



The National Seniors Housing Group of Marcus & Millichap



Golden Hill Health Care Center Presentation

Prepared for:

The Golden Hill Local Development Corporation

Wednesday April 18th, 2012





New York State Long Term Care Landscape

Factors Effecting Owners & Operators of Skilled Nursing Facilities in New York State

- Discussion of Transition to Regional Pricing: 6/1/2011
- LTC Medicaid Rate Rebasing including elimination of bed hold and trend factor 7/1/2011
- Rugs 4.0: 11.1% Average Cut to Medicare Reimbursement-Effective 10/1/2011
- Introduction of Final Statewide Pricing Methodology: 12/15/2011
- Introduction of Managed Care: 2/1/2012
- **COMMON THREAD: UNCERTAINTY**

Additional Factors Effecting County Owners and Operators

- **Restrictions on Revenue Generation:**
 - County Level:** Introduction of Hard Property Tax Cap-2011
 - Facility Level:** Under realized Therapy Utilization, Outmoded IT, Below Average Payor Mix
- **Restrictions on Expense Management**
 - Unsustainable Employment Agreements
 - Above market salaries and automatic wage increases
 - Year over year double digit increases in legacy costs
 - Year over year double digit increases in health insurance premiums
 - Inability to realize economies of scale-single facility ownership
 - Overstaffing
- **COMMON THREAD: SYSTEMATIC ADVERSITY**



*Unrivaled Access to
Investors*

*Specialized Senior
Housing Expertise*

*National Confidential
Marketing Platform*

*Industry Leader in
County Home
Transactions*



Mark L. Myers

National Seniors Housing Group, Senior Director
8750 W. Bryn Mawr Avenue, Suite 600
Chicago, IL 60631
Office: 773-867-1470
Cell Phone: 773-383-6821
License: IL 475.102753
Email: mmyers@marcusmillichap.com



Joshua Jandris

National Seniors Housing Group, Senior Associate
8750 W. Bryn Mawr Avenue, Suite 600
Chicago, IL 60631
Office: 773-867-1482
Cell Phone: 312-399-9797
License: IL 476.388237
Email: jjandris@marcusmillichap.com

Marcus & Millichap Real Estate Investment Services has been the premier provider of investment real estate services since 1971. Marcus & Millichap has established itself as a leading, and expanding, investment real estate company, with more than 1,200 agents in 70 offices throughout the United States.

Our Seniors Housing Group is unique in that it is a boutique brokerage group, with a sole focus on seniors housing, within a national platform that provides the broadest depth of market coverage. The Seller benefits from the best of both worlds, the attention of a boutique with the power and presence of a national firm.



2011 and 2012 YTD Closed Transactions

➤ *Myers Team involved in \$2.16 Billion of Transactions*

➤ *Myers Team Involved in \$1.95 Billion of Seniors Housing Transactions*

➤ *345+ Seniors Housing Transactions Closed*

➤ *2011 & 2012 YTD Transaction Volume: \$337M*

➤ *2011 & 2012 YTD Skilled Nursing Facility Transaction Volume: \$115M*

➤ *6 County Home Transactions closed or under contract in the last 28 months*

Name of Property	License	No. Beds/Units	Location	Closing Date	Sales Price
Brighton of Medford	SNF	142	MA	4/12/12	\$7,500,000
Riverbend Assisted Living Community	ALF	97	IN	3/30/12	\$15,300,000
Premiere Estates Portfolio	SNF/AL	420	NE & IA	3/12/12	\$12,000,000
New Hampton Care Center	SNF	70	IA	3/12/12	\$4,200,000
Mattoon Healthcare & Rehabilitation	SNF	85	IL	1/12/12	\$3,200,000
Pershing Convalescent Center	SNF	51	IL	12/10/11	\$1,260,000
Posada Del Sol Health Care Center	SNF	149	AZ	12/11/11	\$7,800,000
Grand Court Belleville	ILF	74	IL	9/9/11	\$1,950,000
Eastview Manor Care Center	SNF	90	MO	9/10/11	\$700,000
American Senior Communities	ALF/ILF	390	IN	9/11/11	\$52,000,000
Sunrise of Horsham (Land Transaction)	Land	0	PA	9/1/11	\$1,400,000
Webster House	IL/AL	41	CA	8/30/11	\$1,900,000
Sunrise of West Orange (Land Transaction)	Land	0	NJ	8/31/11	\$1,120,000
Summit Pointe of Macedonia	ALF/ILF	150	OH	8/1/11	\$27,250,000
Careage Management Portfolio	ALF/SNF	631	NE & IA	7/10/11	\$27,656,000
Sunrise of Cranberry	ALF	60	PA	7/11/11	\$12,000,000
Sunrise of Fox Chapel	ALF	46	PA	7/11/11	\$3,900,000
Geneva Care Center	SNF	106	IL	7/9/11	\$6,100,000
American Senior Communities	ALF/ILF	151	IN	7/10/11	\$30,400,000
Lynwood Manor	SNF	99	MI	6/11/11	\$2,900,000
The Arbor of Itasca (Lease/Purchase)	SNF	144	IL	6/11/11	\$6,500,000
St. Ann's Healthcare Center	SNF	119	IL	6/11/11	\$1,450,000
American Senior Communities	ALF	197	IN	6/11/11	\$40,360,000
Salem County Nursing Home	SNF	116	NJ	6/11/11	\$7,500,000
Lincoln Manor	SNF	140	IL	5/11/11	\$6,500,000
Nursing Home Managers Portfolio	SNF	477	IL	4/11/11	\$6,500,000
Sunrise of Allentown	ALF	86	PA	4/11/11	\$9,000,000
Kenwell Senior Living Community	SNF	148	NY	3/11/11	\$3,230,000
Golden Living Center	SNF	97	WI	3/11/11	\$3,950,000
Sunrise of Napa	ALF	72	CA	2/10/11	\$2,025,000
Sunrise of Shaker Heights	ALF	59	OH	2/11/11	\$3,187,500
Sunrise of Hamilton	ALF	46	OH	2/11/11	\$3,187,500
Cypress Court	ALF	126	AZ	1/11/11	\$12,855,000
Chula Vista Care Center	SNF	106	AZ	1/11/11	\$5,800,000
Sunrise of Floral Vale	ALZ	36	PA	1/11/11	\$4,500,000
TOTALS		4,821			\$337,081,000



County Nursing Home Active Listings



Sussex County Homestead (Sussex County, NJ)

- 102 bed skilled nursing facility
- Three weeks into the marketing process
- Sealed Bid Auction Process in May 2012



Valley View Rehab & Nursing Center (Orange County, NY)

- 360 bed skilled nursing facility
- Currently accepting offers
- Sealed Bid Process in May 2012



Chautauqua County Home (Chautauqua County, NY)

- 216 bed skilled nursing facility
- Deadline to submit bids is April 16, 2012
- List Price—Undisclosed



Horace Nye Nursing Home (Essex County, NY)

- 100 bed skilled nursing facility
- Negotiating Bids—all offers at or above list price
- List Price—\$4,000,000

Formal Inquiries

County Facility	Registration Agreements Signed
Sussex County Homestead (Sussex County, NJ)	34*
Valley View (Orange County, NY)	53
Chautauqua County Home (Chautauqua County, NY)	46
Horace Nye Nursing Home (Essex County, NY)	46
Buttonwood Hospital (Burlington County, NJ)	57
Cumberland Manor (Cumberland County, NJ)	55
Posada del Sol (Pima County, AZ)	37
Salem County Home (Salem County, NJ)	41
Weatherwood (Carbon County, PA)	47
Laurel Crest (Cambria County, PA)	50+

*Sussex County Homestead has only been available to the market for three weeks.



