MLTSS MANAGED CARE UPDATE

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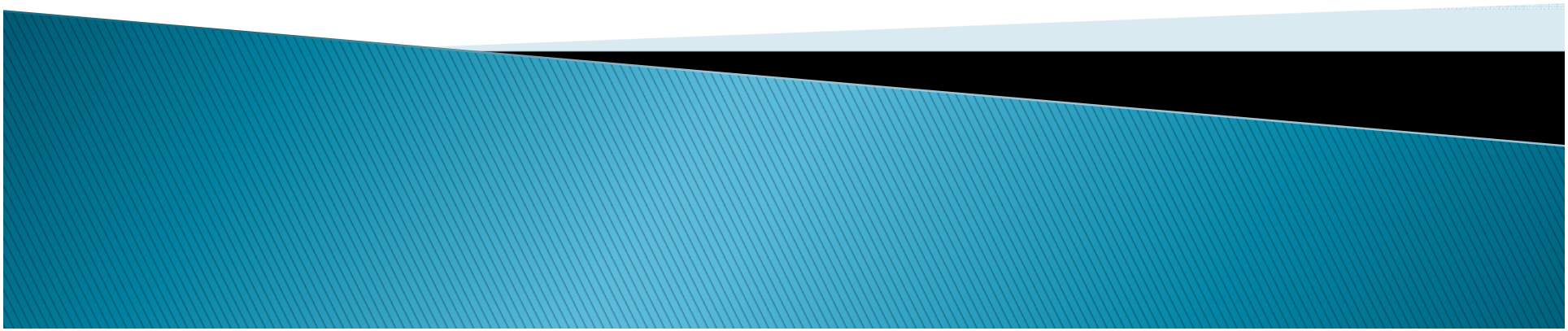
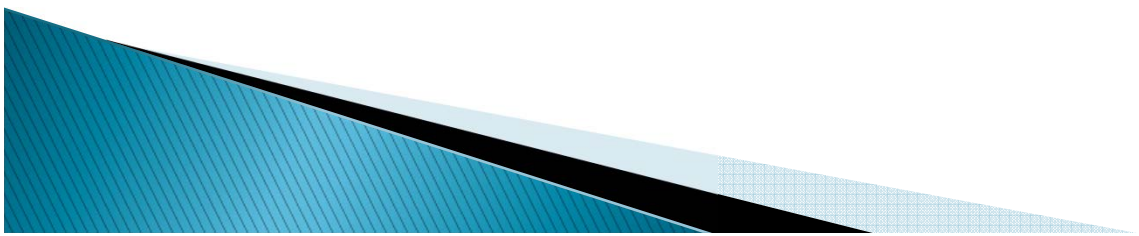


