Introductions
Principles of Reform
Overview of Value Based Purchasing Statute
Identify Key Methodology Issues to be Discussed
Other States
Schedule – June Meeting
  ◦ (December 15, 2009 Commissioner’s Report Due
Principles of Medicaid Reimbursement Reform

- Medicaid Rates should:
  1) Be Transparent and administratively efficient
  2) Pay for Medicaid Patients
  3) Encourage cost-effective care and promote efficiencies
  4) Encourage and reward quality care
  5) Encourage care in the right setting
  6) Be Updated Periodically
  7) Comply with Federal Medicaid Rules
  8) Reinforce health systems planning and advance State health care programs
  9) Be consistent with Budget Constraints
April 1, 2010 – New Value Based Purchasing Methodology Takes Effect
  ◦ Initial rates due 60 in advance of April 1 ~ January 30th

Elements of Value Based Purchasing statute include:
  ◦ Regional Pricing Methodology for Operating Component of Rate
    • 2007 Base Year – base year updated no less frequently than every six years
    • Regional, rather than facility specific rates
    • MDS Case Mix – 53 RUG Groups
    • Medicaid Only Case Mix
  ◦ Quality Incentive Pool or Pools
  ◦ Transition Payments

Total Spending No Greater than Prior Year Spending

Workgroup Recommendations due December 15, 2009
Overview of Value Based Purchasing Methodology
2007 Base Year

- **Regional Direct Price** subject to Regional Ceilings
- **Facility Specific Medicaid Only Case Mix Adjustment**
- **Regional Indirect Price** subject to Regional Ceilings
- **Facility Specific Non-Comparable Price**

- **Total Operating Regional Price**
- **Transition Payments ***
- **Quality Pool(s) Payments***
- **Capital Rate**

**Total NH Rate**

*If applicable
**Addresses Zero Useful Life/Residual Reimbursement
Regional Pricing ~ Key Methodology Issues

- Regions (current model uses 8 NYPHRM regions)
- Ceiling adjustments to allowable costs
- Cost differentials among facility types
- Cost differentials related to direct care staffing among Public, Voluntary and Proprietary facilities ~ relationship to quality pool
- Special needs patients ~ Bariatric, Dementia, Behavioral rate per diem add-ons
- Relationship between costs and quality
- Establishment of quality care pool(s)
### Quality Incentive Pool – Executive Budget Proposal

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Long Stay Measures MDS Resident Outcomes</th>
<th>Survey Scores</th>
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| Total RN Hours + RN Agency Contracted Staff Hours/Total Hours All Staff (RN, Agency Contract, LPN, Aides, Orderlies) | % of Residents Who Have/Had a Catheter Inserted and Left in their Bladder  
% of Residents with a Urinary Tract Infection  
% of Residents Who Lose Too Much Weight  
% of Residents Whose Need for Help with Daily Activities Has Increased  
% of Residents Whose Ability to Move About In and Around Their Room Got Worse | Re-Certification Survey Scores                                                                       |
| Weight: 20%                                                             | Weight: Each Measure 12%, Category 60%                                                                    | Weight: 20%                                         |
| Source: Facility specific ASPEN (Automated Survey Processing Environment) data | Source: Facility specific Minimum Data Set (MDS)                                                        | Source: Facility Specific ASPEN data                |

- Focus competition for resources on quality and not costs
  - First year, 2010-11, reward highest quality achievers
  - Beginning in 2011-12 ~ Reward highest quality achievers and improvers
- Determine scores for each home in each Regional Area Offices (RAO)
  - Top 20% of Homes in Each RAO with Highest Quality Scores Awarded Share of Pool Distributed by Medicaid Patient Days
# Other States ~ Value Based Purchasing

<table>
<thead>
<tr>
<th>Delaware</th>
<th>Idaho</th>
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<tbody>
<tr>
<td>Georgia</td>
<td>Indiana</td>
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<td>Kansas</td>
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<td>Maryland</td>
<td>New York</td>
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<tr>
<td>Minnesota</td>
<td>Medicare Quality Demonstration (4 States, including New York)</td>
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Provide assistance to help nursing homes to transition to Value Based Purchasing and to reconfigure service delivery to address changing health care priorities

Nursing homes with Medicaid Utilization of 50% or more are eligible
  ◦ Public Facilities that receive IGT payments are not eligible for Transition Funding

Transition funds expected to be available over multi-year period

After 2 years, a progress report must be submitted to receive additional funding
HEAL

- Up to $175 million for alternative long term care projects
- Complementary to reduction of RHCF capacity in enacted budget
- Looking for multi providers projects
Next Steps

- Allowable costs ~ (week of June 15th)
- 2007 Full House MDS Data ~ (week of June 15th)
- Separate quality pool discussion (June meeting)