

NYAHS 2011 Financial Managers Annual Conference

Department of Health

September 15, 2011

Nursing Home Discussion Topics

- ▶ Medicaid Global Spending Cap
- ▶ Update on Implementation of Enacted Budget Rate Setting Adjustments
- ▶ MDS Submissions
- ▶ 2010 Cost Reports
- ▶ Financially Disadvantaged Restructuring Plans
- ▶ Negotiated Appeal Settlement Program
- ▶ Sprinklers
- ▶ Recent Weather Events

Global Medicaid Cap

- ▶ Two-year State share actual dollar cap
 - \$15.3 billion SFY 2011-12
 - \$15.9 billion in SFY 2012-13
 - 4 year spending cap linked to 10 yr. Avg. rate for the LT medical component of the CPI (currently estimated at 4%).
- ▶ Health Care Industry challenged to control costs
- ▶ “Super powers” established to ensure that cap is not exceeded
 - DOH and DOB will closely monitor spending – monthly reports available at DOH Website
 - Medicaid Savings Allocation Plans could include modifying/suspending reimbursement methods (e.g., fees, premium levels, rates) and modifying program benefits

Medicaid Global Spending Cap Report ~ July 2011

- ▶ Total Medicaid State spending for all categories of service through July 2011-12 exceed projections by \$35.2 million (.6%)
- ▶ Nursing home spending is roughly on track with projects – actual spending exceeded projections by just 1.3% or \$15.4 million

Medicaid Global Spending Report – July 2011			
Category of Service	Medicaid Spending (Thousands)		
	<u>Estimated</u>	<u>Actual</u>	<u>Variance</u>
Inpatient	\$728,488	\$725,467	(\$3,021)
Outpatient/Emergency Room	\$133,546	\$114,519	(\$19,027)
Clinic	\$139,699	\$146,815	\$7,116
Nursing Homes	\$1,148,708	\$1,164,090	\$15,382
Other Long Term Care	\$668,092	\$661,812	(\$6,280)
Medicaid Managed Care	\$1,182,618	\$1,184,244	\$1,626
Family Health Plus	\$229,668	\$252,935	\$23,268
Non-Institutional / Other	\$1,469,788	\$1,484,403	\$14,615
Cash Audits	(\$118,841)	(\$117,338)	\$1,503
TOTAL	\$5,581,766	\$5,616,947	\$35,181

Update: Nursing Home Rate Setting Schedule

Rate Schedule	Anticipated Date of Payment
<ul style="list-style-type: none"> •Rebasing Rates •Nursing Home Remediation Payments (+\$276.6 M) •2010 Capital Rates 	<p style="text-align: center;">Checks Dated June 27 Paid July 13</p>
<p>2008 Cash Receipts Assessment Reconciliation (+\$61M)</p>	<p style="text-align: center;">Checks Dated June 27 Paid July 13</p>
<p>UPL Payments for Public Facilities</p> <ul style="list-style-type: none"> •2009 (\$167 million) •2010 (\$ 189 million) •2011 Pending CMS Approval/Pricing Methodology 	<p style="text-align: center;">Letter sent in August 2011 informing providers of the payment amounts</p>

Update: Nursing Home Rate Setting Schedule

Rate Schedule	Anticipated Date of Payment
July 2010 Case Mix Adjustment	Rates Anticipated to be sent to eMedNY in October
2011 Trend Factor Increase 1% Applicable to Jan, Feb, Mar 2011 (CMS Approval SPA 11-65, August 18, 2011 to eliminate trend effective April 1, 2011)	
Uniform Rate Reduction of \$27.1 million April, May, June 2011 (CMS Approval SPA, 11-60, July 18, 2011)	
2011 Capital Rates	
Shift Reimbursement of Drugs from NH Rate to FFS	

Rates Anticipated to be Sent to eMedNY in October

July 1, 2010 Rates

- April 1, 2010 rates modified to reflect Medicaid Only Case Mix Update for July 2010 MDS (final case mix adjustment for 2002 re-basing)
- Recalculated scale back adjustment