OVERVIEW

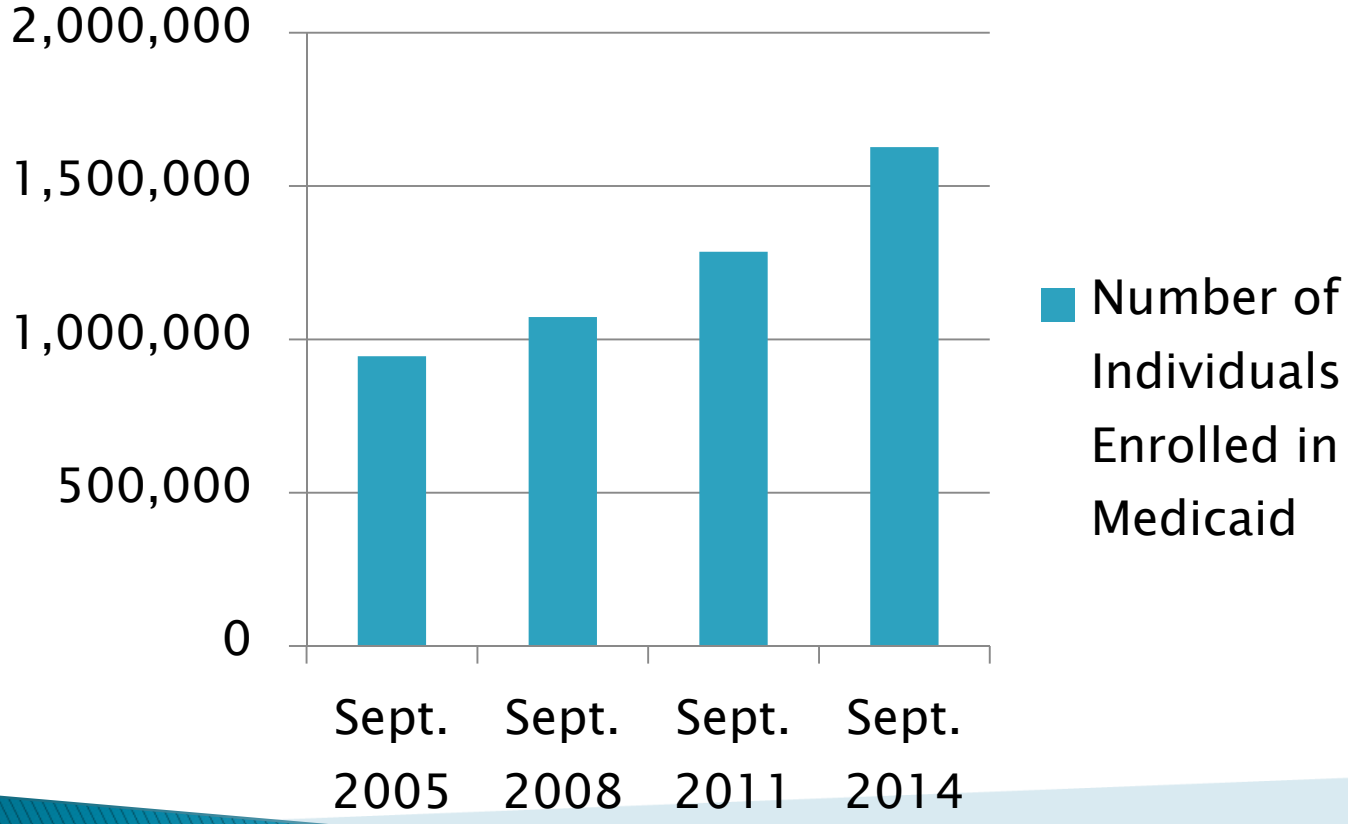
- Big Picture and Lessons from the Adult Medical Day Care MCO Experience
- MCO Contract Starting Points
- DHS Commitments
- Plan Agreements
- Implementation Status and Concerns
- What the Future May Hold



