in 2011-12 due to local cap and phase-out of enhanced Federal financial participation



Medicaid Redesign By Service Category

Overview: Medicaid Spending NYS vs. U.S.

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



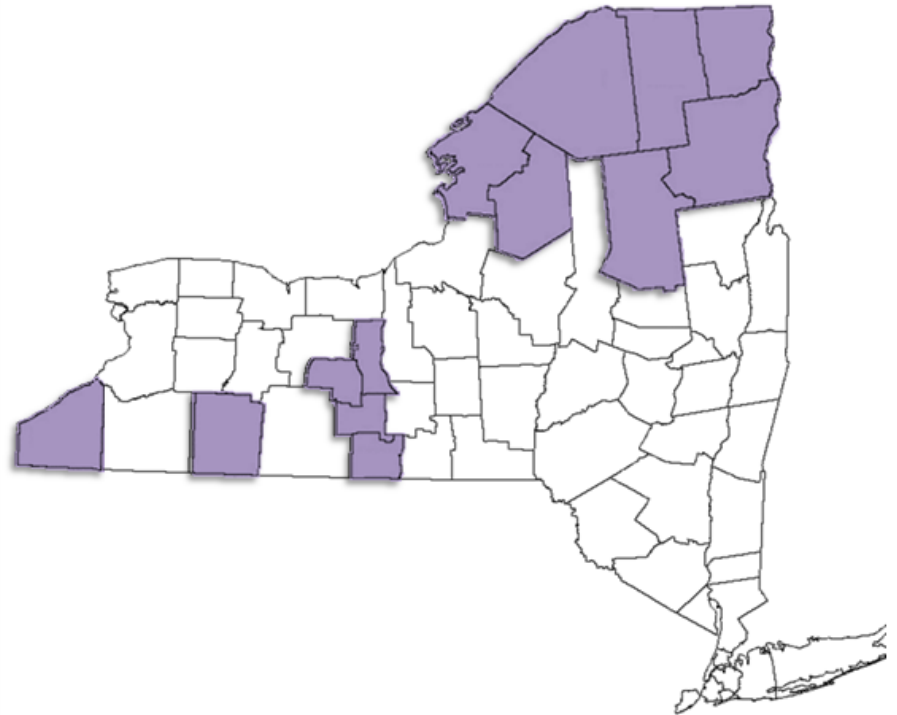
Transition to Managed Long Term Care (Community Medicaid)

28

MLTC Upstate Transition

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

Source: NYS DOH



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

NH Transition to Managed Care - Resources

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

TRANSITION OF
NURSING HOME
POPULATIONS AND
BENEFITS
TO MEDICAID
MANAGED CARE
Frequently Asked
Questions Document
(Jan. 2015)

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

Office of
Health
Insurance
Programs

Transition of Nursing Home
Benefit and Population into
Managed Care

February 2015
Implementation

Consumers, family members and representative have the right to file a complaint with any of the following:

- MMC Complaint line 800-206-8125
- MLTC Complaint line 866-712-7197

NYS Medicaid Redesign: Managed Care

30

- ▶ Add more services to managed care benefits
- ▶ Require more recipients to join “mainstream” plans
- ▶ Require most HCBS recipients to join MLTC plans
- ▶ Enroll certain dual eligibles in integrated Medicare/Medicaid managed care starting in 2014
- ▶ Use health homes, medical homes and ACOs to coordinate care and network services
- ▶ Enroll all Medicaid recipients in managed care/coordinated care models within 5 years

The State's Medicaid Redesign Priorities

31

- Achieve the federal “triple aim”
 - Improve Population health
 - Improved care (Quality/Satisfaction)
 - Lower/Control cost
- Reduce uncertainty and risk for the state
- Contract with, and pay, fewer entities
- “Care management for all”
- Integrate Medicaid with Medicare
- Access federal funding

Defining Features of Managed Care

32

- ▶ Added benefits or lower cost- sharing
- ▶ Care coordination and management
- ▶ Preventative health benefits
- ▶ Capitation and risk
- ▶ Single point of contact
- ▶ Provider network

Managed Care Changes Incentives

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

Types of Managed Care Plans

1. **Commercial Managed Care**

- Preferred provider organizations
- Health Maintenance Organizations
- Exclusive Provider Organizations

2. **Medicare Managed Care**

- Medicare Advantage
- Medicare special needs plans (e.g., Evercare)

