March 30, 2020

Katherine Ceroalo
Bureau of House Counsel, Reg. Affairs Unit
NYS Department of Health
Corning Tower, Room 2438
Empire State Plaza
Albany, NY 12237

RE: HLT-04-20-00011-P: Nursing Home Case-Mix Rationalization

Dear Ms. Ceroalo:

I am writing on behalf of LeadingAge New York in strong opposition to the proposed amendments to Section 86-2.40(m) of Title 10 NYCRR relative to the determination of case-mix index (CMI) adjustments to Medicaid rates of payment for nursing homes. We urge the Department of Health (DOH) to not proceed with these proposed regulations, which would unfairly and retroactively reduce Medicaid funding to nursing homes by an approximate $250 million per year.

LeadingAge NY represents approximately 400 not-for-profit and public providers of long-term and post-acute care and senior services throughout New York State, including nursing homes, home care agencies, adult care and assisted living facilities, managed long term care plans, retirement communities and senior housing facilities.

According to the notice of proposed rulemaking in the *State Register*, the proposed regulatory amendments would: (1) codify DOH's revised methodology to establish nursing home Medicaid rates of payment for patient acuity; (2) codify the range of data that DOH uses for determining case mix; and (3) repeal an existing provision giving DOH discretion to cap changes in a facility's case mix index at 5 percent from one acuity assessment period to the next.

Under these proposed revisions, DOH would retroactively revise the methodology used to determine the CMI adjustment to the direct component of Medicaid rates for rate periods effective beginning July 1, 2019 and Jan. 1, 2020. Case-mix adjustments are made to Medicaid rates semi-annually in January and July. The current method – in place for several years – relies on a semi-annual snapshot taken on a specified date in Jan. and July of each facility's roster of Medicaid residents and the most date-proximate minimum data set (MDS) assessment for each resident. The CMI adjustment determined as of each snapshot is utilized to adjust the Medicaid rate for the semi-annual rate period 6 months after the snapshot is taken (e.g., Jan. 1, 2019 rates are based on July 2018 CMI data, etc.).

The Department instead proposes to use the MDS assessments for all Medicaid residents submitted to CMS during the period Aug. 8, 2018 - March 31, 2019 to determine the CMI adjustment to rates for the July 1, 2019 rate period. DOH has not adequately explained the rationale for its proposed use of data for a 235-day period in this calculation. More importantly, DOH would be changing the methodology

13 British American Blvd. Suite 2, Latham, New York 12110-1431
p 518.867.8383 | f 518.867.8384 | www.leadingageny.org

retroactively under these regulatory amendments and arbitrarily utilize MDS data for a previous time period that are unrepresentative of the assessments and responses that affect CMI determination.

Our specific concerns with the proposed rulemaking follow:

1. ***The proposed methodology for determining CMI adjustments is at odds with the New York State legislation which referenced it.*** Chapter 57 of the Laws of 2019 incorporated the following language referencing a change in the methodology utilized to calculate CMI adjustments to nursing home Medicaid rates:

   > "The Commissioner of Health or his or her designee shall convene and chair a workgroup on the implementation of the change in case mix adjustments to Medicaid rates of payment of residential health care facilities that will take effect on July 1, 2019. The workgroup shall be comprised of residential health care facilities or representatives from such facilities, representatives from the statewide associations and other such experts on case mix as required by the commissioner or his or her designee. **The workgroup shall review recent case mix data and related analyses conducted by the department with respect to the department's implementation of the July 1, 2019 change in methodology, the department's minimum data set collection process, and case mix adjustments authorized under in the Public Health Law (Section 2808 (2-b)(b)(ii)).** Such review shall seek to promote a higher degree of accuracy in the minimum data set data, and target abuses. The workgroup may offer recommendations on how to improve future practice regarding accuracy in the minimum data set collection process and how to reduce or eliminate abusive practices. In developing such recommendations, the workgroup shall ensure that the collection process and case mix adjustment recognizes the appropriate acuity for residential health care residents. The workgroup may provide recommendations regarding the proposed patient driven payment model and the administrative complexity in revising the minimum data set collection and rate promulgation processes. **The Commissioner shall not modify the method used to determine the case mix adjustment for periods prior to June 30, 2019.** Notwithstanding any changes in federal law or regulation relating to nursing home acuity reimbursement, the workgroup shall report its recommendations no later than June 30, 2019." **[Emphasis added]**

   During the first Workgroup meeting on May 22, 2019, DOH clearly indicated its intent to unilaterally revise the methodology used to determine the CMI adjustment for the July 1, 2019 rates along the lines reflected in the proposed rulemaking to achieve a reduction of at least $123 million in state spending ($246 million of total provider impact, inclusive of federal funding) in State Fiscal Year 2020. This approach would, contrary to Chapter 57, change the method used to determine the CMI adjustment for periods prior to June 30, 2019 using unrepresentative patient assessment data from the period Aug. 8, 2018 through March 31, 2019. Under the current State Plan, the two CMI adjustments made to Medicaid rates effective for Jan. 1st and July 1st of each year are based on a "snapshot" of patient assessments drawn six months earlier. By calculating the July 1, 2019 CMI adjustment using data from Aug. 2018 – March 2019, the proposed regulations would in fact modify "…the method used to determine the case mix adjustment for periods prior to June 30, 2019."