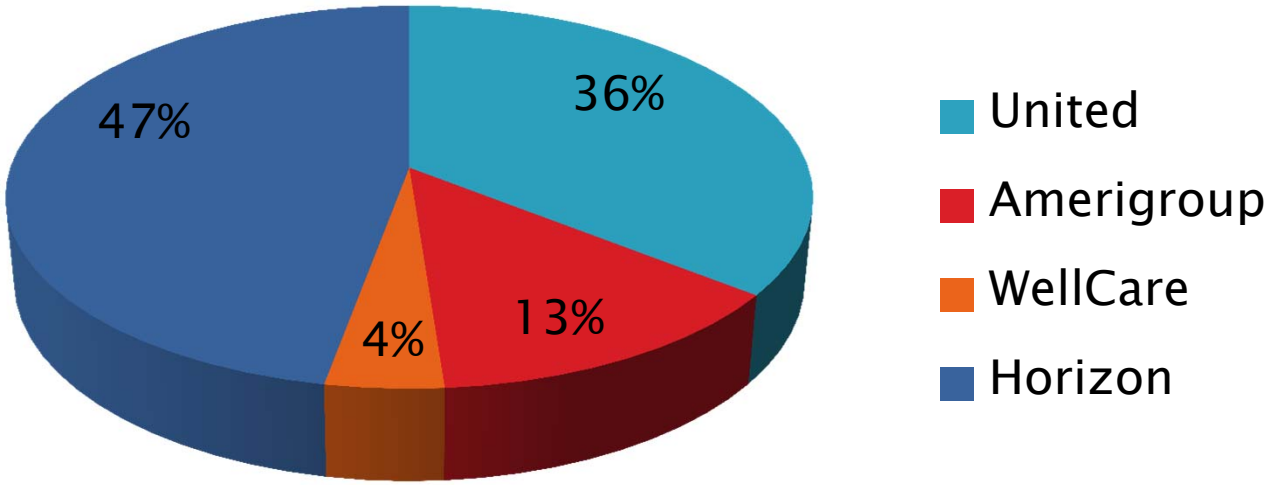
NJ Medicaid Conversion to Managed Care

- Began in earnest with Adult Medical Day Care and Home care/PCA in 2012
- Medicaid MCO experiments in other states was done in accelerated fashion for LTC and AL providers
- Medicaid enrollment grew substantially in NJ following the implementation of the ACA, up to 1.6 million residents

Medicaid Enrollment 2005 – 2014



DHS Programs HMO Membership Total
3/31/2012



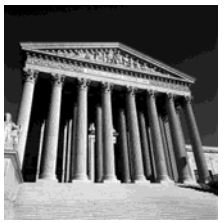
Lessons from the Managed Care Experiences of Adult Medical Day Care Providers

- "Any Willing Provider" status does not last forever
  - Some plans cut providers from Network after 2 years, requiring litigation
  - Some plans did not ever offer Network contracts
- State-approved Rates do not last forever
  - Rates set at $78.50 lasted 2 years
  - New providers were enrolled at lower rates
  - Moratorium on new provider enrollment started
- Payments sometime take forever
  - 30+ day turnaround was an ongoing battle

More Experiences

- Not all Plans are Created Equal
  - Provider-friendliness varies
  - National vs. NJ-based
  - Market share varies significantly
- Negotiation Leverage is limited
  - MCO's contract with all levels of health care providers- MLTSS is a small portion of their business model
  - They are not the government- market forces apply
- The State is not always your ally

Antitrust Law Limitations



- Unrelated Providers cannot negotiate rates jointly with insurers
- Each provider must make its own business decision on whether to sign a contract
- HCANJ can advise members on contract issues, and HCANJ counsel can recommend and advise members only on the acceptability or non-acceptability of contract terms

Litigation Lessons

- Termination Clauses are Important
- Arbitration Clauses can Cause Strategic Problems
- State “Verbatim” language trumps MCO contract terms

The Starting Point

- MCO's presented providers with standard network contract forms. Many providers signed them immediately without review.
- The following slides are a graphic of how different the MCO contracts were from one another when we started to review them:

Contract Length/Termination Right by MCO

- Horizon
- United Healthcare
- Amerigroup
- Healthfirst/Wellcare

- 90 days--120 days
- 1 year-- 30 days
- 2 years--120 days
- 1 year-- 90 days

Payment Rate- Inclusiveness

- Horizon
- United Healthcare
- Amerigroup
- Wellcare

- "Plan rate"- n/a
- "Plan rate"- all-inclusive
- "Plan rate"-n/a
- "Plan rate"-all-inclusive

Unilateral Amendment Rights

Horizon	Not addressed
United Healthcare	Mutual agreement
Amerigroup	30 days notice
Wellcare	30 days notice

Claims Filing/Processing Deadlines

Horizon	As required by law
United Healthcare	180 SNF 90 AL/Law
Amerigroup	180 days/30 days
Wellcare	180 days/30 days

Medical Necessity/Medicaid Fair Hearing Rights Specified

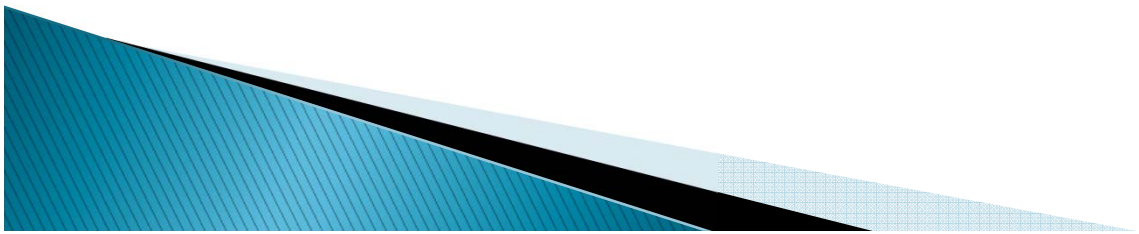
Horizon	Plan decides/ None
United Healthcare	Plan decides/None
Amerigroup	Plan decides/None
Wellcare	Plan decides/None

