Financial and Operational Implications of Managed Care
November 13, 2013

By Rob Nasso

Outline

- Past/Present Rate Methodology
- NYS Managed Care Transition - proposed
- FIDA Program
- Managed Care – Financial/Operational Implications
Current Rate Methodology

- Cost based/Acuity Adjusted
  - 2002 base year (2009-2011)
- Statewide Pricing Methodology
  - Facility specific WEF, capital, non-comp.
  - Peer groups for over 300 bed/hospital based
  - Acuity adjusted
  - 6 year transition period (1.75, 2.5, 5, 7.5, 10, Full)

Why Managed Care?

- DOH wants to get out of the “rate setting” business.
- Current Medicaid growth rate unsustainable.
- Provide predictable state expenses
- Improve care coordination
- Transition of Long term care from institutional to community based
- Access to Federal funds
Triple Aim

1. Improving Health – weight, smoking, etc
2. Improving quality of care – quality measures, prevention, immunization, controlling blood pressure, diabetes mgmt, chronic disease mgmt.
3. Reducing costs – nursing home per beneficiary costs remain high.

Managed Care - Wikipedia

Managed Care is used to describe a variety of techniques to reduce the cost of providing health benefits and improve the quality of care for organizations that provide healthcare services…

…intended to reduce unnecessary healthcare costs… by providing economic incentives for physicians/providers and patients to select less costly forms of care.
NYS Managed Care Workgroup

- Financial Planning and Rate Development
- Network and Contracting
- Eligibility/Enrollment Phase-in Schedule
- Access to Care and Quality

NH Transition to Managed Care

- Phase-in New Enrollees
  - Downstate – January, 2014
    - NYC Boroughs, Nassau, Suffolk and Westchester.
  - Upstate – July, 2014
    - Rest of the State
Nursing Home Transition to Managed Care

- **Beneficiary Enrollment**
  - Current NH recipients (1/1/14) not required to enroll, but may voluntarily.
  - New Medicaid recipients will be required to enroll in a MLTCP or MMCP (NH LTC needs)
  - Non-dual eligible needing NH long term placement after 1/1/14 will no longer be dis-enrolled (MLTCP)
  - No one will be required to change nursing homes from the transition.

NH Transition to Managed Care

- **Eligibility**
  - Recommendation for NH based upon medical criteria that individual is not expected to return to the community (Physician/Discharge Planner/NH)
  - Recommendation for approval must go to MCO with supporting documentation. MCO authorizes all levels of care.
Eligibility continued

- Determination of LTC eligibility
  - Beneficiaries will have 60 days to complete application for custodial placement
  - Review of assets, 60 month look-back
  - New enrollees
    - Recipient will be “educated” to pick MCO which contracts with NH they’re residing at or they can change NH.
    - If resident doesn’t choose, s/he will be enrolled in an MCO that contracts with their NH.
    - If resident is ineligible, NH will seek reimbursement from recipient/family.

Eligibility continued

- Auto enrollment
  - Recipient has 60 days to choose MCO.
  - No lock in – resident can change MCO’s with enrollment on 1st day of following month.

- Penalty period
  - Recipient not eligible until penalty period ends.
  - MCO recoups from NH
  - NH collects from patient/family for penalty period.

- MCO’s role is to review request for services and make coverage decisions
Networking and Contracting

- NH residents can change MCO’s.
- MCO’s must contract with at least two Specialty Nursing Home’s
- Minimum # of participating Homes

<table>
<thead>
<tr>
<th>Counties</th>
<th># NH’s</th>
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<tbody>
<tr>
<td>Kings, Queens, Bronx, Suffolk, Nassau, Westchester, Erie, Monroe</td>
<td>8</td>
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<tr>
<td>New York, Richmond</td>
<td>5</td>
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<tr>
<td>Oneida, Dutchess, Onondaga, Albany</td>
<td>4</td>
</tr>
<tr>
<td>Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster</td>
<td>3</td>
</tr>
<tr>
<td>All Other Counties</td>
<td>2</td>
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Networking and Contracting

- Network inadequate if they don’t meet minimum requirements or have insufficient beds
- If network inadequate or insufficient beds, MMC required to (upon member request) to receive services at non-participating NH
- MMC plans authorizing out of network placement can’t require person to move at later date.
- Members must be provided with MCO’s available for selection as well as participating providers.
Access to Care and Quality

- Discharge Planning
  - Transitioning process (resident needs must be met)

- MCO authorizations for care
  - No authorizations for emergency transfers, urgent care to network

Quality Metrics/Incentives

- NYQP
- Uniform Assessment System (UAS-NY)
- Utilization Measures
- Quality and Patient Safety
- Transitions NH > Community
Finance – Rate Transition

- Existing NH Residents
  - Will continue to receive SWP rates for 2 years.