3. **Medicaid Managed Care**

- Mainstream Medicaid Managed Care
- Family Health Plus/Child Health Plus
- Healthy New York
- HIV Special Needs Plans (HIV-SNPs)
- Managed Long Term Care (MLTC)

4. **Medicaid and Medicare (Dual eligibles)**

- Medicaid Advantage (Dual special needs & Institutional special needs plans)
- Medicaid Advantage Plus (MAP)
- Programs of All-Inclusive Care for the Elderly (PACE)
- Managed Long Term Care (MLTC)
- Fully Integrated Duals Advantage (FIDA)

Critical Issues - Summary

35

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

Critical Issue - Managed Care Changes Incentives

36

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

Conflict-Free Evaluation and Enrollment Center (CFEEC)

37

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

Are you in the network?

38

- New York is not an “any willing provider” state, therefore a managed care organization can choose to exclude a provider from its network for any reason.
- Number of contracts to manage and number of available plans in an area.
- New York is not an “any willing provider” state, therefore a managed care organization can choose to exclude a provider from its network for any reason.
- Number of contracts to manage and number of available plans in an area.

Critical Issue - Networks

39

- Providers need to be making strategic decisions about which plan networks to join.
 - Administrative work in managing contract.
 - Value of being in a network.
 - Cost of not being in a network.
 - Role and responsibilities of various plans and billing practices.

State Receives Final Approval of \$8 Billion Medicaid Waiver

- On April 14, 2014, Governor Cuomo [announced](#) that the federal government has officially signed off on New York's Medicaid waiver, which will allow the State to reinvest, over the next five years, \$8 billion in federal savings generated by Medicaid Redesign Team (MRT) reforms.
- The \$8 billion reinvestment will be allocated as follows:
 - \$6.42 Billion for the [Delivery System Reform Incentive Payment \(DSRIP\) Program](#) – including DSRIP Planning Grants, DSRIP Provider Incentive Payments, and DSRIP administrative costs;
 - \$500 Million for the Interim Access Assurance Fund – temporary, time-limited funding to ensure current trusted and viable Medicaid safety net providers can fully participate in the DSRIP transformation without disruption; and
 - \$1.08 Billion for other Medicaid Redesign purposes – funding to support Health Home development, and investments in long term care, workforce and enhanced behavioral health services.

Critical Issue: DSRIP

41

- DSRIP, like managed care, will significantly impact how the overall system functions and this will eventually impact provider relationships and how residents/patients receive care.
For example:
 - Reducing unnecessary re-hospitalizations will drive much of the decision making.
 - Ensure delivery system transformation continues beyond the waiver period through leveraging managed care payment reform.
- ***Key theme is collaboration!***

DSRIP

Q: What is DSRIP?

A: [Delivery System Reform Incentive Payment Program](#) (DSRIP). It is the main mechanism by which New York State will implement the Medicaid Redesign Team (MRT) Waiver Amendment. DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. Up to \$6.42 billion dollars are allocated to this program with payouts based upon achieving predefined results in system transformation, clinical management and population health.

DSRIP

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

Partners should include:

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

Responsibilities must include:



DSRIP

PPS by County- Central NY

Broome		Madison
United Health Services Hospitals		CNY DSRIP Performing Provider System
Cayuga		Mohawk Valley PPS (Bassett)
CNY DSRIP Performing Provider System		Montgomery
Finger Lakes PPS		Ellis Hospital
Chemung		Oneida
Finger Lakes PPS		CNY DSRIP Performing Provider System
United Health Services Hospitals		Onondaga
Chenango		CNY DSRIP Performing Provider System
United Health Services Hospitals		Oswego
Cortland		CNY DSRIP Performing Provider System
United Health Services Hospitals		Saint Lawrence
Fulton		Adirondack Health Institute
Adirondack Health Institute		Samaritan Medical Center
Ellis Hospital		Schuyler
Hamilton		United Health Services Hospitals
Adirondack Health Institute		Tioga
Herkimer		United Health Services Hospitals
Mohawk Valley PPS (Bassett)		Tompkins
Jefferson		United Health Services Hospitals
Samaritan Medical Center		Yates
Lewis		Finger Lakes PPS
CNY DSRIP Performing Provider System		
Samaritan Medical Center		

DSRIP

Attribution:

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

DSRIP

Not Just New York

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

Critical Issues for Discussion:

47

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

Critical Issues for Discussion:

48

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

FIDA

49

FIDA (Fully Integrated Dual Advantage)