Requests for Clarification to DHS

1. Term of the Agreement- 2 years
2. Termination Clauses- prohibit
3. Amendments- None (except mandatory)
4. Continuity of Care- indefinite following termination
5. Claims Filing Limits- 180 days
6. Prompt Payment of Claims – 15 days

Additional Points

- 7. Compensation Method- State rates
- 8. Covered Services- Fee-for-service only
- 9. Eligibility for Services- Use current regulatory standards for LTC authorizations
- 10. Fraud Prevention Policies- no greater than DHS/CMS requirements for LTC/AL
- 11. Record Keeping- No more than DOH/CMS requirements



DHS Responses

- 1. Term will be mandated at 2 years
  - – any willing provider confirmed– no credentialing requirements such as 5-star ratings permitted
- 2. Termination Clauses– none permitted
  - – only state-mandated terminations for fraud, etc. would be authorized
- 3. Amendments– None permitted
  - Only mandatory regulatory changes can be made
- 4. Continuity of Care– DHS agreed to evaluate post-2016 continuity issues

DHS Responses

- 5. **Claims Filing**- consistent 180 day filing period authorized
  - corrections permitted within 365 days
- 6. **Prompt Pay**- All MCO's required to process MLTSS claims in 15 days
- 7. **Compensation Methodology**-the higher of:
  - a) State set rates as of 4/14 or
  - b) provider negotiated rates. AL rates will be state rates.
- 8. **Covered Services**: all services included in Medicaid fee for service per diem payments;
  - Global payment negotiations permitted

DHS Responses

- 9. Eligibility for LTC/AL
  - will be determined solely by the state, and plans will use the NJ Choice tool; full Medicaid hearing rights apply to adverse determinations
- 10. Fraud Prevention policies –
  - MFD supported MCO's right to impose compliance plan requirements higher than state. However, CB checks would be uniformly set by the state.
- 11.Record keeping requirements
  - these would be evaluated to ensure that they do not become burdensome to providers

Implementation

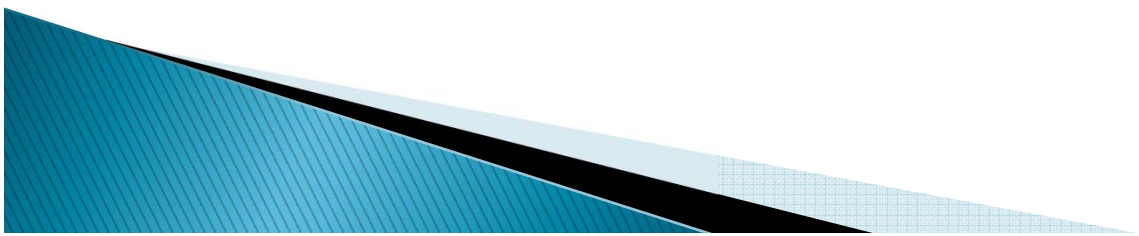
- State Issued a “Verbatim” Contract Amendment that superseded MCO terms
- DHS Letter circulated to MCO’s
- All MCO’s adopted the Verbatim appendix and were required to issue updated contracts to all providers whether signed or not
- Contract discussions with MCO’s on behalf of HCANJ members commenced

Implementation Status by MCO

- **Horizon**: Has issued a second 90-day Memorandum of Agreement in lieu of a full network contract. Time to negotiate the terms of the full contract has been committed to by Horizon.
- **Amerigroup**: Has agreed to an acceptable contract form. They obtained DOBI/DHS approval of the amendments. Waiting as of 10/20 for implementation plan.