Contrary to the law, the State also failed to furnish the Workgroup with the "case-mix data and related analyses conducted by the department with respect to the department's implementation of the July 1, 2019 change in methodology." Furthermore, the Workgroup was not provided with any information as to how the $246 million in estimated savings was arrived at by the State. We believe this contravenes the law establishing the Workgroup and attempts to circumvent the preliminary injunction issued on Nov. 7. 2019 in *LeadingAge New York et al v. Zucker et al* [NYS Supreme Court, Albany County, Index No. 907319-19] (the "*LeadingAge NY* case").

2. ***The Department failed to properly notify the public that this regulation was under consideration.*** This proposed regulation was not listed in DOH's 2019 or 2020 Regulatory Agenda, contrary to the New York State Administrative Procedures Act § 202-d. The proposed rule, which was published in the Jan. 29, 2020 *State Register*, indicates it was not included in the agenda because it was not under consideration at the time DOH submitted the agenda for publication. In fact, as previously noted, DOH had already indicated its intent to proceed with the methodology in question in May 2019 during the Workgroup proceedings. The 2020 agenda itself was published in the same edition of the State Register, so the omission suggests this rulemaking has been proposed in response to arguments made in the previously referenced *LeadingAge NY* case.

3. ***The proposed regulations would retroactively change CMI calculations for at least two rate periods.*** The proposed rulemaking would result in major changes to nursing homes' Medicaid rates nine months after the fact (i.e., more than nine months has elapsed since July 1, 2019), and would also affect rate calculations for the six-month rate period beginning Jan. 1, 2020. According to the adoption notice for the regulations underlying the current statewide pricing methodology [see NYS Public Health Law (PHL) § 2808(2-c)]:

   > "The new pricing reimbursement methodology reforms and replaces an outdated, complex, and administratively burdensome (to both providers and the Department) rate-setting system **with a stable, predictable and transparent methodology** that rewards efficiencies and incentivizes quality outcomes."[1] **[Emphasis added]**

   DOH is proposing to retroactively change a major component of the rate-setting methodology without affirmative statutory authorization, and contrary to the requirement of PHL § 2807(7) that Medicaid rate changes require 60 days' prior notice in advance of the effective date of such rates. We believe this is wholly inconsistent with the stated intent of the regulations in that it would not only destabilize the rates and make them more unpredictable, it would also make them less transparent (i.e., by using MDS datasets that are not subject to provider verification).

4. ***Removal of the 5 percent constraint will add to rate volatility and is contrary to state law.*** The proposed regulatory amendments would eliminate the 5 percent limitation on changes to each facility's CMI from one rate period to the next. The 5 percent constraint has served to add stability to facilities' rates by limiting positive or negative CMI changes to 5 percent, and holding any payment adjustments associated with the change over 5 percent pending an audit by the Office of the Medicaid Inspector General (OMIG) to verify the accuracy of the reported data. While the

[1] Notice of Adoption dated Feb. 9, 2014. Posted at: https://regs.health.ny.gov/sites/default/files/pdf/recently_adopted_regulations/2014-02-19_statewide_pricing_methodology_for_nursing_homes.pdf.

constraint has most often served to limit increases in CMI, the proposed methodology as applied to the July 2019 rates would result in rate reductions for 89 percent of all nursing homes, many of which would experience decreases of greater than 5 percent in their CMIs. In this context, eliminating the constraint seems opportunistic and runs counter to the claim in the regulatory notice, that the methodology: "…will also smooth the rates for facilities allowing for more accurate forecasting." It is also contrary to PHL § 30 (i.e., the legislative intent of establishing the OMIG was to create a "more efficient and accountable structure" for targeting Medicaid waste, fraud and abuse) and PHL § 2808(2-b)(b)(ii), which requires that the Commissioner's CMI regulations provide for audit review.

5. ***The July 1, 2019 rates would be based on less timely resident assessment data.*** Under the existing methodology, there is an approximate six-month gap between the resident census collection date and the rate period to which it applies. Under the proposed regulation, the July 1, 2019 rates would be based on MDS data for the period August 2018 through March 2019. In this case, the MDS data used to calculate the July 2019 rates could be up to 11 months old. Relying on MDS data that are farther removed in time from the Medicaid rates of payment they are used to calculate cannot be expected to result in more "accurate case mix calculations" as suggested in the regulatory notice.