- Model of managed long term care that will integrate Medicaid and Medicare funding and services in New York City, Long Island and Westchester County.
- *Beginning January 2015:* Adult NH residents (and community residents in need of 120 days of community-based LTC) in Bronx, Kings, Nassau, New York, Queens, and Richmond counties can voluntarily enroll in FIDA plans.
- *Beginning April 2015:* Permanently-placed adult residents in Bronx, Kings, Nassau, New York, Queens, and Richmond counties will be passively enrolled in a FIDA plan. Residents that opt out of FIDA will remain in MLTCP or FFS if permanently placed prior to January 2015.
- **The FIDA roll out for Region II – Westchester and Suffolk - is on hold (March 1 effective date is cancelled) due to lack of network adequacy and there is no new target date.**

FIDA

50

FIDA Enrollment Update*

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

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

*As of March 7, 2015

Source: NYS DOH

NH Transition to Managed Care

Transition to Managed Care for Nursing Home Residents

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

Individuals who are already permanent nursing home residents at the time that the requirement goes into effect in their county will not be required to enroll into a plan and may continue in fee-for-service Medicaid.

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

NH Transition to Managed Care

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

Source: NYS DOH

NH Transition to Managed Care

Three Year Rate Protection

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

DOH has proposed high-cost and high-capital cost nursing home pools for managed care plans to neutralize intrinsic disincentive for plans to avoid utilizing higher cost homes.

NH Transition to Managed Care

Provider Contracting

- All agreements must be negotiated in good faith.
- All Agreements will have the “New York State Standard Clauses for Managed Care Provider/IPA Contracts”.
- Due process rights must be included for providers that allow the provider to appeal any determination identified by the MCO.
- In the event a contract is terminated, for reasons other than imminent harm or fraud and abuse, the MCO may not require members to transfer to a participating NH.
- • The rate of payment for the OON provider will be the fee for service rate in effect at the time of service.
- MCOs will establish a process to train contracted providers relating to claims adjudication.
- Required contract provisions are discussed in the MCO and IPA Provider Contract Guidelines available on the Department's web site at:

http://www.health.ny.gov/health_care/managed_care/hmoipa/docs/guidelines.pdf

NH Transition to Managed Care

Plan Selection and Enrollment

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

NH Transition to Managed Care

Transitions: Hospital to Nursing Home

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

NH Transition to Managed Care

Transitions: Hospital to Nursing Home

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

NH Transition to Managed Care

Transitions: Hospital to Nursing Home

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

NH Transition to Managed Care

Transitions: Hospital to Nursing Home

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

NH Transition to Managed Care

Transitions: Community to Nursing Home

- Nursing Home Role:
 - Checks eligibility; notifies MCO of need for long term stay
 - Conducts mandatory assessments
 - Arranges meetings with enrollee, family and team
 - Physician or clinical peer makes recommendation for transition and care plan based on:
 - Clinical needs of enrollee
 - Functional criteria
 - Availability of services in the community
 - Communicates recommendation, care plan (specific enrollee needs) and supporting documentation to MCO for authorization
 - Obtains authorization for stay prior to admission

NH Transition to Managed Care

Transitions: Community to Nursing Home

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

NH Transition to Managed Care

Benchmark Rates

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

NH Transition to Managed Care

Billing/ Cash Flow

- The Department has taken steps to ensure that Nursing Home cash flow will not be negatively impacted by the shift to Managed Care. For example,:
 - Scenario 1 – Mainstream Managed Care patient is at NH for rehabilitation and applies for long term care eligibility, the Plan will pay the NH at the benchmark rate during this period.
 - Scenario 2 – Managed Long Term Care patient regresses from the community into a long term NH stay, the Plan will pay NH the benchmark rate during the eligibility process.
 - Scenario 3 – FFS patient requires long term NH stay and goes into eligibility process, the NH must wait until a determination is made and the member is deemed eligible for long term placement. At that point, NH can bill FFS retro to the eligibility date. Once enrolled in Managed Care, the NH must bill the Plan.
- Clean Claims:
 - DOH has implemented a readiness review survey to ensure that Nursing Homes can submit clean claims to Plans on a quarterly basis.
 - Active discussion to develop uniform billing codes among Plans and NH
- As an emergency stop gap when there are unavoidable billing problems between Plans and providers, the Department can eliminate or temporarily reduce the two week cash lag.

NH Transition to Managed Care

Plan Billing

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

Questions?

65

- I am sure, more questions than answers at this point.