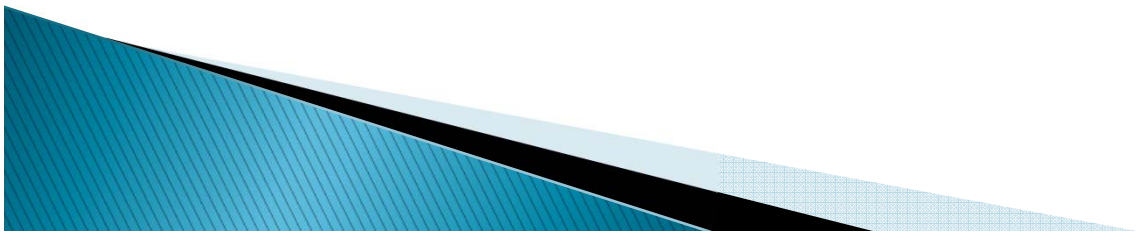
Implementation Status

- **Wellcare**: Agreed to all requested network contract term revisions. Issued a contract with a standard custodial SNF and AL rate above state published rates.
- **United**: Agreed to network contract changes in August 2014. Payment appendix terms circulated in September remain under negotiation. SNF and AL contracts are being separately negotiated.



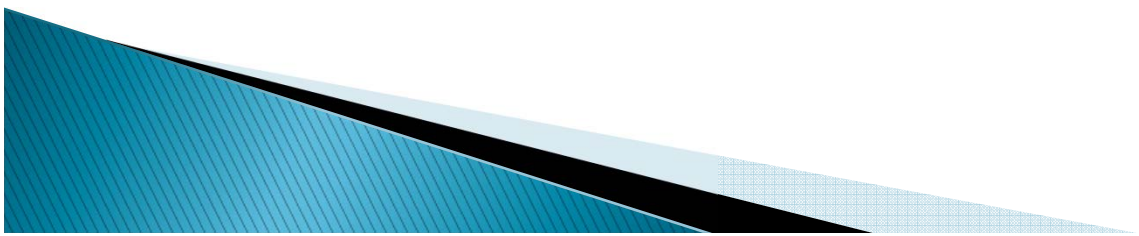
New MCO Plans

- Additional MCO plans are in process
  - Aetna
  - Carepoint
  - VNS has withdrawn
- Additional MCO's can benefit providers
  - Rate/market share competition
  - Access to new admissions
- New Contract forms not reviewed by HCANJ



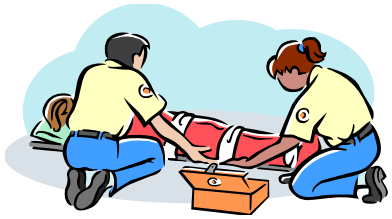
Ongoing Concerns with Current MCO relationships

- Non-participating facilities should be getting single patient agreements to facilitate "any willing provider" policy until contracts are executed (United/Amerigroup)
- Medicare proof of denials for custodial, Medicaid-only members still required
- Cost-share calculation issues remain
- Retroactivity of rate adjustments



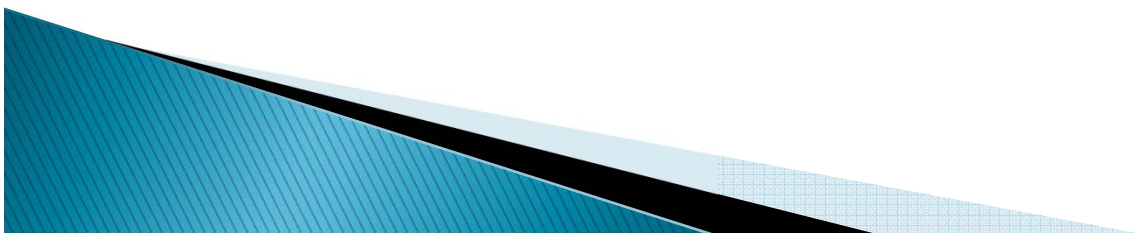
DHS Critical Incident Reporting

- DHS submitted its MLTSS waiver application to CMS with a promise that all providers would follow DHS Critical Incident/Unusual Incident Report (UIR) reporting mechanisms
- They also required providers to follow DHS "Unable to Contact Member" reporting procedures
- CMS made it a condition of approval and MCO's were told to implement this