County Nursing Homes Under Contract and Closed Transactions



Buttonwood Hospital (Burlington County, NJ)

- 200 bed skilled nursing facility
- Under contract to sell as of March 2012
- Contract Price—\$15,000,000
- Procured buyer for facility at minimum bid level despite losing appx. \$5M in state reimbursements two weeks before auction



Cumberland Manor (Cumberland County, NJ)

- 196 bed skilled nursing facility
- Under contract to sell as of January 2012
- Contract Price—\$14,000,000
- Customized sales process to meet County's requirements and earned a price \$4.0M greater than minimum bid level



Posada Del Sol (Pima County, AZ)

- 149 bed skilled nursing facility
- Sold in December 2011
- Sale Price—\$7,800,000
- At time of sale, achieved price \$2.8M greater than the most recent County-procured appraisal



Salem County Home (Salem County, NJ)

- New Jersey 116 Bed skilled nursing Facility
- Sold in June 2011
- Sale Price—\$7,500,000
- Drove sales price from \$6 Million to \$7.5 Million and closed within 90 days of engagement



Weatherwood (Carbon County, PA)

- 200 bed skilled nursing facility
- Sold in July 2010
- Sale Price—\$11,050,000
- Drove sales price from \$8 Million to \$11 Million over three rounds of bidding



Laurel Crest (Cambria County, PA)

- 370 bed skilled nursing facility
- Sold in January 2010
- Sale Price--\$14,250,000
- Drove sales price from \$11 Million to \$14.25 Million over three rounds of bidding



County Home Case Study:



Orange County, NY

Valley View Center for Nursing Care and Rehabilitation

Scenario: We were engaged approximately 45 days ago, to market for sale, the 360-bed Valley View Nursing Home. It is widely known that the facility is experiencing significant operating deficits, over \$20 Million for 2011. The ever-increasing legacy costs, coupled with the over staffing at the facility account for most of the losses. The County believes that the only real solution to "right-sizing" the operating costs for Valley View is to privatize it, and we are in the process of helping them effectuate that strategy.

- 360 Bed Skilled Nursing Facility
- Approximately 92% Occupied
- \$30M+ in 2011 Revenue
- \$20M+ in 2011 Operating Deficits

Outcome: To date, we have received approximately 53 Registration Agreements from potential bidders for Valley View, and we have arranged 7 tours of the facility. Despite heavy operating losses, we believe that the bidding for Valley View will be intense because of its strong occupancy, robust revenue and proximity to New York City. We expect the Purchase Price for Valley View to exceed \$20 Million. Due to the nature of the facility's current Collective Bargaining Agreement (CBA) with the CSEA, buyers are aware that the present benefit and wage packages can be eliminated, or mitigated upon privatization. Conceivably, a new owner's path to profitability will involve a new Collective Bargaining Agreement with CSEA's private arm, or by introducing a new union to Valley View; which has been the case with the 7 other County nursing homes we have marketed for sale in NY, NJ, IL and WI.



Marcus & Millichap Marketing Tools

Marcus & Millichap
Real Estate Investment Services
Liaison
REAL-TIME CLIENT COLLABORATION

Briefcase Admin

Sussex County Homestead (102 Bed NH in Newton, NJ)
Click text to edit description.

Add Description

Documents

Attach File To Folder: None Add Folder

Download ZIP of All Files

Click a file in the list to download.

File Name	Size	Date	Actions
Financials			
2011 Homestead re Comparative Statement 4.11 Millichap.x	110.5 KB	3/1/2012	Edit Delete
Homestead 2010 Cost Report (2).pdf	1.31 MB	3/1/2012	Edit Delete
Homestead 2011 Census 2.27.12.xlsx	15.7 KB	3/1/2012	Edit Delete
Homestead Census 2010 2.27.12.xlsx	15.5 KB	3/1/2012	Edit Delete
Homestead Census Data 2010 and 2011 YTD 5.25.11.xlsx	14.3 KB	3/1/2012	Edit Delete
Homestead Cost Report 2009.pdf	3.19 MB	3/1/2012	Edit Delete
14Sept11 Reso Review Postretirement Health Plan Actuarial	2.71 MB	3/1/2012	Edit Delete
30nov2011homesteadfinancialanalysis.pdf	451 KB	3/1/2012	Edit Delete
31december2011homesteadfinancialanalysis.pdf	875.5 KB	3/1/2012	Edit Delete
2006 Homestead Cost Report.pdf	2.23 MB	3/1/2012	Edit Delete
2007 Homestead Cost Report.pdf	2.88 MB	3/1/2012	Edit Delete
2008 Homestead Cost Report.pdf	3.04 MB	3/1/2012	Edit Delete
2009 Homestead Cost Report.pdf	3.96 MB	3/1/2012	Edit Delete
2010 Homestead Cost Report.pdf	2.04 MB	3/1/2012	Edit Delete
countyimpactstatement-2012medicaidreimbursementrates.p	84 KB	3/1/2012	Edit Delete
General Ledger with Budget Activity.pdf	38.6 KB	3/1/2012	Edit Delete
Homestead Central Services Indirect Costs & Fixed Assets	6.03 MB	3/1/2012	Edit Delete
Homestead Projected Revenue and Cost (unaudited) 30Sept	993.7 KB	3/1/2012	Edit Delete
Homestead-Cost-Analysis-2010-Final.pdf	47.7 KB	3/1/2012	Edit Delete
Oct2011 Ltr Hav Group Homestead OPEB Liabilities.pdf	136.9 KB	3/1/2012	Edit Delete
14Sept11 Reso Review Postretirement Health Plan Actuarial	2.71 MB	3/21/2012	Edit Delete
General Ledger with Budget Activity.pdf	38.6 KB	3/21/2012	Edit Delete
homestead care mix revenue 2011.pdf	11.1 KB	3/21/2012	Edit Delete
Homestead Central Services Indirect Costs & Fixed Assets	6.03 MB	3/21/2012	Edit Delete
homestead financial evaluation presentation updated 2011	3.41 MB	3/21/2012	Edit Delete
Oct2011 Homestead OPEB Liabilities Ltr Hav Group.pdf	136.9 KB	3/21/2012	Edit Delete
Due Diligence			
Collective Bargaining Agreement			Edit
Sussex County Homestead Offering Memorandum.pdf	3.23 MB	4/3/2012	Edit Delete

Feedback

Marcus & Millichap
Real Estate Investment Services
REACH
Clients Effectively

1 DESIGN
Email

2 CHOOSE
Recipient

3 SEND
Email

4 VIEW
Reports

User: Mark Myers (Logout)

Design Email > Email Folder

Email Folder: Burlington County

To create a new email, click on the "Add New" button to the right.

ADD NEW

Email Name	Actions
Buttonwood Hospital offering in Burlington County, NJ	<div style="display: flex; gap: 5px;"> <div style="border: 1px solid #ccc; padding: 2px; border-radius: 5px;">EDIT</div> <div style="border: 1px solid #ccc; padding: 2px; border-radius: 5px;">DELETE</div> <div style="border: 1px solid #ccc; padding: 2px; border-radius: 5px;">PREVIEW</div> <div style="border: 1px solid #ccc; padding: 2px; border-radius: 5px;">DUPLICATE</div> </div>
modify me NO UNSUBSCRIBE LINK PRESENT	<div style="display: flex; gap: 5px;"> <div style="border: 1px solid #ccc; padding: 2px; border-radius: 5px;">EDIT</div> <div style="border: 1px solid #ccc; padding: 2px; border-radius: 5px;">DELETE</div> <div style="border: 1px solid #ccc; padding: 2px; border-radius: 5px;">PREVIEW</div> <div style="border: 1px solid #ccc; padding: 2px; border-radius: 5px;">DUPLICATE</div> </div>

Useful Tip:

Additional Resources:

>> Brokerage Tools Learning Center

http://reach.marcusmillichap.com/cgi-bin/admin/templates/view_reach.pl?p=52616e46f6d495611fb0d - Windows Internet Explorer

Sent on behalf of Joshua Jandris & Mark Myers,

Below is a marketing flyer and link to the online data room for the **Buttonwood Hospital offering** - a county owned 200 bed long t Pemberton (Burlington County), New Jersey.

If you would like to review an offering memorandum and related financial information for this offering, please click on the link below a standard Marcus & Millichap Seniors Housing Group confidentiality agreement and gain access to the data room.

