July 16, 2019

Mr. Ricardo Holligan
Acting Associate Regional Administrator
Department of Health & Human Services
Centers for Medicare & Medicaid Services
New York Regional Office
Division of Medicaid and Children's Health Operations
26 Federal Plaza - Room 37-100 North
New York, New York 10278

RE: SPA NY-19-0033: Long Term Care Facility Services

Dear Mr. Holligan:

On behalf of our respective provider memberships, we collectively write to express grave concerns about the change in acuity adjustments to the July 1, 2019 Medicaid rates for nursing homes proposed by New York under Medicaid State Plan Amendment (SPA) #19-0033. Based on the potential for this proposed retroactive change in methodology to destabilize nursing home finances and endanger beneficiary access to quality care, we respectfully urge the Centers for Medicare & Medicaid Services (CMS) to disapprove SPA NY-19-0033.

The State proposes a retroactive change to the methodology used to determine the case-mix adjustment to the direct component of Medicaid rates for the rate period effective beginning July 1, 2019. Case-mix adjustments are made to Medicaid rates semi-annually in January and July. The current method – which has been in place for several years – relies on a semi-annual snapshot taken on a specified date in January and July of each facility's roster of Medicaid residents and the most date-proximate minimum data set (MDS) assessment for each resident. The case-mix 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 case-mix data, etc.).

The State instead proposes to use the MDS assessments for all Medicaid residents submitted to CMS during the period August 8, 2018 - March 31, 2019 to determine the

case-mix adjustment to rates for the July 1, 2019 rate period. The State has not explained the rationale for its proposed use of data for a 235-day period in this calculation. More importantly, the State would be changing the methodology retroactively, and would arbitrarily utilize MDS data for a previous time period that are unrepresentative of the assessments and responses that affect case-mix determination.

Our specific procedural and substantive concerns with SPA NY-19-0033 follow:

1. **The State's public notice did not include sufficient information to ensure that interested parties could provide meaningful input prior to SPA submission.** Federal regulations at 42 CFR § 447.205 require states to issue public notice of proposed changes in statewide methods and standards for setting Medicaid payment rates. Among other things, these notices must: (1) describe the proposed change in methods and standards; (2) give an estimate of any expected increase or decrease in annual aggregate expenditures; and (3) explain why the agency is changing its methods and standards.

   A public notice was published by the NYS Department of Health (NYSDOH) in the *NYS Register* on March 27, 2019, which incorporated various proposed changes to Medicaid payments and included only the following wording on the change proposed in SPA NY-19-0033:

   > "Effective on or after April 1, 2019 nursing home reimbursement case mix collections which impact the direct price component of nursing home Medicaid reimbursement. The direct statewide price shall be adjusted by a Medicaid-only case mix and shall be updated for a Medicaid-only case mix in January and July of each year, using the case mix data applicable to the previous period.
   >
   > The estimated annual net aggregate decrease in gross Medicaid expenditures attributable to this initiative contained in the budget for state fiscal year 2019-2020 is ($191 million)."

   This wording neither describes the proposed change in methods and standards, nor does it explain why the agency is changing its methods and standards. It simply restates the general approach to case-mix adjustment which existed prior to April 1, 2019 and that would continue under the proposed SPA. Furthermore, the published negative impact of the proposed change is considerably and inexplicably less than the estimated $245.6 million impact that is reflected in the enacted NYS Budget for State Fiscal Year 2019-20 and the State's financial plan.

2. **The proposed change in methodology is at odds with the New York State legislation which references it.** The SPA wording indicates that the proposed amendment is being submitted based on enacted legislation. Chapter 57 of the Laws of 2019 incorporated the following language referencing a change in the methodology utilized to calculate case-mix (i.e., resident acuity) 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, the State clearly indicated its intent to unilaterally revise the methodology used to determine the case-mix adjustment for the July 1, 2019 rates in an effort to achieve a reduction of at least $122.8 million in state spending ($245.6 million of total provider impact, inclusive of federal funding) over the balance of the State's fiscal year ending March 31, 2020. This approach would, contrary to Chapter 57, change the method used to determine the case-mix adjustment for periods prior to June 30, 2019 using unrepresentative patient assessment data from the period August 8, 2018 through March 31, 2019. Under the current State Plan, the two case-mix adjustments made to Medicaid rates effective for January 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 case-mix adjustment using data from August 2018 – March 2019, the State is in fact modifying "…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 $245.6 million in estimated savings was arrived at by the State.