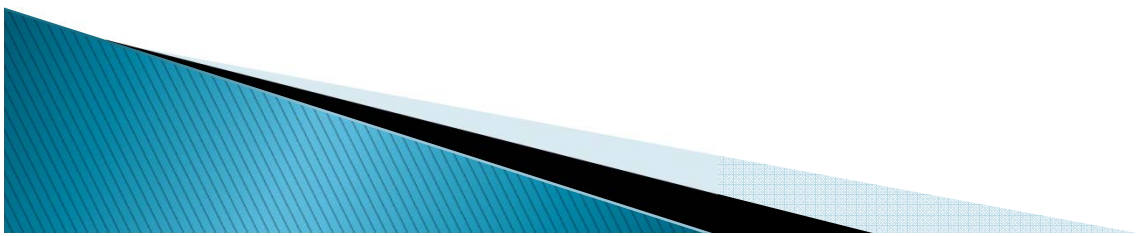
UIR Reports

- UIR reporting is the DHS process governing DDD, mental health, addiction and other service categories
- DHS has a full unit dedicated to reviewing and investigating UIR reports
- There are140+ categories of incidents under different levels of significance (see DHS Administrative Order 2:05)
- Telephone and Written Reports are required



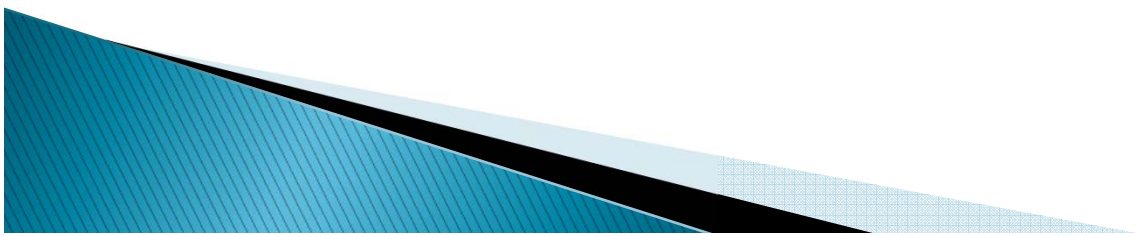
UIR Category Examples

- Physical/Sexual Abuse and Sexual Incidents
- Deaths
- Injuries
- Physical Assault
- Media Interest
- Elopement
- Errors in Medical Treatment and Medications
- Criminal Acts, Fires, Thefts
- Restraint Use
- Rights Violations



Concerns about Critical Incident Reporting Requirements

- Duplicative of DOH/ Ombudsman reporting
- Creates liability for provider–
  - Increased number of DHS/DOH investigations of a greater number of categories
  - Plaintiff liability
  - Increases risks of MCO termination/non-payment
- Greater provider staff time required for reporting, surveys, follow-up POC's
  - Excess work for DHS and MCO staff



Current Status of CBC Issues

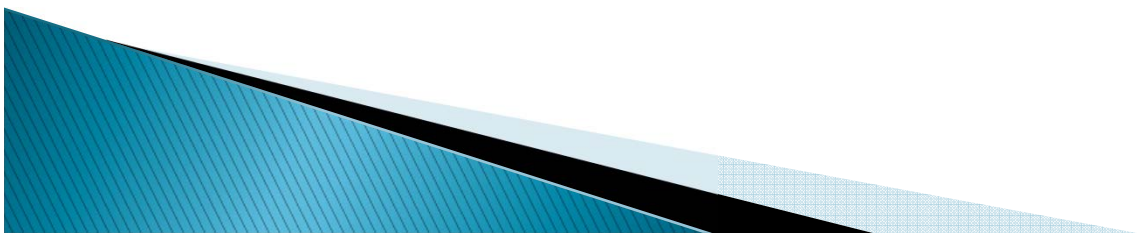
- DHS was asked to interpret the effect of requirement being placed in MCO contracts
- DHS responded that MCO's should have both NFs/SCNFs and AL programs report critical incidents to the health plan.
- MCO care managers will be required to report Critical Incidents they observe during visits or are informed about to the state
- HCANJ continues to object to this requirement