- Newly enrolled NH Residents
  - Benchmark Premium (Rate) – includes all existing scheduled pricing/transition through 2017.
  - Negotiated Premium (Rate) – NH’s/plans can engage in other financing arrangements, but not less than the benchmark rate.
  - State will monitor negotiation agreements.
  - State will assess impact after one year to determine whether to extend transition beyond two years.

Finance – What’s in the rate?

- Statewide pricing rates 2014 - 2017
- Capital
- Cash Receipts Assessment
- CMI changes
- Universal Settlement
- Retroactive rate changes?
- OMIG?
Finance – Capital Component

- After 2 year transition
  - DOH will continue to publish “benchmark” rates
  - Nursing homes will continue to receive the capital calculated benchmark premium

- Capital Pool
  - Plans with disproportionately impacted by high capital NH’s could have access to capital pool.

Finance – Capital Component

- Nursing Home Capital Workgroup
  - DOH/Providers/Associations
  - Updated/revised refinancing approval process
  - Reviewing current capital reimbursement methodology
  - Considering revisions to promote capital investment, improve quality and efficiency, reduce costs
Finance – Shared Savings

- State will facilitate/develop strategies/financial incentives with plans and providers to share savings

Premium Development

- **Mainstream**
  - Mercer establishing new premium groups
  - Separate “cell” for NH population
  - Will reflect higher costs and allow recipients to be tracked as they transition from FFS to MMCP’s.

- **MLTC**
  - DOH considering separate cell for NH population
  - Need to verify that CMS will allow it
  - Must not incentivize NH placement
Premium Development

- **Net Available Monthly Income (NAMI)**
  - Initially will be collected from the member by the MCO
  - Long Term – The State will assume responsibility for the collection of the NAMI

- **Risk Mitigation**
  - Addresses cost anomalies of providing NH care
  - Risk pool vs. modification to reimbursement program to address disproportionately higher mix of high need members

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Fully Integrated Duals Advantage (FIDA)

- **FIDA Demonstration project - 7/1/14 – 12/31/17**
  - Partnership between CMS and NY
  - MOU signed 8/26/13.
  - Downstate only (NYC, Long Island, Westchester)
  - NYSDOH and CMS are testing the delivery of integrated services through a capitated managed care model
  - Comprehensive service package
  - Broad Medical necessity definition
  - Interdisciplinary Team (IDT) authorizes virtually all services
FIDA Objectives

- Better align costs/incentives between Medicare and Medicaid
- Better coordinate services (eliminate fragmentation)
- Reduce costs – since there’s significant variation in costs among dual eligibles
- Improve quality/person centered care.

FIDA Eligibility (Duals)

- Over 21, Part A, B and D, full Medicaid benefit
- Nursing Facility Clinically Eligible (NFCE) – receiving LTSS
- Reside in FIDA County
- Excluded
  - Residents in ALP
  - Residents in OPWDD facility
# FIDA Enrollment

- **Community based LT Support Services**
  - Voluntary 7/1/14
  - Passive 9/1/14

- **Facility based LTSS**
  - Voluntary 10/1/14 (applications accepted starting 8/14)
  - Passive 1/1/15 (Phased in over 4 months based upon MCD reauthorization dates)

- Passive enrollment will use algorithm to assign the patient to an appropriate FIDA plan.

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# FIDA Network Adequacy

- Must adhere to all existing Medicare/Medicaid network adequacy standards
- 2 or more provider types within 15 mile/30 minute drive of member zip code
- FIDA plans required to contract with all NH's
- Must allow participants to maintain current providers/service levels for 90 days.
FIDA Covered Benefits

- Includes all current benefits – Medicare and Medicaid (i.e. Hospitalization, SNF, Ambulance, Diagnostic, Physician, Behavioral health, Home Care, Rx, etc)
- FIDA plans may supplement services where so doing would address participant needs
- Comprehensive assessment and service planning completed by Interdisciplinary Team (IDT)

FIDA Plan Quality Metrics

- Quality withhold – 1%, 2%, 3% (years 1 to 3)
- Year 1
  - Encounter Data, Assessments, Customer Service, getting appointments timely, documentation
  - Nursing Facility Diversion measure
- Years 2 & 3
  - Readmissions, Flu vaccine, Falls, Blood pressure, Rx mgmt, ADL improvement/stability, Nursing Facility Diversion
FIDA Financing – Rate Cells