Please contact Joshua (312.399.9797) or Mark (773.383.6821) directly with any questions or comments.

https://liaison3.marcusmillichap.com/ZYZSLJP9

Seniors Housing Offering Summary

INVESTMENT HIGHLIGHTS

- County Owned Facility
- Less than 1 Hour From Cherry Hill, NJ, Philadelphia and Approximately 1 Hour & 45 Minutes From New York City



Valley View Center Marketing Timeline Action Item	Timing
Create Marketing Materials Individual Offering Memorandums E-Brochures Registration Agreements Online Data Room (Liaison)	March 12th, 2012
Distribute Marketing Materials (Email Database of 4,000 Owners/Operators and Investors) Contact Potential Buyers and Review Materials Obtain Draft Purchase & Sale Agreement (PSA) from Seller & Updated third Party Reports (Environmental, ALTA Survey, Title Work) from Seller and place these and all Other Due Diligence Materials into Password-Protected Data Room Conduct tours of the subject facility with potential buyers.	March 12th, 2012- April 27th, 2012
Call for Offers Proposed Bid Deadline	May 4th, 2012
Tour Potential Buyers' Facilities	By May 4th-22nd, 2012
Second Bid Round (if necessary): Bids Submitted as Marked Up Versions of Seller's Draft PSA	May 22nd, 2012
Select Qualified Buyer and Close Bidding Process Right of First Refusal Waiting Period Finalize and Execute the Asset Purchase Agreement and Administrative Service Agreement Earnest Money Becomes Non-Refundable	By June 1st, 2012 June 1-July 15, 2012 July 15 th -July 31st, 2012
Licensure Submission by Buyer	By August 15, 2012
*Buyer takes over under ASA, MSA, CSA, Friendly Receivership or operating arrangement	September 1, 2012
Licensure Approval and Closing	By March 2013

Orange County Marketing Timeline and Opportunity Created for Golden Hill

- Established Market Interest from Orange County
- Buyer Market Studies Completed
- Only Possible for One Purchaser of Valley View
- Interested Parties Defined
- “Best Practices” Established for Ulster Transaction

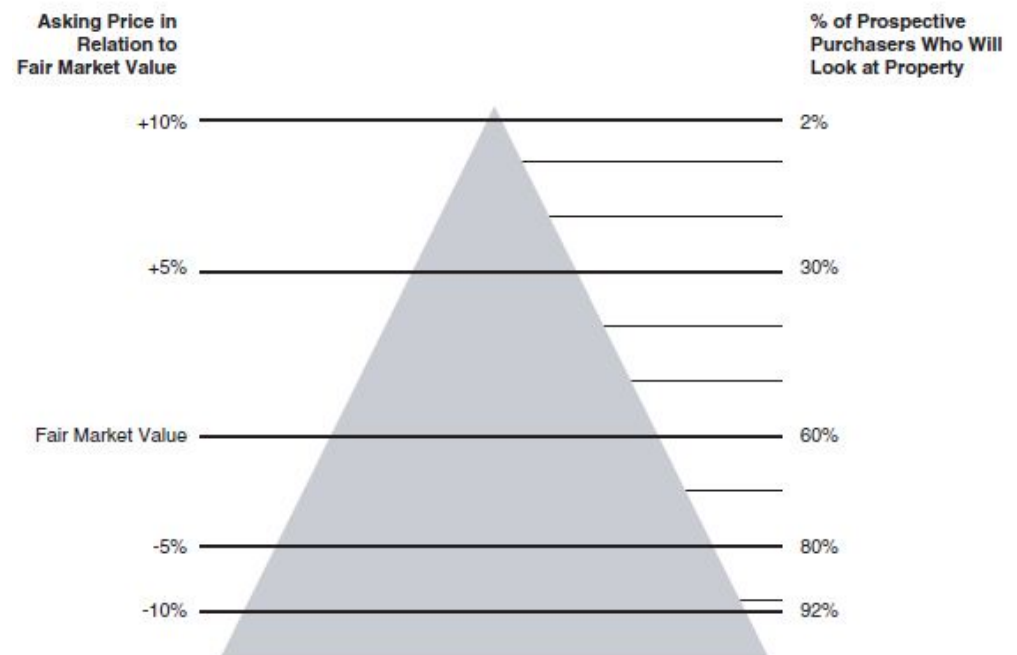
*Pending issue is how the buyer will take over operations prior to Change of Ownership, “CHOW;” whether it is via a Management Services Agreement (MSA), a Consulting Services Agreement (CSA), Friendly Receivership, or some other form of ownership.



Using Market Knowledge to Maximize Economic Return

PRICING EVALUATION

The diagram below shows the segment of prospective purchasers who are likely to see YOUR PROPERTY based upon the relationship of its asking price to its fair market value.



If you want to have a cushion for negotiation, you must still have people to negotiate with. If you over-price your property, it is not likely to be shown.

If your property is being shown, but not sold, maybe it is being used to make other listings more attractive.

These percentages are based upon a multi-state study conducted by a national marketing organization.



Golden Hill Health Care Center Marketing Timeline Action Item	Timing
Create Marketing Materials Individual Offering Memorandums E-Brochures Registration Agreements Online Data Room (Liaison)	April 27th, 2012
Distribute Marketing Materials (Email Database of 4,000 Owners/Operators and Investors) Contact Potential Buyers and Review Materials Obtain Draft Purchase & Sale Agreement (PSA) from Seller & Updated third Party Reports (Environmental, ALTA Survey, Title Work) from Seller and place these and all Other Due Diligence Materials into Password-Protected Data Room Conduct tours of the subject facility with potential buyers.	April 30th, 2012- June 15th, 2012
Call for Offers Proposed Bid Deadline	June 21st, 2012
Tour Potential Buyers' Facilities	By June 21st-July 12, 2012
Second Bid Round (if necessary): Bids Submitted as Marked Up Versions of Seller's Draft PSA	July 12th, 2012
Select Qualified Buyer and Close Bidding Process	By July 20th, 2012
Right of First Refusal Waiting Period	July 20th-Sep 3rd, 2012
Finalize and Execute the Asset Purchase Agreement and Administrative Service Agreement	Sep 3rd-Sept. 17th, 2012
Earnest Money Becomes Non-Refundable	
Licensure Submission by Buyer	By October 1, 2012
*Buyer takes over under ASA, MSA, CSA, Friendly Receivership or operating arrangement	October 15, 2012
**Licensure Approval and Closing	By April 2013

Golden Hill Health Care Center Proposed Marketing Timeline

- Projected Timeline assumes hire date of 4/20/2012
- The pace at which the Marketing & Sales Process is run can be determined by the GHLDC
- Potential for lengthy New York Change of Ownership Process

*Pending issue is how the buyer will take over operations prior to Change of Ownership, "CHOW;" whether it is via a Management Services Agreement (MSA), a Consulting Services Agreement (CSA), Friendly Receivership, or some other form of ownership.

**Marcus & Millichap has no bearing on the speed of Change of Ownership approvals. However, selecting a buyer that has navigated the process previously or one with an attorney that has, will greatly increase the likelihood of a smooth and expedited transition.



Services Marcus & Millichap will Provide

- **Assist GHLDC creating RFP, Notice of Sale, Asset Purchase Agreement (APA)**
- **Make 400-500 calls a week into the marketplace**
- **Distribute notice of sale to 14,000+ Senior Housing Industry Stakeholders/Buyers**
- **Insure that Registration Agreements are signed**
- **Coordinate the distribution of Marketing Memorandum to potential buyers**
- **Direct potential buyers to the data room**
- **Answering any questions pertaining to the asset and sales process**
- **Coordinate tours in conjunction with the GHLDC**
- **Assist in developing a Bidder Information Package**
- **Keep pulse on the reimbursement environment in real-time as to mitigate any risks**
- **Assist the county in procuring third party reports**
- **Qualify potential bidders**

*As the purpose of this slide was to highlight some of the services provided, a more comprehensive list can be found in the appendix.



Marcus & Millichap's Methods for Qualifying Bidders

- **Include Restrictions & Conditions to Sale in RFP**
 - Appendix F_County Home Restrictions Analysis
- **Have all bidders submit two year Medicare star rating for all facilities owned**
- **Have all bidders submit three year survey history for all facilities owned**
- **Have all bidders submit financials in order to prove ability to close**
- **Once bids are collected, tour final candidates' facilities or a sample of their portfolio**
 - Appendix G_Pima County Article on Bidder Qualifications



Marcus & Millichap Commission Rate Structure

Two and Three Quarters Percent (2.75%) of the Total Gross Purchase Price. Gross Purchase Price as used in this Agreement shall include, but shall not be limited to:

1. Cash, stock, equity interests, membership interests, and/or partnership interests;
2. Payments made in installments;
3. Notes, securities and all other property;
4. The assumption and/or restructuring of any liabilities, including all debt and guarantees assumed, refinanced or reorganized, whether on-balance sheet and off-balance sheet;
5. Contingent payments (whether or not related to future earnings or operations);
6. Any interest or other payments made on or in respect of debt;
7. Any other payment made on or in respect to the equity interests in the Property and/or its affiliates;
8. Any consideration payable under consulting agreements and/or non-compete agreements;
9. Any assignment of leases, whether real or personal property;
10. Any constructive payments; and
11. Any release or assumption of bonds or debt instruments of any kind.

Additional Expense Information

As our payment is contingency based, GHLDC will not incur any costs as it relates to the payment of Marcus & Millichap until a ready, willing and able buyer is procured by M&M in conjunction with the GHLDC, and a transaction is closed. All costs related to the marketing of Golden Hill will be paid for by M&M, including air travel and lodging if and when necessary.