Current Minimum Obligation

- Copy the MCO when you file a DOH Reportable Incident form when it relates to their member.
- Neither DHS or the MCO's have provided further instructions on what the reporting requirements are under MLTSS contracts
- There is no statutory authority for DHS to enforce these requirements- it is solely a condition of their contract with CMS, and is between the MCO and the provider

MCO Criminal Background Check Requirements

- DHS states that the requirement for Criminal History Record Information (CHRI) is a CMS requirement under the Special Terms and Conditions (STC) in the 1115 Waiver
- MCO's again all included references in their contracts to conducting a CBC of any provider employee who provides direct services to a Member
- HCANJ again objected to this requirement

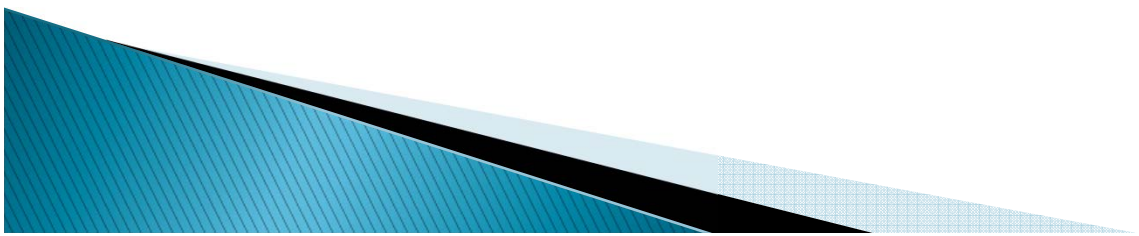


Criminal Background Check Concerns

- No statutory authority exist to mandate these
- The criteria are not supported by and addressed in state regulation
- Providers have no guidance as to what criminal acts must result in termination or non-hiring decisions
- This process conflicts with the new state “ban the box” law

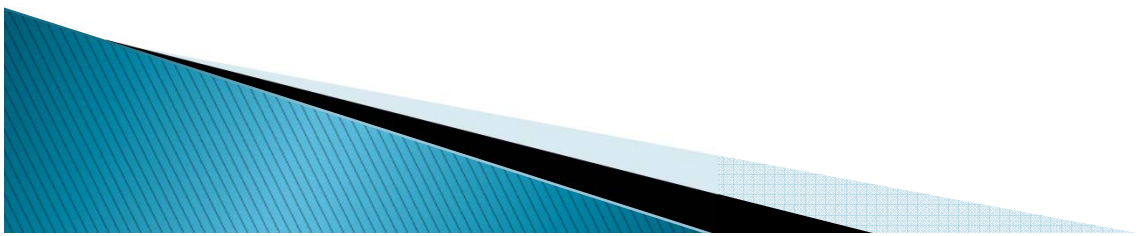
Duplication of CBC's

- DOH mandate for CBC's is statutory- applies only to CNA's, Assisted Living administrators, medical day care owners/administrators
- An annual CBC is not required by the state
- Licensing boards require CBC only upon initial application
- NJAC 8:39-9.3 only requires a reasonable background check inquiry at the time of hiring for all other LTC employees



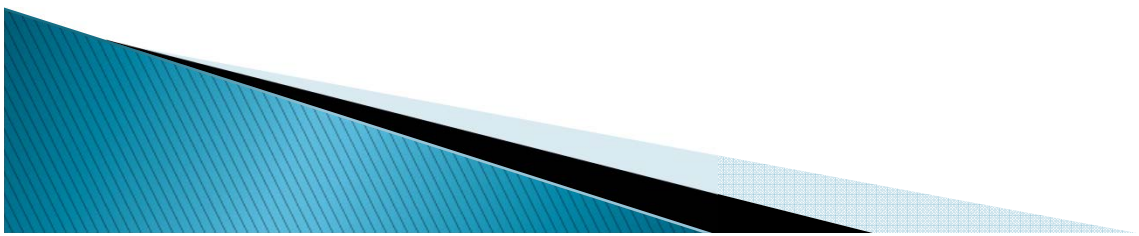
DHS Response to Objections to MCO Criminal Background Checks