- Community Non-NH Certifiable – Rate cell for individuals, >120 days LTSS, but don’t meet Nursing Home Level of Care (NHLOC) standard
- Nursing Home Certifiable – Rate cell for individuals who meet NHLOC standard
- Rate cells will risk adjusted
- Rates based upon regional averages

FIDA Financing

- Savings
  - Year 1 = 1%, Year 2 = 1.5%, Year 3 = 3%
- Target Medicaid Loss Ratio of 85%
  - Less than 85% - remit to CMS/State
  - Greater than 85% - ???
- CMS/State required to monitor the financial stability of FIDA plans and make rate adjustments if needed.
Preparing for Managed Care

- Financial
- Quality/Operational
- Contracting

WHAT’S YOUR PITCH?
High Quality vs. High Value

$75,000  $17,000
What’s your pitch?

- Good value (low cost), acceptable quality
- Good value, good quality
- Reasonable value, good quality
- High cost, high quality
- Specialty services
- Leverage
  - Desirable facility (excellent reputation)
  - Significant player
  - Full continuum of care

Financial Implications

- Know your rates
- Know your costs
- Know the rates for your region
- Know your competitors
Current Medicaid Rate

1. Operating Component
2. Capital Costs
3. Cash Receipts Assessment
4. Subsequent Adjustments

- Know what you’re currently being paid for?
- All Inclusive Rate – what does that mean?
- What services are in your contract?
- What will you be responsible for?
- What might you want to add?
Capital Costs

- Current Medicaid rate -1/1/14
- New Building vs. Old Building
- High costs vs. Low Costs
- Capital costs vs. your competitors
- MCO capital pool.

Cash Receipts Assessment

- Make sure this is part of your Medicaid rate

- Compare your current per diem to your reimbursable per diem.
Subsequent Adjustments

- Case Mix Adjustments
- Appeals
- OMIG Adjustments
- Universal Settlement
- Future Transitional Adjustments
  - Years 4, 5 and 6

Negotiating Rates

- Medicaid rate will be the starting point
- How does your rate compare to others in your county/region?
- How does your Medicaid rate compare with your costs?
- Let's look at some data…
Albany/Glen Falls Region
4/1/2013 Medicaid Nursing Facility Rates

Average - $188.13

Rates used in analysis include capital and cash receipt assessments.


Data Provided by NYSDOH and Summarized by Rotenberg Healthcare Consulting, LLP

Binghamton/Elmira Region
4/1/2013 Medicaid Nursing Facility Rates

Average - $183.05

Rates used in analysis include capital and cash receipt assessments.

The Binghamton/Elmira region includes Broome, Chenango, Schuyler, Steuben, and Tioga counties.

Data Provided by NYSDOH and Summarized by Rotenberg Healthcare Consulting, LLP
Central Region
4/1/2013 Medicaid Nursing Facility Rates

Average - $196.93

Rates used in analysis include capital and cash receipt assessments.
The Central region includes Madison and Onondaga counties.

Data Provided by NYSDOH and Summarized by Rotenberg Healthcare Consulting, LLP

Hudson Region
4/1/2013 Medicaid Nursing Facility Rates

Average - $205.09

Rates used in analysis include capital and cash receipt assessments.
The Hudson region includes Chenango, Delaware, Dutchess, Greene, Orange, Otsego, Putnam, Sullivan, and Ulster counties.

Data Provided by NYSDOH and Summarized by Rotenberg Healthcare Consulting, LLP
New York City Region
4/1/2013 Medicaid Nursing Facility Rates

Rates used in analysis include capital and cash receipt assessments.
The New York City region includes Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, and Westchester counties.

Data Provided by NYSDOH and Summarized by Rotenberg Healthcare Consulting, LLP

Rochester Region
4/1/2013 Medicaid Nursing Facility Rates

Rates used in analysis include capital and cash receipt assessments.
The Rochester region includes Livingston, Monroe, Ontario and Wayne counties.

Data Provided by NYSDOH and Summarized by Rotenberg Healthcare Consulting, LLP
Rural Region
4/1/2013 Medicaid Nursing Facility Rates

Rates used in analysis include capital and cash receipt assessments.
The Rural region includes Cayuga, Clinton, Cortland, Franklin, Herkimer, Jefferson, Lewis, Oneida, Oswego, Seneca, St. Lawrence, Tompkins and Yates counties.