Appendix A

Introduction of Final Statewide Pricing Methodology: 12/15/2011



13 British American Blvd. | Suite 2 | Latham, New York 12110 | P 518.867.8383 | F 518.867.8384 | www.leadingageny.org

MEMORANDUM

TO: RHCF Members

FROM: Dan Heim, Executive Vice President
Darius Kirstein, Senior Policy Analyst

DATE: December 15, 2011

SUBJECT: **Details/Estimated Impacts of Final Statewide Pricing Methodology**

ROUTE TO: Administrator, Department Heads

ABSTRACT: Department of Health finalizes nursing home statewide pricing methodology.

Introduction

LeadingAge New York and other associations met on December 14 with Department of Health (DOH) officials for a briefing on the state's **final** methodology on Medicaid nursing home pricing, which will be implemented effective January 1, 2012. We also discussed a possible settlement option proposed by DOH that, if agreed to, could result in additional funding during and after the transition to the pricing system.

DOH has made changes to the pricing methodology and transition plan that address some of the concerns we have raised about the level of redistribution and volatility that pricing would bring about. Over the last few weeks, LeadingAge NY advocated with the governor's office and DOH to revise the initial pricing proposal to address the potential redistributions of funding we were seeing globally at the sponsorship and regional level, as well as the significant level of volatility evident at the facility level. During this same period, we continued to work with the Healthcare Association of New York State and the Continuing Care Leadership Coalition to address these concerns.

We are grateful for the input provided over the last several weeks by the LeadingAge NY nursing home cabinet and its finance workgroup, as well as members at large.

Changes to the Methodology

In response to input from LeadingAge NY and other groups, DOH made two fundamental changes to the statewide pricing methodology they proposed in mid-November:

1. **Peer Groups:** Instead of basing every facility's rate on single statewide prices for the direct and indirect components, the new system will divide all facilities into two peer groups. The first will be made up of 300+ bed facilities and hospital-based facilities, while the second will be "all other" facilities (i.e., <300 bed freestanding facilities). 300+ bed and hospital-based status are based on the existing designations. Every facility will receive direct and indirect prices based on a blend of 50% of the statewide price (which includes all facilities) and 50% of the relevant peer group price (i.e., either the 300+/hospital based group or the "all other" group).
2. **Transition period:** DOH had originally proposed a four-year phase in to full pricing implementation, with annual facility-specific gain/loss limits of 2.5% in 2012; 5% in 2013; 7.5% in 2014 and 10% in 2015. The Department has added a year to the transition, which will limit 2012 gains/losses to 1.75%, and to 2.5% in 2013; 5% in 2014; 7.5% in 2015; and 10% in 2016. Full implementation of pricing will occur beginning in 2017.

LeadingAge NY believes these changes are positive, but we continue to have concerns about the lack of an ongoing gain/loss cap beyond 2016, as well as other issues. DOH shares our concern about the estimated negative impacts to certain financially challenged facilities and specialty units/facilities, and agreed to more closely examine these situations and work with us to try to address them in some way in the future.

DOH also clarified their position on three system elements that were addressed in their November proposal:

1. **Case-mix changes:** Case-mix will still be based on the current Medicaid-only RUG-53 model, and updated every six months based on the roster submission process. Case-mix will be allowed to "float" (i.e., changes in case-mix will be made outside of the gain/loss limits and no longer be subject to a "scaleback" adjustment as in rebasing, but could be constrained if overall spending were to exceed the Medicaid global cap).

However, in an effort to minimize retroactive rate adjustments under statewide pricing, DOH is planning to begin prospectively adjusting rates for case-mix by lagging case-mix by six months. This means, for example, that instead of being based on July 2012 case-mix data, the July 2012 rates will be based on January 2012 case-mix data. The initial pricing rates will be based on January 2011 case-mix, which will remain in effect until July 2012. Under the current process, case-mix adjustments to the rates are not made until 4-5 months after the effective date of the rates, necessitating a retroactive adjustment.

2. **Quality pool:** DOH plans to allocate \$50 million per year in 2012 and 2013 for quality incentives. In 2012, facilities will be asked to report certain data to DOH and if they comply, there would be no effect on their reimbursement. Beginning in 2013, DOH will make payments to facilities based on performance on the selected quality measures. The \$50 million allocation would apparently be funded out of the reimbursement base, which we are concerned about. LeadingAge NY and other stakeholders will serve on a workgroup to establish the quality measures.

3. **Per diem add-ons:** As previously proposed, DOH will continue the current per diem add-ons for dementia (\$8), bariatric (\$17) and TBI (\$36) patients. These payments will be made outside of the annual gain/loss limitations, and will be based on the same schedule as noted above for case-mix changes (i.e., a 6-month lag). However, DOH will begin requiring facilities to document how these funds are spent and the resulting outcomes for the patients. Further details are not yet available on this requirement.

A description of the final statewide pricing methodology, together with examples and calculation details is provided in the [PowerPoint presentation](#) DOH provided to us on December 14.

Facility-Specific Impacts and DOH Webinar

DOH has just provided us with a facility-specific listing of the estimated impacts of the pricing system during the 5-year transition period (i.e., 2012-16) and at full implementation (i.e., 2017 and beyond). You can access the listing by clicking [here](#). As you will see, we have developed and included in the impacts document a list of the major assumptions used to develop the estimated impacts.

The Department will be recording a Webinar this coming Tuesday, December 20, which will shortly thereafter be made available to all facilities. The Webinar will summarize the methodology and basis for the estimated impacts, and describe the upcoming implementation plan.

Next Steps in Process

State law, enacted as part of the 2011-12 budget, authorizes the Department to implement a statewide pricing methodology effective no later than January 1, 2012. However, federal approval is also needed before payments under the new system can begin. The state intends to publish a public notice next week generally describing the final methodology, and shortly thereafter submit a Medicaid state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) for the change to statewide pricing. Although the methodology will take effect January 1, 2012, DOH said that CMS approval and actual implementation is not likely to occur until April 2012, necessitating rate adjustments retroactive to January 1, 2012.

As part of the process of submitting the SPA to CMS, the Department will be performing the calculation of the Medicare “upper payment limit” (UPL). Besides assuring CMS that the statewide pricing rates would not result in payments exceeding what would be paid under Medicare principles of reimbursement, the UPL also determines the amount of intergovernmental transfer funds that can be paid to public facilities.

Possible Litigation and Appeals Settlement

Although the statewide pricing methodology described above is final, DOH also proposed a “universal litigation and appeals settlement” for consideration by the industry. If fully agreed upon, this proposed settlement could result in additional funding during and after the transition to the pricing system.

To summarize, the state carries a potential liability of \$100 million or more on its books for the settlement of nursing home Medicaid rate litigation and rate appeals. In exchange for the withdrawal of all pending litigation and outstanding operating rate and methodology-related capital component appeals (i.e., for rate periods prior to 1/1/12), the state would make \$100

million available to ensure that: (1) no facility incurs a loss from statewide pricing in the first two years of transition; and (2) the facilities that would benefit from pricing would have their gains accelerated in the first three years of transition. More details on how the proposal would work are provided in the [PowerPoint presentation](#) DOH distributed at yesterday's meeting. LeadingAge NY will be working with its members and legal counsel to closely review this proposal, and we will provide input to DOH on it by early January, as they have requested.

We will continue to provide you with information on statewide pricing, as it becomes available. If you have questions in the meantime, please contact Darius Kirstein at dkirstein@leadingageny.org or Dan Heim at dheim@leadingageny.org; or call us at (518) 867-8383.