- DHS assured that they were not intending to impose unnecessary or burdensome requirements on providers.
- DHS agreed to accept the requirements in NJAC 8:39-9.3 (b) for NF/SCNF, and for ALs, NJAC 8:36-9.1(d)
- Facilities will need to certify and attest that they meet the requirements of DOH requirements as part of MCO credentialing



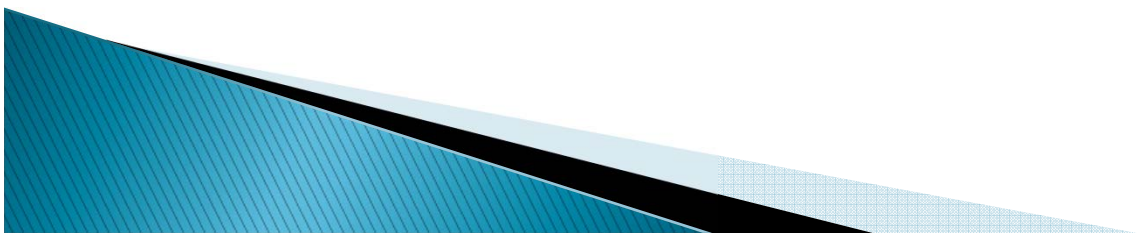
Current DOH rule:

- NJAC 8:39- 9.3(b) The facility shall make reasonable efforts to ensure that staff providing direct care to residents in the facility are in good physical and mental health, emotionally stable, of good moral character, and concerned for the safety and well-being of residents, and have not been convicted of a crime relating adversely to the person's ability to provide care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify for employment at the facility. ("Reasonable efforts" shall include an inquiry on the employment application, reference checks, and/or criminal background checks where indicated or necessary.)



Ongoing Issues

- MCO's continue to issue policies and statements requiring CBC's of provider employees
- Costs are not accounted for in rates
- Standards are not provided for employment decisions (eg. types of convictions, charges, etc)
- Scope of CBC is not detailed (fingerprint, commercial services, state police, FBI, etc.)

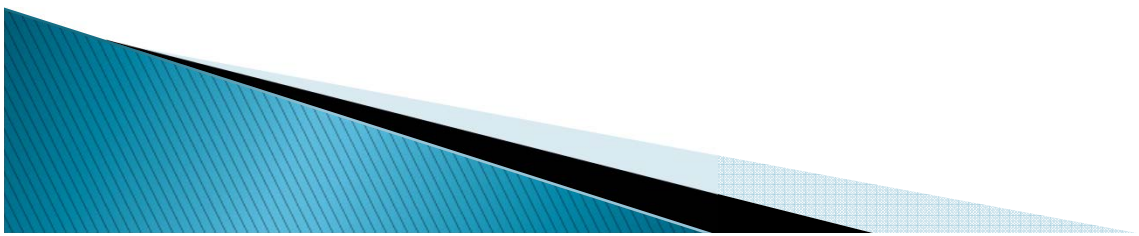


Medicaid Revalidation Process

- States are mandated by the ACA to revalidate all Medicaid-enrolled providers
- 2-year process
- Full Medicaid enrollment packets are being distributed
- Seek advice on what to report- non-reporting can result in recoveries or termination of a provider's Medicaid provider #
  - Criminal Background check question- ***any*** convictions, pleas, charges, and even motor vehicle criminal charges must be disclosed

OIG Exclusion Checks

- Employee data base being created by Molina from lists of employees providing SSN's, DOB's, license #'s
- Medicaid exclusion and possibly licensure checks will be performed monthly by Molina for MFD
- MFD can use these as a basis for recoveries
- Lesson: perform your own OIG exclusion checks monthly and have a compliance plan



MLTSS Next Steps

- Complete contracting processes
- Resolve CBI/Critical Incident reporting
- Address payment/reimbursement problems
- Implement rate increases
- Address New MCO contracts (Aetna/Carepoint)
- Plan for 2016 strategy post-AWP