Data Provided by NYSDOH and Summarized by Rotenberg Healthcare Consulting, LLP

Western Region
4/1/2013 Medicaid Nursing Facility Rates

Rates used in analysis include capital and cash receipt assessments.
The Western region includes Alleghany, Cattaraugus, Chautauqua, Genesee, Erie, Niagara, Orleans, and Wyoming counties.

Data Provided by NYSDOH and Summarized by Rotenberg Healthcare Consulting, LLP
Statewide Pricing - Average 2012 Medicaid Nursing Facility Rates
Albany/Glen Falls Region

For comparison purposes, average rates used in analysis are operating components only - capital was not included.

The public facilities average rates used above include the IGT funding at 2010/2011 levels ($189 mil statewide or $58.33 per day).

Average Case Mix Index data for January, 2011.

Average Cost Per Day Information was taken from the 2011 RHCF-4 cost report.


Statewide Pricing - Average 2012 Medicaid Nursing Facility Rates
Central Region

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Statewide Pricing - Average 2012 Medicaid Nursing Facility Rates
New York City Region

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Average Case Mix Index data for January, 2011

Know your costs

- Review your cost structure
  - Benchmark against other facilities
  - Identify cost drivers – nursing staffing, therapy utilization, ancillaries, overhead
- Perform cost accounting
  - Costs per unit – TCU's vs. SNF
  - Costs per resident
    - Specialty populations
  - Fixed costs vs. variable
Quality Measures

- Triple Aim
- New York State Quality Pool
- CMS 5 Star Rating
- Survey (QIS)
- MLTC/FIDA Measures

New York State Quality Pool

- Quality Pool 2013
  - Quality measures (60 pts)
  - Compliance Component (20 pts)
  - Potentially Avoidable Hospitalizations (20 pts)
Quality Measures (MDS)

1. % long stay high risk w/pressure ulcers. (risk adjusted)
2. % long stay residents assessed/ given approp. Pneumococcal vaccine
3. % long stay residents assessed/given approp. seasonal influenza vaccine
4. % long stay residents experiencing fall with major injury
5. % long stay residents who have depressive symptoms
6. % low risk long stay residents who lose control bowels/bladder
7. % long stay residents who lose too much weight (NYS to review)
8. % long stay residents who received Anti-psychotic medication
9. % long stay residents who self report moderate – severe pain
10. % long stay whose need for help with ADL’s increase
11. % long stay residents UTI’s
12. % of Employees vaccinated for the Flu
13. CMS 5 Star Rating for Staffing (not NYS calculated)
14. Annual % level of Temp Cont/Agency Staff used

Quality Measures (60 pts)

- Pay for highest performance as well as improvement from previous year
- Points awarded for top 60%
  - Top Quintile - 4.29 points
  - 2nd Quintile - 2.56 points
  - 3rd Quintile – 0.83 points
  - 4th/5th Quintile – 0 points
3 Quality Measures – All or Nothing…

- Annual level of contracted/agency
  - Maximum awarded if < 10%
- % of long stay residents assessed and given appropriately the seasonal influenza vaccine and pneumococcal vaccine
  - Maximum awarded if > 85%

Compliance 20 points

- 5 Star (as of 4/1/2013)
  - 5 Stars – 10 points
  - 4 Stars – 7 points
  - 3 Stars – 4 points
  - 2 Stars – 2 points
  - 1 Star – 0 points.
- Cost reports (timely filed) – 5 points
- Employee Flu vaccinations report (timely filed) – 5 points
Avoidable Hospitalizations (20 pts.)

- NYS Developed quality indicator
- Long stay episodes – 101 days or more
- MDS 3.0 data will be used
- Period – 1/1/12 – 12/31/12
- Hospitalizations from NH’s identified through SPARCS data
- Identified as PAH or not, risk adjusted
- # of PAH/Total long stays
- Points – 10, 8, 6, 2, 0

Excluded Facilities

- Negative quality per diem (regardless of your quality score)
  - JKL deficiency during measurement year (1/1/12 – 6/30/13) – 41 facilities
  - Fraud/Abuse determined by OMIG/AG during measurement or payment year – 44 facilities.
  - 26 facilities above were in the top 3 quintiles.
- Not eligible
  - Non-Medicaid facilities
  - Special Focus Facility at any time
  - Specialty facilities/units
Distribution Formula

1. Top Quintile – 3 times share
2. 2\textsuperscript{nd} Quintile – 2 times share
3. 3\textsuperscript{rd} Quintile – 1 times share
4. 4\textsuperscript{th}/5\textsuperscript{th} quintile – zero share

Quality Pool Dollars- It’s in there!
Quality Pool - $1.71 per day?