NURSING HOME PRICING CALCULATIONS (the methodology behind DOH impact estimates)

Select your home using the drop-down menu:

GOLDEN HILL HEALTH CARE C ▼

Click below to access the
LeadingAge memo on the
new methodology



[Click here for memo](#)

Line Number	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6
	1.75% Gain/Loss	2.5% Gain/Loss	5.0% Gain/Loss	7.5% Gain/Loss	10% Gain/Loss	No Constraint

DIRECT COMPONENT CALCULATION

9	Peer Grp. Blend Direct Mean (Part B Incl.)	102.54	108.38	113.00	114.32	114.85	115.37
10	Peer Grp. Blend Direct Mean (Part B Eligible)	101.12	106.88	111.43	112.73	113.25	113.76
11	2007 Peer Grp. All Payer CMI	0.9075	0.9075	0.9075	0.9075	0.9075	0.9075
12	2011 Jan Facility Medicaid only CMI	0.7800	0.7800	0.7800	0.7800	0.7800	0.7800
13	CMI Change % [line 12/line 11]	0.8595	0.8595	0.8595	0.8595	0.8595	0.8595
14	Direct WEF	1.0268	1.0268	1.0268	1.0268	1.0268	1.0268
15	Direct Component with CMI & WEF (B Incl.) [Line 9*13*14]	90.50	95.65	99.73	100.89	101.36	101.82
16	Direct Component with CMI & WEF (B Eligible) [Line 10*13*14]	89.24	94.32	98.34	99.49	99.95	100.40

INDIRECT COMPONENT CALCULATION

18	Peer Grp. Blend Indirect Mean	50.82	53.71	56.00	56.66	56.92	57.18
19	Indirect WEF	1.0141	1.0141	1.0141	1.0141	1.0141	1.0141
20	Indirect with WEF [line 18*19]	51.54	54.47	56.79	57.46	57.72	57.98

NON-COMPARABLE COMPONENT

22	Non-Comparable (facility-specific 2007)	8.95	8.95	8.95	8.95	8.95	8.95
-----------	---	------	------	------	------	------	------

NEW OPERATING RATE (Before Special Population Add-ons)

24	Operating Rate (B Incl.) [lines 15+20+22]	150.99	159.08	165.48	167.30	168.03	168.75
25	Operating Rate (B Eligible) [lines 16+20+22]	149.73	157.75	164.09	165.90	166.62	167.34

MEDICAID VOLUME (2010 MEDICAID DAYS)

27	2010 B Eligible Days	430	430	430	430	430	430
28	2010 B Incl. Days	76,442	76,442	76,442	76,442	76,442	76,442
29	Rate times Days [lines (24*27)+(25*28)]	11,510,818	12,127,157	12,614,690	12,753,829	12,809,233	12,864,110

APPLICATION OF STOP-LOSS/GAIN

31	<i>Maximum/Minimum Revenue Using Constraint</i>	13,609,341	13,505,453	13,159,159	12,812,865	12,466,572	<i>na</i>
32	Estimated Annual Revenue with Loss/Gain Limit Applied	13,609,341	13,505,453	13,159,159	12,812,865	12,809,233	na
33	Estimated Annual Medicaid Revenue Change Percentage (Before Add-ons)	-1.75%	-2.50%	-5.00%	-7.50%	-7.53%	-7.13%

SPECIAL POPULATION ADD-ONS APPLIED AFTER STOP-LOSS/GAIN TEST

35	TBI/BMI/ Dementia Add-ons (Jan 2011)	200,750	200,750	200,750	200,750	200,750	200,750
36	Estimated Annual Mcaid Rev. Under Pricing	13,810,091	13,706,203	13,359,909	13,013,615	13,009,983	13,064,860

COMPARISON RATE

38	7/7/2011 Rate less Capital (B ineligible)	180.61	180.61	180.61	180.61	180.61	180.61
39	7/7/2011 Rate less Capital (B ineligible)	180.19	180.19	180.19	180.19	180.19	180.19
40	Estimated Annual Mcaid Rev. (Using 7/7/2011 Operating Rates and 2010 Medicaid days)	13,851,746	13,851,746	13,851,746	13,851,746	13,851,746	13,851,746
41	Estimated Annual Impact	(41,656)	(145,544)	(491,837)	(838,131)	(841,763)	(786,886)
42	Percent Impact (Add-ons Included)	-0.3%	-1.1%	-3.6%	-6.1%	-6.1%	-5.7%

Note: Estimates are based on 2010 Medicaid volume and use January 2011 CMI which will be updated semi-annually starting July 2011



Appendix B

Introduction of Managed Care: 2/1/2012



Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Report Indicates Consumer Satisfaction Rates High Among Members of New York's Managed Long-Term Care Plans

The New York State Department of Health (NYSDOH) recently announced that a customer satisfaction survey of enrollees in Medicaid managed long-term care plans (MLTCs) rate their plans highly. The survey conducted by the IPRO concludes that 85 percent of enrollees rated their managed long-term care plans good or excellent. Ninety-one percent would recommend their plan to a friend and 84 percent said the plan helped them and their families manage their illness better. Ratings of plan communication were also high with 85 percent indicating that the plan explains services clearly and 98 percent reporting that they were treated with courtesy and respect.



MLTC plans provide long-term care services such as home care and adult day care to people who are chronically ill or have disabilities, allowing them to stay in their homes and communities as long as possible. The MLTC plan arranges and pays for a large selection of long-term care health and social services including nursing home services when the enrollee is no longer able to stay in his/her home.

The report is based on a standardized satisfaction survey conducted in 2011. Members also rated their caregivers very highly: 87 percent rated the quality of care provided by their care managers as good or excellent with similar levels of satisfaction with their visiting nurses, 86 percent.

"These satisfaction results indicate that managed long-term care will provide excellent service while making our Medicaid system sustainable," said Jason Helgerson, New York State Medicaid Director.

The goal of moving this population to care management is also to improve outcomes. New York currently ranks last in the nation in terms of inappropriate hospital admissions for Medicaid patients. The MLTC program creates incentives for the plans to keep people healthier and in their homes.

A more detailed report of these findings and additional information about the MLTC program are located at: http://www.health.ny.gov/health_care/managed_care/mltc/.



**New York City
Human Resources
Administration (HRA)
has a new phone #!**

**INFOLINE'S NEW NUMBER
IS 718-557-1399**

FEBRUARY 2012 NEW YORK STATE MEDICAID UPDATE

POLICY AND BILLING GUIDANCE

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New Populations to Enroll in Medicaid Managed Care

Effective April 1, 2012, and contingent on New York State receiving the necessary federal approvals, the following circumstances **will no longer** be sufficient reasons for non-dually eligible beneficiaries (Medicaid beneficiaries NOT in receipt of Medicare benefits) to be exempt or excluded from enrolling in a Medicaid managed care plan in mandatory counties. These changes are needed in order to enroll additional populations into Medicaid managed care or other care coordination programs over the next two years, as required by the Governor's Medicaid Redesign Team (MRT) and authorizing legislation. These include:

- **Persons with end stage renal disease (ESRD);**
- **Homeless individuals;**
- **Persons receiving services through the Chronic Illness Demonstration Program (CIDP);**
- **Infants born weighing under 1200 grams or babies under six months of age with a disabling condition;**
- **Persons with characteristics and needs similar to those in the following programs and facilities: Long Term Home Health Care Program (LTHHCP), Care at Home (CAH) program, Traumatic Brain Injury (TBI) program, Nursing Home Transition and Diversion (NHTD) waiver program and the Intermediate Care Facilities for the developmentally disabled program (ICF/DD).**

All providers are strongly encouraged to enter into contractual arrangements with Medicaid managed care plans in their service area in order to continue to provide needed services to members once they transition into a Medicaid managed care plan.

Current Medicaid recipients who fall into one of the above categories and who receive a mandatory informational/enrollment packet, will have thirty days to choose a Medicaid managed care plan. Anyone who fails to choose a plan within thirty days will be automatically assigned to a plan. New Medicaid applicants are expected to choose a plan upon application or they will be automatically assigned. **Providers are encouraged to assist their patients in choosing a plan in which the provider participates.** Persons with self-identified approved exemptions will receive an "End of Exemption" letter and will be afforded time to apply for an alternate exemption, if available.

Persons with ESRD – Please see separate article on enrollment of this population.

Homeless Individuals

Enrollment of homeless individuals will be phased in beginning April 2012. Where identifiable, the state will make every effort to target families with children prior to enrolling single individuals and childless couples. Undomiciled individuals (street homeless) will be targeted last for enrollment to allow ample time to educate these harder to locate individuals. Over a six month period, all homeless individuals will be enrolled statewide.

Medicaid managed care plans will be required to include in their network providers who traditionally treat the homeless population, including at least two federally qualified health centers (FQHCs) with designation under Section 330H of the Public Health Services Act, where available. Additional information will be provided in subsequent Medicaid Updates.

-continued on next page-

Chronic Illness Demonstration Program (CIDP) Participants

The CIDP is scheduled to phase out as of March 31, 2012, and participants will no longer be excluded from Medicaid managed care as of April 1, 2012. CIDP providers will be assisting participants in choosing a health plan that includes the providers the consumer is seeing.

Disabled and Low Birth Weight Infants – Please see separate article on enrollment of this population.

