Managed Care Transitions

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Medicaid Redesign Update

Medicaid: Care Management for All

- Goal - Most Medicaid enrollees served in care management by April 2016
  - Enrollment increases from 77% to 95%
  - FFS drops to 4%
  - Additional $24 billion in annual spending shifted (Total $45B)
  - Includes plans for all but a handful of benefits and populations to be included
Medicaid Redesign Update

MRT Waiver Amendment: Where did the $$ go?

- 2012: $10 Billion in savings as result of MRT was requested over 5 years to address needs resulting from changes under MRT – including funds for nursing home capital.

- 2013: A year from submission CMS said NO to several requests in original submission including: capital; rental subsidies; Regional Planning; Evaluation; and Health Information Technology (HIT)

New York is moving forward with a three-part approach:

- State Plan Amendment ($525M/5yrs)
- Managed Care Contract Payments ($2.1B/5yrs)
- Delivery System Reform Incentive Payment (DSRIP) Plan ($7.375B/5yrs)
Medicaid Redesign Update

State Plan

- Health Home Development Fund:
  - Member Engagement and Health Home Promotion
  - Workforce Training and Retraining
  - Clinical Connectivity – HIT
  - Joint Governance Technical Assistance and Implementation Funds

Managed Care

- Primary Care Technical and Operational Assistance ($305M)
  - require Plans to provide assistance to network providers to expand
- Health Workforce: Retraining, Recruitment and Retention ($495M)
  - require Plans to invest to attract, retrain, recruit health workers and reduce health disparities by placement of workers; refers to home care and existing Doctors Across NY and Primary Care Service Corps for MDs
Medicaid Redesign Update:

Managed Care

- SMI/SUD Transition ($1.3B) prepare for transition of SMI/SUD populations to managed care:
  - training for Plans, care managers and providers; network development and delivery of HCBS (peer support, mobile and intensive crisis intervention); assessment development

Medicaid Redesign Update:

DSRIP – Applications by April 2014

- Providers compete for funding;
- Reduce inappropriate hospitalizations;
- Performance based payments

- 3 focus areas pre-approved by CMS: Hospital Transition/Public Hospital Innovation/Vital Access Provider/Primary Care Expansion (16 programs); Long Term Care Transformation (4 programs); and Public Health Innovation (5 programs)
Medicaid Redesign Update:

**DSRIP – Applications by April 2014**

- Long Term Care Transformation Programs:
  - Development of inpatient transfer avoidance program for skilled nursing facilities to reduce avoidable hospitalizations
  - Expand pressure ulcer prevention program to reduce avoidable hospitalizations
  - Implement medication error prevention program to reduce avoidable hospitalizations
  - Create a bed buy-back program for nursing homes

Nursing Home Transition Update

- Population and Benefits
- Timeframe
- Voluntary Enrollment
- Transition Policy
- Eligibility/Enrollment
- Medicaid
- Placement Decisions: Coverage and Necessity
- Authorizations
- Network Requirements
- Credentialing
- Rates
- Contracts
Nursing Home Transition Update

**Population and Benefits:**
- All eligible recipients over age 21 in need of *Long Stay/Custodial Placement* will be required to enroll in MMCP or MLTC.
- *Current custodial care consumers* in a skilled nursing facility prior to March 1, 2014 will remain FFS and will not be required to enroll (See voluntary enrollment)
- NH care is presently a benefit for enrollees of MLTC.

**Timeframe:**
- Pending CMS approval, transition begins March 1, 2014: NYC, Nassau, Suffolk and Westchester counties.
- Transition continues September 1, 2014 in Rest of State.
Nursing Home Transition Update

Voluntary Enrollment:
- Six months following transition period for a geographic area: Any nursing home resident may enroll on a voluntary basis.
- Begins September 1, 2014 for individuals in first phase (i.e. NYC, Nassau, Suffolk, Westchester) who are in a long stay/custodial placement in a nursing home will have to get notices of this possibility. May be confusing with FIDA roll out
- These individuals will be exempt rather than excluded from enrollment (can enroll but aren’t required to do so)

Transition Policy:
- Existing managed care enrollees will not be dis-enrolled if they require long stay custodial placement.
- Plans will be responsible for the NH benefit after February 28, 2014 for enrolled members.
- No individual will be required to change nursing homes resulting from this transition.
- Plans must ensure that placement is in the most integrated, least restrictive setting available to meet the enrollee’s needs.
Nursing Home Transition Update

Eligibility/Enrollment:

- The Olmstead Decision requires that services, programs, and activities are administered in the most integrated and least restrictive setting appropriate to meet the needs of the individual.
- Recommendation for long stay/custodial care placement is based on all currently required assessments and evaluations.
- Recommendation is based upon medical necessity, functional criteria, and the availability of services in the community, consistent with current practice and regulation.