- Quality pool = $50M
- Represents approximately 0.81% of total Medicaid dollars
- Rate = $211/day x 0.81 = $1.71
- Top receive extra $3.42
- 2nd receive extra $1.71
- 3rd breakeven
- 4th/5th – lose $1.71

2014 QP Changes

- Employee Flu – 2 submission points (11/15/13)
- Proposing PAH’s reduced to 10 points
- Adding Emergency Room Utilization measure
- Staffing measures (Hrs worked from cost report, consistent assignment, staff turnover (Sch P))
- Resident Satisfaction (DOH RFA)
- Dental Health (2015?)
2013 Results – what now?

- **WINNERS**
  - Celebrate if you’ve done well, use it to your advantage.
  - Top 2 Quintiles – public release? Employee bonus?

- **LOSERS**
  - Review current metrics to determine if QM weaknesses have been resolved.
  - Develop action plan to improve quality scores.

Nursing Home Compare
5 Star System

- **Health Inspections (Survey)**
  - #/type of deficiencies
  - Findings from complaint investigations

- **Staffing -**
  - RN hours per day
  - Total Staff hours per day

- **Quality Measures**
  - 9 of 18 QM’s based upon MDS

- **Overall Rating**
  - Composite measure based upon above
NYS Managed Care Quality Measures

- NYS Nursing Home Quality Pool
  - DOH committed to current dollars ($50M), but will re-evaluate as FFS transitions to MCO's.

- Quality Metrics
  - Uniform Assessment System for NY (UAS-NY)
  - ADHC, ALP’s, LTHHC, MLTC’s, Personal Care Services, NHTD waiver

- Utilization
  - Prevalence of I/P Acute Hospitalizations last 90 days
  - Prevalence of ED visits last 90 days.
  - % of plan members admitted to NH’s vs. % of admissions that are permanent placement in the NH.

NYS Managed Care Quality Measures

- Quality and Patient Safety (DOH will calculate using UAS-NY)
  - Prevalence of members who received influenza vaccine
  - Prevalence of Falls requiring Medical intervention (risk adjusted)

- Transitions in Care (NH to community)
  - Baseline assessment and follow-up assessment in the community
    - Prevalence of I/P acute hospitalizations
    - Prevalence of ED visits
    - Prevalence of Falls resulting in Medical Intervention
FIDA Quality Metrics

- Year 1
  - Encounter Data, Assessments, Customer Service, getting appointments timely, documentation discussion of goals.
  - Nursing Facility Diversion measure

- Years 2 & 3
  - Readmissions, Flu vaccine, Falls, Blood pressure, Rx mgmt, ADL improvement/stability, Nursing Facility Diversion

Quality - What to do now?
Strategic Quality Focus

- Refresh Quality Assurance Program
  - Identify all quality metrics that MCO will be using
  - Establish Quality metric system that incorporates any/all potential quality measures
  - Add quality metrics to monthly dashboard reports
  - Consider financial/operational incentives to Administrators/DON’s
  - Cost for poor quality metrics...

Contracting - Financial

- Payment structures
  - Fee For service
  - Capitation
  - Gain sharing
  - Bundling/Episodic
  - Pay for performance, improved outcomes
- Claims Submission
  - Know the process, electronic, forms (CMS 1500), timing
  - Clean claims – know the definition
  - Timing for payment – paper vs. electronic
  - Rebilling – adjustments/changes
  - Denial Policy – dispute resolution/timeframes/contact person
Contracting - Operational

- Identify most important issue for the MCO
  - Improve outcomes/lower costs/access to members?
- Member notification requirements (Prior Authorization)
  - Make sure you who, what, when, where
  - Educate your staff on different plan requirements
- Document precertification details
  - Precertification #, MCO representative, dates of service, services approved
  - Recertification process
- Understand MCO’s data requirements
  - Quality metrics, plan compliance, access to data, ongoing reporting, etc.
- Know the process, electronic, forms (CMS 1500?), timing
  - Clean claims – know the definition
  - Timing for payment – paper vs. electronic
  - Rebilling – adjustments/changes
  - Denial policy – dispute resolution/timeframes/contact person

Managed Care Contingency Plans

- Drop in Utilization may occur
  - Reduced LOS
  - Reduced demand for LTCS
- Delay in payment
  - MMCO will pay slower
  - More claim problems will delay payment
  - Accounts Receivable management will be even more important
  - Establish/increase line of credit to accommodate this
Questions

Rob Nasso, Partner
EFP Rotenberg, LLP
(585) 295-0540
rnasso@efprotenberg.com