Waiver Program “Look-alikes”

“Look-alikes” are persons who are not enrolled in the waiver program, but have needs similar to persons enrolled in the waiver, and are eligible for nursing home level of care, or care in an ICF/DD, but remain in the community. **Please note that all individuals with Restriction Exemption Code 95 (RE95), as designated by OPWDD, will remain exempt from mandatory enrollment into managed care until such time as the proposed People First 1115 demonstration waiver is fully implemented within their county of residence.**

The LTHHCP waiver program provides enhanced services to individuals who are elderly or disabled, and who are medically eligible for nursing home care to allow them to remain in the community. Beginning April 2012, the state will begin enrolling individuals who “look like” participants in this program, i.e., individuals who are eligible for nursing home level of care but whose needs can safely be met in the community and are not currently enrolled in the waiver program. Additionally, individuals who “look like” participants in the Traumatic Brain Injury (TBI) program, the Care at Home (CAH) program, and who “look like” residents of Intermediate Care Facilities for the mentally retarded (ICF/DD) will be required to enroll in Medicaid managed care. “Look-alike” exempt persons will receive an end of exemption letter to allow an individual to apply for an alternate exemption, if applicable, prior to receiving a mandatory informational/enrollment packet.

Transitional Care Requirements for New Enrollees

Individuals newly enrolled in a Medicaid managed care plan who are undergoing a course of treatment may be eligible to continue the course of treatment with their current provider for a transitional period, regardless of whether the provider is in the plan’s network. **Non-participating** providers may provide transitional care for a period of up to 60 days from date of enrollment. For persons with an already approved course of treatment, such as home care or personal care services, **participating** providers may provide transitional care until the health plan’s approved treatment plan is in place. While transitional care is required to be covered by the plan, prior authorization rules through the plan must be followed.

Information on other exemptions and exclusions from enrollment in Medicaid managed care, as well as information on how to apply for another exemption not listed above, is available from NY Medicaid Choice at (800) 505-5678, the Local Departments of Social Services (LDSS) or in New York City, the Human Resources Department (HRA). See box above to register for a webinar on new populations enrolling in Medicaid managed care, as well as new benefits that will be covered by Medicaid managed care plans.

For a list of managed care plans by county, please visit: www.nyhealth.gov/health_care/managed_care/pdf/cnty_dir.pdf.

For more information on the Medicaid Redesign Team initiatives now being implemented, please visit: http://nyhealth.gov/health_care/medicaid/redesign.

If you have any managed care enrollment questions, please e-mail: OMCmail@health.state.ny.us.

WEBINAR:

Transition of New Populations and Benefits into Mainstream Medicaid Managed Care

Date: Wednesday, March 7, 2012

Time: 3:00 – 4:30PM EST

After registering, you will receive a confirmation via e-mail containing information about joining the webinar.

System Requirements:

PC-based attendees

Required: Windows® 7, Vista, XP or 2003 Server

Macintosh®-based attendees

Required: Mac OS® X 10.5 or newer

Space is limited. Reserve your webinar seat at:

<https://www1.gotomeeting.com/register/637495184>

Health Department Regulations Adopted for Observation Unit Operating Standards

New York State Medicaid, including Medicaid managed care and Family Health Plus (FHPlus) plans, have reimbursed providers, effective April 1, 2011, for hospital observation services delivered in observation units. Payment has been contingent upon approval of a site-specific waiver from the Office of Health Systems Management (OHSM), Division of Certification and Surveillance.

Effective January 11, 2012, Title 10 of the New York Code of Rules and Regulations, Section 405.19, was amended establishing observation unit operating standards. Accordingly, new observation units must be established in compliance with the process and standards set forth in section 405.19, rather than through a waiver. New York State Medicaid will reimburse providers for observation services in observation units that meet the new standards identified in the recently filed regulations.

The regulations governing provision of observation services are available online at:

<http://w3.health.state.ny.us/dbspace/NYCRR10.nsf/56cf2e25d626f9f785256538006c3ed7/8525652c00680c3e8525652c00630a77?OpenDocument&Highlight=0,405.19>.

New York State Medicaid will continue to reimburse hospitals for observation services delivered in an observation unit under authority of a waiver issued by the OHSM. However, please note that pursuant to the recently adopted regulations, facilities that had been granted a waiver are required to comply with the provisions of the new regulatory standards within 24 months of the effective date of the regulation change (i.e., January 11, 2014). Facilities that are not in compliance with the regulations by January 11, 2014, will not be eligible for reimbursement.

Previously published billing instructions for observation services may be found in the May 2011 Medicaid Update at: http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-05.htm#eme.

Please contact the Division of Certification and Surveillance at (518) 402-1003, if you have questions about the process for establishing an observation unit or operating standards.

If you have questions about Medicaid reimbursement for observation services, please contact the Division of Program Development and Management at (518) 473-2160.

Infants with Low Birth Weight and Infants with Disabilities under Six Months of Age in Medicaid Managed Care

Effective April 1, 2012*, infants born on or after April 1, 2012, weighing less than 1200 grams and infants under six months of age who are disabled **will no longer** be excluded from enrolling in a Medicaid managed care plan and will be enrolled in Medicaid managed care. These changes are being made in response to recent legislation requiring New York State to enroll additional populations into Medicaid managed care or other care coordination programs over the next three years. Infants born prior to April 1, 2012, that are already enrolled in fee-for-service will remain in fee-for-service until they are six months old, at which time they will receive an enrollment packet with a choice of plan.

If the infant's mother is enrolled in a Medicaid managed care plan (HIV-SNP in New York City), the infant will be automatically enrolled in the mother's plan. If the mother is enrolled in a Family Health Plus (FHPlus) plan, and that plan also has a Medicaid managed care product, the infant will be enrolled in that plan's Medicaid managed care product. If the mother's FHPlus plan does not offer a Medicaid option, the infant's mother must choose a Medicaid managed care plan. If the mother fails to choose a plan, the infant will automatically be assigned to a plan. Providers are encouraged to assist their patients in choosing a plan in which the provider participates.

Managed care plans are responsible for notifying the local social services district (LDSS), or HRA in New York City, of any enrollee that is pregnant within thirty days of becoming aware of the pregnancy. In addition, managed care plans should notify the LDSS/HRA when a newborn weighing 1200 grams or more appears to otherwise qualify as disabled.

For a list of managed care plans by county, please visit:
http://www.nyhealth.gov/health_care/managed_care/pdf/cnty_dir.pdf.

For more information on the Medicaid Redesign Team (MRT) initiatives, please visit:
http://nyhealth.gov/health_care/medicaid/redesign.

***contingent upon CMS approval**

Beneficiaries with End Stage Renal Disease Must Enroll in Medicaid Managed Care

Effective April 1, 2012*, recipients with a diagnosis of End Stage Renal Disease (ESRD) **will no longer** be exempt from enrolling in a Medicaid managed care plan in mandatory counties. These changes are being made in response to recent legislation requiring New York State to enroll additional populations into Medicaid managed care or other care coordination programs over the next three years. Effective April 1, 2012, individuals who are identified on eMedNY with a diagnosis of ESRD or individuals who were approved for an ESRD exemption and are otherwise eligible for mandatory enrollment will be sent informational/enrollment packets on how to enroll from either the Local Department of Social Services (LDSS) or in counties that utilize the New York State Enrollment Broker from New York Medicaid CHOICE. Individuals who applied for an ESRD exemption and were approved will receive an "End of Exemption" notice prior to receipt of their mandatory informational/enrollment packet.

Many individuals with ESRD are in receipt of Medicare; those individuals with dual coverage continue to be excluded (unable to enroll) in Medicaid managed care plans but may choose to enroll into a Managed Long Term Care or Medicaid Advantage plan if one is available in their county.

Current Medicaid recipients with ESRD who receive informational/enrollment packets will have thirty days to choose a Medicaid managed care plan. Anyone who fails to choose a plan within thirty days will be automatically assigned to a plan. Providers are encouraged to assist their patients in choosing a plan in which the provider participates. New Medicaid applicants are expected to choose a plan at application or they will be auto assigned; this includes those with ESRD.

Individuals newly enrolled in a Medicaid managed care plan that are undergoing a course of treatment, including dialysis, may be eligible to continue receiving services from their current provider for a transitional period, even if the provider does not participate in the plan's network. Medicaid managed care plans must reimburse **non-participating** providers for such ongoing services during a transitional period of up to sixty days from date of enrollment while the enrollee is transitioned to a participating provider.

The Medicaid Redesign Team (MRT) and legislative initiatives require most Medicaid recipients to enroll in a managed care plan by April 2013. As a result, **all providers are strongly encouraged to enter into contractual arrangements with Medicaid managed care** plans in their service area in order to continue to provide needed services to members once they transition into a Medicaid managed care plan.