Eligibility/Enrollment:

- The Plan is responsible for reviewing all documentation and approving or adjusting the care plan to ensure the needs of the consumer are appropriately met.
Nursing Home Transition Update

Medicaid Eligibility:

- Individuals in need of long stay/custodial care subject to institutional rules for chronic care budgeting. LDSS has 45 days from date all required documentation is received to make determination. Certain transfers during the look-back period can result in a transfer penalty which delays eligibility.
- For those already in a Plan, MCOs must authorize all long stay custodial placements in nursing homes, and pay the nursing home while long term eligibility is being conducted.

- Newly eligible, in need of NH care, must have an eligibility determination from the local district prior to enrollment. Consumers residing in a nursing home who are determined eligible will have 60 days to select a Plan. Enrollment is effective 1st of the month following enrollment. NH paid FFS and retro until that selection.
- If a plan is not selected within 60 days, a Plan contracting with the nursing home will be assigned.
- Lock in rules will not apply (i.e. can change Plans monthly)
Nursing Home Transition Update

Placement Decisions: Coverage and Necessity

- An enrollee or their designated representative is included in determining the most appropriate setting for the receipt of services, equipment and supplies. The choice of settings will consider the provider network, the needs of the member and the most integrated least restrictive setting to meet those needs.

- Initial recommendation is made by nursing home physician. Based on:
  - Medical necessity
  - Functional criteria
  - Availability of services in the community

Plan reviews all documentation and approves or adjusts the care plan to ensure member’s needs are met.
Nursing Home Transition Update

**Authorizations:**
- Emergency Care - No prior authorization
- Urgent Care – No authorization if transferred to a network hospital
- Prior authorization needed to non network hospital (unavailability of network hospital or clinical needs cannot be met at network hospital)
- Plans without 24/7 authorizations processes: nursing home must request an authorization on the next business day with all necessary documentation
- Plan must cover all urgent hospital services provided and applicable bed holds while authorization is pending

Nursing Home Transition Update

**Network Standards:**
- Number of “Standard” NHs:
  - 8 – Queens, Bronx, Suffolk, Kings, Erie, Westchester, Monroe, Nassau
  - 5 – New York, Richmond
  - 4 – Oneida, Dutchess, Onondaga, Albany
  - 3 – Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster
  - 2 – All other counties (or 1 if only one NH in the county)
Nursing Home Transition Update

Network Standards:
- “Specialty” Nursing Homes: A Minimum of two of each type if available in each county.
- If plans do not have a nursing home to meet the needs of its members, it must authorize out of network placement.
- Members will be allowed to change plans to access the desired nursing homes (no lock-in).
- If beds are not available at the time of placement in network, the plan must authorize out of network.

Credentialing:
- Delegation to the NH.
- Plans must have a process to verify the NH is complying with Federal and State requirements.
- Plans will credential NH, but will minimize additional NH requirements.
Nursing Home Transition Update

Rates:
- For 2 years after a county is deemed mandatory Plans will be required to pay contracted nursing homes either:
  - FFS/ Benchmark Rate or
  - A Negotiated Rate, acceptable to both Plans and Nursing Homes

Rates:
- FFS/Benchmark Rate: includes all the existing scheduled FFS pricing/transition phase-in adjustments through 2017, and the Universal Settlement, if an agreement reached.
  - Any existing contracted rates must increase if they fall below the current market Benchmark Rate at any point.
  - Rate components will include operating, capital, quality and assessment (Assessment will remain the Nursing Homes' responsibility to pay the state)
Nursing Home Transition Update

Rates:

- **Negotiated Rate**: allows other financing agreements, such as sub-capitation, and will encourage alternative payment arrangements (this is required in Year 2 of FIDA).
  - State will review the terms of the contract under the current review process to ensure that Plans and providers are achieving acceptable agreements.

Nursing Home Transition Update

Capital Component:

- After the 2 Year transition period, Nursing Homes will continue to receive the calculated capital component in the benchmark rate:
  - Such capital component will be paid pursuant to a contractual arrangement between the Plan/ State/ Nursing Homes.
  - CMS has rejected the state request to pass through capital cost on a fee for service basis.
Nursing Home Transition Update

Capital Component:
- A pool/price corridor will be established to ensure that Plans that contract with Nursing Homes containing large per-diems are not disadvantaged
- Modifications (if any), which may arise as a result of the Nursing Home Capital Work Group, will be reflected in the capital rate and will be incorporated into Plan premiums.

Premium Development:
- Consensus among consumer advocates, Plans and Providers: reimbursement should align with the overall acuity of the patients. NYSDOH concern about data availability to fully develop a blended acuity adjusted rate.
- Long Term Goal: Create an acuity based rate for the entire population.
  - One blended (community/NH) rate cell; or
  - Two rate cells for High and Low acuity patients.
- Short Term Goal: Establish a single NH Rate Cell with two pools to mitigate the risk of the population and incentivize community placement.
  - High Need Pool; and
  - Community Place Pool
Nursing Home Transition Update

**Premium Development:**
- As the nursing home populations shifts Nursing Home quality measures and dollars will be proportionally moved into other quality incentive programs.