3. **We have no evidence indicating that the State properly undertook and documented public input processes related to access to care prior to submitting this SPA.** Under the regulations at 42 CFR § 447.204, prior to submitting SPAs to CMS, states must make

information available so that beneficiaries, providers and other stakeholders may provide input on beneficiary access to the affected services and the impact that the proposed payment change will have, if any, on continued service access. Under these requirements, states are expected to obtain input from beneficiaries, providers and other stakeholders, and analyze the input to identify and address access to care concerns. States must obtain this information before submitting a SPA to CMS, and maintain a record of the public input and how the agency responded to the input. When a state submits the SPA to CMS, the regulation requires the state to also submit a specific analysis of the information and concerns expressed in input from affected stakeholders.

The NYSDOH first made its specific plans to revise the case-mix methodology known at a provider Workgroup meeting (see Workgroup discussion above) on May 22, 2019. The Workgroup meetings were not subject to the NYS Open Meetings Law [NYS Public Officers Law, Article 7] and thus were not open to members of the public including beneficiaries, providers not named to the Workgroup, and other stakeholders. The potential impact of the proposed payment change on access to care was not, and could not be, meaningfully discussed by the Workgroup without knowing how the change would impact specific facilities and regions of the State. To our knowledge, the State has not as of yet shared its estimated facility-specific or regional impacts with any external parties.

4. **We have substantive concerns about the impact that the proposed SPA could have on beneficiary access to quality care.** By far, our biggest substantive concern is the large and unpredictable fiscal impact that DOH's proposed methodology will create effective July 1, 2019, and how it will affect the provision of resident care throughout New York.

New York's Medicaid reimbursement to nursing homes is based on facility costs incurred in 2007, and providers have received no inflation adjustment since 2007. 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.[1]

The average 2017 operating margin for New York's nursing homes was -1.3 percent, while the median value was 1.02 percent.[2] These figures take into account all patient care revenues (including Medicare, private pay and other insurance) and other operating income. 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

[1] *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.

[2] 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.

to an estimated 56 percent.[3] 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 of the states.[4] Higher occupancy rates make it more likely that facility downsizings and closures could adversely affect Medicaid beneficiary access to nursing home care.

The case-mix cut 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 case-mix 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 case-mix cut is implemented.

We agree that 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 NYS Office of the Medicaid Inspector General ("OMIG") is tasked with auditing the data that is the basis for nursing home acuity adjustments. The existing approach places a limit of 5 percent on period-to-period changes to each facility's case-mix, pending completion of an OMIG audit for that rate period.[5] We believe this helps to ensure the integrity and consistency of resident acuity adjustments to Medicaid rates.

New York state hospitals continue to shift patients with lower inpatient acuity to more appropriate outpatient and post-acute providers resulting in more medically complex patients receiving care in those settings. New York's nursing homes have increased their capabilities to serve residents with more complicated medical conditions and managing-in-place conditions that previously required hospitalization both reducing hospital admissions and length of stay. At the same time, the increased availability of services in the community including assisted living, home care and adult day services has decreased the number of lower-need individuals living in nursing homes. These changes are in line with New York State's Section 1115 Medicaid Redesign Team waiver program and Medicare policy initiatives and have resulted in an increase in the average acuity of the nursing home population, further calling the State's proposal into question.

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

[4] *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.

[5] The State does not intend to apply the 5 percent constraint to the July 1, 2019 rates which apparently would expedite promulgation of rates reflecting case-mix changes greater than 5 percent. Whether this policy change would continue and how it would affect selection of facilities for OMIG audit is unknown.

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 threaten Medicaid beneficiary access to high quality nursing home care. For these reasons, we respectfully urge CMS to disapprove SPA NY-19-0033.

Sincerely,

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