For a list of managed care plans by county, please visit:
http://www.nyhealth.gov/health_care/managed_care/pdf/cnty_dir.pdf.

For more information on the Medicaid Redesign Team initiatives, please visit:
http://nyhealth.gov/health_care/medicaid/redesign.

Please note that individuals in fee-for-service Medicaid with chronic medical issues, including ESRD, who have had a relationship for at least six months with a specialist provider not participating in **any** managed care plan are allowed one exemption for a limited period of six months, only. This exemption will defer enrollment into a Medicaid managed care plan for up to six months, and is limited to persons who are in active treatment at the time of the exemption request.

***contingent upon CMS approval**

Billing for Post-op Follow-up Days

The following information clarifies Medicaid's fee-for-service policy on billing for post-op follow-up days.

Patients often return to the hospital clinic for aftercare appointments following a surgical procedure that took place in one of the following settings:

- Inpatient hospital;
- Hospital ambulatory surgery unit; or
- Hospital clinic.

Facilities may bill Medicaid for these visits. This policy applies to post-op aftercare visits that are billed under Ambulatory Patient Groups (APGs), as well as to those aftercare visits that took place prior to the implementation of APGs.

NOTE: The physician may not bill for aftercare visits. Payment to the physician for surgical procedures includes the surgery and the follow-up care. The number of follow-up days assigned to each surgical procedure can be found in the "Physician Manual – Surgery Services Fee Schedule." This information can be accessed at the following website:

<https://www.emedny.org/ProviderManuals/Physician/index.aspx>.

Medicaid Managed Care

Medicaid managed care and Family Health Plus (FHPlus) plans will reimburse in-network providers according to established provider agreements. Reimbursement for out-of-network providers will be at negotiated rates. Questions concerning managed care reimbursement rates should be directed to the health plan Provider Services number.

Questions regarding Medicaid fee-for-service policy and claiming should be sent via e-mail to:

pffs@health.state.ny.us.



Appendix C

Introduction of Managed Care: 2/1/2012

Hilding, Charles

Subject: FW: New York Articles and Other Info on Managed Care and Pricing System
Attachments: 3-12-12 DOH Issues New Timetable for MLTC Mandatory Enrollment.txt

From: Myers, Mark
Sent: Tuesday, April 17, 2012 11:23 AM
To: Hilding, Charles
Subject: RE: New York Articles and Other Info on Managed Care and Pricing System

Here you go.

From: Dever, Koy [KDever@loebandtroper.com]
Sent: Thursday, February 16, 2012 7:50 PM
To: Dever, Koy
Subject: FW: DOH Issues New Timetable for MLTC Mandatory Enrollment

FYI

From: Home Care Association of New York State [<mailto:roger@hcanys.ccsend.com>] On Behalf Of Home Care Association of New York State
Sent: Thursday, February 16, 2012 1:17 PM
To: Dever, Koy
Subject: DOH Issues New Timetable for MLTC Mandatory Enrollment

Having trouble viewing this email? [Click here](#)

MEMBER E-ALERT

DOH Issues New Timetable for Mandatory Enrollment
July 1 is new startup date

This morning the state Department of Health (DOH) issued a revised timetable for requiring dual-eligible individuals, 21 and older, who need more than 120 days of non-institutional long term care services to enroll into a managed long term care (MLTC) plan or care coordination model (CCM).

The timetable, originally slated to start on April 1, 2012, is now scheduled to begin in a phased approach starting on July 1, 2012.

This revised schedule is contingent on receiving approval from the U.S. Centers for Medicare and Medicaid Services (CMS).

DOH has also informed HCA that the April 1, 2012 deadline for enrolling non-dual-

eligible or Medicaid-only LTHHCP patients into mainstream Medicaid managed care plans has been postponed until January 1, 2013.

In addition, HCA continues to advocate for budget amendments and/or other action by the Legislature to secure a revised and reasonable timetable and plan for implementation that also includes critical safeguards, options and pathways for consumers and providers.

At this time, the revised DOH schedule for dual-eligible cases is as follows:

Phase One

Starting July 1, 2012, any new dual-eligible cases, which fit the above criteria, in New York City will be identified for enrollment and referred to Maximus, the enrollment broker. Maximus will send materials to those who are being targeted for enrollment into an MLTC (or CCM).

Enrollment will be phased in by service type, by borough in NYC, and by zip code for existing cases. People will be given 60 days to choose a plan according to the schedule outlined below.

- * July 1, 2012: Begin personal care cases in Manhattan (all individuals receiving personal care while enrolled in Medicaid Advantage plans will begin MLTC enrollment in January 2013)
- * August 1, 2102: Continue personal care cases in Manhattan
- * September 2012: Continue personal care cases in Manhattan and begin personal care cases in the Bronx; and begin Consumer Directed Personal Assistance Program (CDPAP) cases in Manhattan and the Bronx
- * October 2012: Continue personal care and CDPAP cases in Manhattan and the Bronx and start in Brooklyn
- * November 2012: Continue personal care and CDPAP cases in Manhattan, the Bronx and Brooklyn
- * December 2012: Continue personal care and CDPAP cases in Manhattan, the Bronx and Brooklyn and start in Queens and Staten Island
- * January 2013: Initiate enrollments citywide of long term home health care program (LTHHCP), home health cases over 120 days, adult day health care program (ADHCP) and private duty nursing cases not already enrolled under the personal care enrollment requirement
- * February 2013 and until all people receiving services are enrolled: Personal care, CDPAP, LTHHCP, home health cases over 120 days, ADHCP and private duty nursing cases in all of NYC

Other Phases

As plan capacity is established, dually eligible community-based long term care recipients in other counties will be enrolled into MLTCs according to the anticipated schedule outlined below.

- * Phase II (January 2013): Long Island and Westchester
- * Phase III (June 2013): Rockland and Orange counties
- * Phase IV (December 2013): Albany, Erie, Onondaga and Monroe counties
- * Phase V (June 2014): Other counties with capacity

Final Phase

Previously excluded dual-eligible groups in the following programs will be enrolled into MLTCs contingent upon development of "appropriate" programs: Nursing Home Transition and Diversion, Traumatic Brain Injury, nursing home residents, Assisted Living Program residents, and dual eligibles that don't require community-based long term care services.

HCA will be providing additional guidance to members on advocacy in relation to the entire managed care enrollment policy. Members should also continue to share comments, questions and issues with HCA at info@hcanys.org under the subject heading "Mandatory Enrollment Comments, Questions, Issues."

In addition, the state's mandatory enrollment plan and other related issues will be discussed at two important upcoming member forums: the February 28 Statewide LTHHCP Forum in Albany and the March 2 Downstate LHCSA Forum in New York. HCA's Forums are free of charge, but you must be a member and you must register in advance.

Registration for the LTHHCP Forum is available here. Registration for the Downstate LHCSA Forum is here.

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Mark L. Myers

Senior Vice President Investments
Senior Director, National Senior Housing Group

Marcus & Millichap
8750 West Bryn Mawr Avenue
Suite 650
Chicago, IL 60631

(773) 867-1470
(773) 867-1510 fax
(773) 383- 6821 mobile
mark.myers@marcusmillichap.com (<http://www.goodnewstracts.org/assets/tracts/better.looking>)

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Appendix D

Impact of Medicaid Reform: New York

http://m.nypost.com/p/news/opinion/opedcolumnists/the_perils_of_cuomo_medicaid_reform_Z2dI15tWm0wf1Gfe1Bf7LI

The perils of Cuomo's Medicaid reform By RUSSELL SYKES

Last Updated: 7:11 AM, April 4, 2012



AP

The Cuomo administration's Medicaid-reform strategy is riskier than most New Yorkers realize — in good part because it doesn't reform the Empire State's longstanding practice of seeking to grab every federal Medicaid dollar it can get.

Lord knows, the state's program needs reform. Medicaid now covers nearly one in three New Yorkers, at a cost of \$53 billion a year. We not only provide more services and have more generous eligibility levels than most states, we're far more relaxed about seeing if applicants truly qualify for taxpayer help.

And the rolls keep growing — up 73 percent from April 2000 to April 2010, rising 13 percent in the last of those years alone.

Compassion has trumped even the most basic anti-fraud measures: Applicants no longer need any face-to-face interview to become eligible. Up-front screening for potential error or fraud is modest at best. Even the screening of service-providers for patterns of likely fraud has become less aggressive.