**NAMI Proposal:**
- The State or State’s designee will assume financial and organizational responsibility to distribute NAMI information, as well as collect NAMI income from all Medicaid recipients residing in a Nursing Home. Proposal requires Federal approval.
- Benefit to Patients – Reduce risk of MLTC disenrollment
- Benefits to Providers – Cost Savings
Nursing Home Transition Update

**NAMI Proposal:**
- State oversight/administration may allow a new point-of-entry system to align with Medicaid’s overall effort to redesign entry into the program:
  - collect NAMI more efficiently and potentially secure resources up front
  - better position to judge whether NAMI collection is appropriate or not
  - State can perform care management to distinguish these cases individually and assess when money should remain with patients.

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Medicare

**Medicare:**
- $700 billion in cuts to Medicare over 10 years impact all Providers:
  - Hospitals
  - Nursing Homes
  - Home Health
  - Physicians
  - Medicare Advantage Plans

- Strategies offered: ACOs, Bundling, Integrated Demonstrations, Health Homes- all require increased care management

- *Jimmo v. Sebelius:* Improved Coverage for Beneficiaries
Medicare/Medicaid Integration

**Fully Integrated Duals Advantage (FIDA):**

- By December 1, 2014 FIDA Plans required to develop a plan for fully integrated payment system for providers that are NOT traditional FFS but alternative such as pay for performance or bundled payments
- By January 2015 FIDA Plans required to implement payment changes

**Medicare/Medicaid Integration Terminology**

**Partially Capitated Managed LTC (MLTC):** Medicaid benefit package is long term care and ancillary services including home care, unlimited nursing home care.

**Program of All-Inclusive Care for the Elderly (PACE):** Medicare and Medicaid benefit packages include all medically necessary services – primary, acute and long term care.

**Medicaid Advantage Plus (MAP):** Medicare and Medicaid benefit packages include primary, acute and long term care services (excludes some specialized mental health services). health.
Terminology

**Fully Integrated Duals Advantage (FIDA):** Medicare and Medicaid benefit packages include all primary, acute, long term care—including behavioral health—Federal Demonstration—limited to Downstate.

**Medicare Advantage Plans (MA):** Medicare benefit package includes all Medicare services.

**Mainstream Medicaid Plans (MMC):** Medicaid benefit package includes all primary, acute, expanding long term care services and most behavioral health.

Market Conditions

- Population Demographics – what are the specifics
  - 65+
  - Medicare
  - Medicaid
  - Duals

- Plan Availability – know difference between network development and enrollment approval – by Plan type

- Competition – occupancy, bed size and specialties – recall network standards
Market Conditions

- MLTC plans across 32 counties Upstate. Downstate/NYC has 31+
- Next set of mandatory counties: Erie, Monroe, Onondaga, Albany started January 1, 2014
- MLTC expansion:
  - National health insurer
  - Provider sponsor to serve selected Upstate counties
  - Article 44 plans seeking to add MLTC as a new business line
  - 4 MLTCs seeking additional Upstate service expansion
  - 4 NYC based MLTCs seeking to expand Upstate

List of Plans under review for participation in FIDA Plans:

• Aetna • Agewell • AlphaCare • Amerigroup • Amida • Catholic Managed Long Term Care, Inc. (Archcare)
• Centerlight • Centers Plan for Healthy Living
  - Elderplan (Homefirst) • Elderserve
• Fidelis Care of NY (NYS Catholic Health Plan)
• GuildNet • Healthfirst (Managed Health, Inc.) • HHH Choices
• HIP • Independence Care Systems • Integra • MetroPlus
• Montefiore • North Shore LIJ Health Plan, Inc.
  • Senior Whole Health • United Healthcare
  • VillageCare MAX • VNYSNY Choice • Wellcare
Market Conditions

- New York is one of 13 states where the MA penetration rate exceeds 30 percent
- Over 900,000 New Yorkers are enrolled in MA plans
- Even in counties like Livingston, Ontario and Genesee, more than 50 percent of Medicare-eligible beneficiaries are enrolled in MA plans.

Contract Provisions

- Who is contract with: IPA, BHO, Plan?
- Type of Plan(s)
- Provider Manual
- Claims Processing
- Scope of Services
Contract Provisions

- Definition of Benefit/Covered Service
  - Out of Network Provider
- Expertise – clinical and specialty beds
- Rates and Payment Terms
- Your Obligations (Policies):
  - Reporting – Utilization/Quality
  - Recordkeeping
  - Credentialing
  - Legal Compliance: does this make you a subcontractor to the government? (UPMC Braddock case)

Negotiate

- Relationships with Referral Sources – who are your friends?
- Quality Standing / Accreditation – where are you?
- Expertise – Know what you can provide?
- Occupancy – what do you have available?
- IT – what can you do now and what do you need?
- Back Office Capacity – multiple payors and cash flow
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