6. ***The new methodology is not transparent and may result in inaccurate payment.*** Contrary to the underlying intent of the statewide pricing methodology (see point #2 above), the new CMI determination methodology is not transparent and would not give facilities the ability to validate the MDS data that would be utilized in CMI calculations. Despite requests during and after the Workgroup process for an explanation as to why an 8-month period of MDS data would be used for the July 2019 rates instead of the normal 6-month period, DOH offered no satisfactory explanation. Furthermore, under the existing CMI determination methodology, nursing homes are given the ability to verify that the correct MDS assessments are being used in the data collection, and that key data elements such as the payer code and entries that determine eligibility for rate add-ons (e.g., TBI extended care, bariatric care, etc.) are correctly picked up. When DOH applied the new methodology to the July 1, 2019 rates, facilities were not permitted to verify that the correct MDS assessments were utilized, nor were they permitted to verify data relating to payer code or rate add-ons. Without this validation, facilities would have no assurance that the rates for periods on or after July 1, 2019 are correctly based on the CMI scores of Medicaid residents or that they are receiving the rate add-ons required by existing regulations.

7. ***The proposed change could negatively impact beneficiary access to quality care.*** By far, our biggest substantive concern is the major fiscal impact that DOH's proposed methodology will create retroactive to July 1, 2019, and how it will affect the provision of resident care throughout New York. According to a November 2018 report from a national accounting firm, New York's Medicaid program paid the average nursing home in New York 20 percent less than its actual costs of providing care, a $64 per patient per day shortfall.[2]

[2] *A Report on Shortfalls in Medicaid Funding for Nursing Center Care*, Hansen Hunter & Company, PC, Nov. 2018: https://www.ahcancal.org/facility_operations/medicaid/Documents/2017%20Shortfall%20Methodology%20Summary.pdf.

The average 2017 operating margin for New York's nursing homes was -1.3 percent, while the median value was 1.02 percent.[3] Overlaying the case-mix cut on 2017 operating performance results in a statewide average operating margin of -3.2 percent and a median value of - 0.95 percent, and would increase the proportion of nursing homes with negative operating margins from 41 percent to an estimated 56 percent.[4] Negative operating margins are unsustainable and are associated with business failures. Indeed, 12 nursing homes have closed in New York since 2014 and another 4 were merged into other facilities. The average occupancy rate in New York is relatively high; over 10 percentage points higher than the national average and tied for second among all the states.[5] Higher occupancy rates make it more likely that facility downsizings and closures could adversely affect Medicaid beneficiary access to nursing home care.

The CMI change will further damage those facilities offering the highest quality of care, based on the CMS 5-Star Rating system. Forty-three percent of the nursing homes projected to have negative operating margins after the CMI change are 4-Star or 5-Star facilities, and 20 percent of the facilities projected to have a negative operating margin after the change are 5-Star facilities. Put another way, we estimate that half of the 5-star nursing homes in the State for which financial information is available will have a negative operating margin if this CMI change is implemented. This runs counter to the intent of the statewide pricing methodology, which is to incentivize quality outcomes (see point #2 above).

8. ***The proposed regulation will likely increase costs to regulated entities.*** The regulatory flexibility analysis incorrectly claims that the proposed regulation will "streamline reporting requirements and reduce administrative burdens for all nursing homes" and that there will "be no additional costs to private regulated parties." We acknowledge that facilities would no longer have the administrative responsibility of submitting census rosters to DOH, which would save some clerical time. However, basing the CMI calculations on all assessments performed on Medicaid residents will require facilities to expend considerable additional nursing time to carefully validate all RUG-III scoring elements in all MDS assessments conducted, as well as to complete additional MDS assessments that would not otherwise be performed in order to capture any changes in RUG-III scoring elements that would affect Medicaid reimbursement.

We agree the State should have a dependable method for evaluating resident acuity that relies on accurate assessment data and provides a consistent approach. Under the current State Plan, the OMIG is tasked with auditing the data that is the basis for nursing home CMI adjustments. As previously noted, the existing approach places a limit of 5 percent on period-to-period changes to each facility's CMI, pending completion of an OMIG audit for that rate period. We believe this helps to ensure the integrity and consistency of resident acuity adjustments to Medicaid rates.

A change of this importance should be undertaken prospectively, in a carefully considered and transparent way, to ensure the integrity of acuity adjustments, improve process efficiency, and minimize unintended consequences. To do otherwise will destabilize nursing home finances and

[3] Based on 2017 cost report data for the 535 of New York's nursing homes for which nursing home-specific operating performance could be calculated.

[4] Calculated by allocating the estimated impact of the case-mix cut to each facility based on 2017 Medicaid volume.

[5] *Nursing homes, beds, residents, and occupancy rates, by state: United States, selected years 1995–2016*, Centers for Disease Control, 2017: https://www.cdc.gov/nchs/data/hus/2017/092.pdf.

threaten Medicaid beneficiary access to high quality nursing home care. For these reasons and in light of the preliminary injunction issued in the *LeadingAge NY* court case, we respectfully urge DOH to not take any action on the proposed regulations.

Conclusion

Thank you for the opportunity to provide input on the proposed regulations. If you have any questions on our comments, please contact me at (518) 867-8383 or dheim@leadingageny.org.

Sincerely,

Daniel J. Heim
Executive Vice President