Gov. Cuomo's new cap on Medicaid state-spending growth of 4 percent is a step in the right direction. And, to its credit, the governor's Medicaid Redesign Team sensibly wants to contain costs via an aggressive managed-care approach for all long-term care, mental-health and substance-abuse patients — three populations who drive more than 70 percent of all Medicaid costs.

It's an overdue approach — but not without risk. The scope of change is ambitious, and the feds must sign off.

The reforms are expected to save the federal government \$18 billion; the Cuomo administration will soon ask the Obama administration to grant the state a waiver that would allow us to keep \$10 billion of that savings to underwrite reform.

The managed-care plan hinges on a major expansion of New York's "health homes" pilot program and similar approaches, where a single care coordinator directs patients into primary-care rather than emergency settings, as well as on the broad sharing of electronic-patient information to allow providers to successfully coordinate care in a team approach.

Extra federal funding is available for both efforts, but only temporarily. New York has already gotten the green flag for expanding "health homes," with two years of greater funds from Washington for each patient enrolled.

But, again, \$10 billion of the anticipated funds depend on getting that waiver — which the Obama administration might not grant. Health Secretary Kathleen Sebelius just rejected a major waiver request from California Gov. Jerry Brown.

A bigger worry: New York is also counting on more federal funding, under the ObamaCare law, for upping Medicaid enrollment. The law offers enriched Medicaid funding in 2014 to states, like New York, that maintain current eligibility and benefits until then. It also promises significant funds down the line to states, like New York, that already provide generous Medicaid coverage to the populations all states will have to cover in 2014 under the Obama law.

The Empire State will fare very well — if ObamaCare kicks in, those match rates kick in. But the Supreme Court may overturn all or some of the law, putting New York's bold plan for federal reinvestment at risk. Even if it doesn't, this November's elections could further undermine support in Washington for the original ObamaCare vision.

If the law goes, so too does the promise of enriched federal dollars. This could prove the knockout punch to most of New York's aggressive approach and planned savings. Where does that leave Gov. Cuomo's Medicaid reforms? Up in the air — much like the anticipated revenues from casino gambling.

Russell Sykes is a senior fellow at the Manhattan Institute's Empire Center for New York State Policy.



Appendix 1

Services Provided by Marcus & Millichap

SERVICES MARCUS & MILLICHAP WILL PROVIDE

1. Collect and analyze financial data relating to the facility and recommend pricing of the asset.
2. Create all marketing materials and confidentiality agreements.
3. Distribute marketing materials.
4. Create data room.
5. Provide County with sample Letters of Intent forms, Purchase Agreements, Escrow Agreements, Bid Procedures and related documents.
6. Make recommendations for highly acclaimed and experienced professional advisors, including transaction attorneys, licensure attorneys, labor attorneys, accountants, appraisers and so forth.
7. Contact buyers via e-mail, personal phone calls and meetings, including conferences such as NIC.
8. Arrange tours for prospective bidders (PB).
9. Field calls from PB and obtain answers to their questions and provide them with any due diligence and other data to make the most aggressively high offer possible.
10. Collect the offers and provide a synopsis of the offers to the Seller via a Bid Matrix.
11. Conduct multiple bid rounds, update the Bid Matrix, and make recommendations as to the ultimate Winning Bidder (WB).
12. Assist Seller in negotiating P&S and Operations Transfer Agreement (OTA) and other transaction documents with WB.
13. Assist Seller in the collection of the Earnest Money from the WB.
14. Assist WB with its Due Diligence and Financing (if any), including arranging tours for WB, its staff, advisors, third party engineers, appraiser, and so forth.
15. Assist Seller and WB in filing WB's applications for any and all government approvals necessary to operate the nursing home.
16. Assist Seller with closing conditions and closing documents.
17. Assist Seller and Title Company/Closing Agent in closing the transaction, collection and distribution of funds.
18. Assist Seller and WB with Post-Closing matters, including any Escrow hold backs, collection of Accounts Receivable, transitioning of employees, and payment of payables ("Wind-Down" matters).
19. Assist in any other matters critical to the transaction for which M&M is qualified. (Note: M&M is not qualified to give legal or accounting advice and Seller and Buyer must hire their own legal and accounting advisors for such matters).



Appendix /

County Home Restrictions Analysis

Potential Conditions to Sale-Restriction Analysis

Scale of 1-10 (10 being most restrictive and 1 being the least)

Employee Matters

- | | |
|--|----|
| 1 Retain all employees under the current terms of the union contract | 10 |
| 2 Retain ALL employees, move them to new union agreement and terms | 8 |
| 3 Guaranteed offers of employment to those employees who file an application and pass a basic background check | 6 |
| 4 Same as above, but buyer can not hire anyone back based on findings from interviews and past performance reviews | 4 |
| 5 Buyer decides who they want to hire | 0 |

Facility/Physical Plant

- | | |
|---|---|
| 1 Facility must be operated as a nursing home for a period of 5 years | 2 |
| 2 Property Sold in "As-Is" "Where Is" Condition | 5 |

Resident Matters

- | | |
|--|---|
| 1 Buyer must retain 100% of current residents | 4 |
| 2 Payor mix restrictions: the buyer cannot discriminate against any Medicaid/indigent applicants | 8 |
| 3 Buyer must maintain current facility's payor mix for 24 months following the sale | 6 |
| 4 Buyer must reserve 80% of licensed beds for Burlington County Residents | 4 |

Buyer Qualifications

- | | |
|---|----|
| 1 Buyer must own and operate a skilled nursing facilities and psychiatric hospitals | 10 |
| 2 Buyer must own and operate a minimum of one skilled nursing facility in New Jersey | 7 |
| 3 Buyer must currently have an average star rate per Medicare.gov of at least 3 | 5 |
| 4 Buyer must submit proof of ability to obtain all licenses and regulatory approvals necessary to operate the Facility as it is currently being operated. | 2 |

*Nursing homes are unique because they are purpose built, and highly accretive when run efficiently. This should be included, but it is unlikely anyone would operate it as anything else.



Appendix fi

Pima County Article on Bidder Qualifications



Supes satisfied by answers on buyer's record

Pima County sells nursing home for \$7.8M

Rhonda Bodfield Arizona Daily Star | Posted: Tuesday, August 16, 2011 12:00 am

County supervisors agreed Monday to sell Pima County's nursing home after settling some of their questions about the buyer's track record.

Hunter Property Investments, on behalf of William Rothner, offered \$7.8 million for the 156-bed complex the county has owned and operated since 1971.

The new owners agreed, as part of the package, to serve existing residents - including those needing ventilators and behavioral health support - as long as there continues to be a need. The company also agreed to keep the staff intact, including offering similar salaries and benefits.

Supervisors delayed the vote earlier this month after employees raised concerns about the Rothner family's record in the industry. The patriarch, Eric Rothner, is involved in numerous nursing homes, and some have been cited for significant problems by regulators. One Indiana property, for example, was denied funding by Medicare and Medicaid in 2010, with regulators determining its residents were in immediate jeopardy.

The county sent two employees, including Posada's current administrator, Pat Wilson, to Lincoln, Neb., to see firsthand two facilities operated by the purchaser.

Wilson, who has been in charge of Posada for 10 years, said what she saw settled her doubts. She said the facilities were adequately staffed and the residents were dressed appropriately and seemed satisfied based on interviews. She said she was given carte-blanche authority to speak to anyone she wanted. One of the facilities, she noted, was facing risk of closure when Rothner bought it in 2008, but received just one deficiency on its latest licensing survey.

Attorney Michael Rusing, representing the bidder with the highest offer for the nursing home, asked the board to rebid the sale of the property. His client, Mavin Enterprises, offered \$9.1 million - more than \$1 million more than Hunter. Hunter was the only company that came up with \$500,000 in earnest money - which Rusing said came too late in the process for his client to address. Bidding again would allow a level playing field, he said, noting the county shouldn't leave \$1 million on the table in a tight economy.

Pima County Supervisor Richard Elías, who said he didn't like some of the respondent's answers when they sat down to talk about the sale, was the sole vote against the sale. The nursing home, he said, "is almost like a sacred turf because the people who live there really are without a voice."

County Administrator Chuck Huckelberry said nursing homes are a highly regulated industry, and the sale is contingent on Hunter receiving all of the necessary permits and licensing to operate the facility. "While all transactions are not risk-free, this is as close as we can get," Huckelberry said.

County officials hope to close the sale within 120 days.

"The nursing home

is almost like a sacred turf because the people who live there really are without a voice."

Richard Elías,

Pima County supervisor

Contact reporter Rhonda Bodfield at rbodfield@azstarnet.com or 573-4243.