January 1, 2011 Rates

- Modified to reflect Medicaid Only Case Mix Update for July 2010
- Recalculated scale back adjustment
- 2011 Capital Rates
- 2011 Trend Factor Increase (applicable to Jan Feb March 2011)

April 1, 2011 Rates

- Modified January 1, 2011 rate to eliminate 2011 trend factor
- Reflect per diem adjustment to effectuate \$27.1 million uniform rate reduction

May 1, 2011 Rates (Only for Homes Receiving Remediation Payments)

- Modified to reflect Medicaid Only Case Mix Update for July 2010
- Recalculated scale back adjustment
- 2011 Capital Rates
- Reflect per diem adjustment to effectuate \$27.1 million uniform rate reduction

Rates Anticipated to be Sent to eMedNY in October

June 1, 2011 Rates (Only for Homes Receiving Remediation Payments)

- Modified to reflect Medicaid Only Case Mix Update for July 2010
- Recalculated scale back adjustment
- 2011 Capital Rates

July 1, 2011 Rate

- April 1, 2011 or June 1, 2011 rate, as applicable, modified to eliminate the uniform rate reduction

July 7, 2011 Rates

- July 1, 2011 rate modified to reflect the shift of reimbursement of prescription drugs from the NH rate to fee-for-service

Plan for Recoupment Percentages Remains in Effect

- ▶ For those homes identified as financially vulnerable the recoupment percentage is automatically set at 5%
- ▶ For those homes not identified as financially vulnerable, the recoupment percentage is set at 10%
- ▶ Homes that currently have a negotiated recoupment percentage lower than the 5% or 10% (depending on which they qualify for) would be recouped using the negotiated percentage
- ▶ For homes with no previous active recoupment the first cycle percentage is 15%

2011-12 Budget Authorizes Pricing Methodology

- ▶ Statewide Price with a Wage and Medicaid Only Case Mix adjustment
 - Effective 10/1/11 (no later than 1/1/12)
 - Transition Pool (Minimum of 4 years)
 - Establish a Quality Pool
- ▶ JATF worked collaboratively but could not reach full consensus
- ▶ Department appreciates JATF efforts and will continue to collaborate with the Nursing Home Industry to develop methodology and implement pricing

Principles of Medicaid Pricing Methodology

- Be transparent and administratively efficient; be predictable and facilitate timely payments
- Pay reasonably and adequately for quality care for Medicaid patients
- Encourage cost-effective care and promote efficiencies
- Include appropriate payment adjustments to reflect cost-influencing factors
- Encourage and reward quality care and promote care innovations
- Encourage care in the appropriate setting; assure adequacy of alternate settings
- Be updated periodically
- Comply with Federal Medicaid rules
- Reinforce health systems planning and advance state health care programs
- Be consistent with available resources

MDS Submissions

- ▶ Roster Submissions and Resulting MDS data is complete for:
 - January 2009 (effective in April 1, 2009 rates)
 - July 2009
 - January 2010
 - July 2010 (Case mix adjustments will be reflected in rebasing rates schedule to be sent to eMedNy in October)
 - January 2011 (will not be used for case mix update in 2002 re-basing)
- ▶ July 2011 submission
 - Census Date: July 27, 2011 (All Residents in house, Regardless of Payer)
 - Upload Period has been expanded to three weeks:
 - October 3, 2011 – October 21, 2011

Statewide Case Mix Changes

Statewide CMI	January 1, 2009	July 1, 2009	January 1, 2010	July 1, 2010	January 1, 2011
All Payer	1.0602	1.0972	1.1055	1.1238	1.0977
Medicaid Only	0.9381	1.0043	1.0103	1.0376	1.0064

- ▶ Statute requires rebasing rates to be updated to reflect case mix changes for April 1, 2009 (January 2009), July 1, 2009, January 1, 2010 and July 1, 2010
- ▶ Rebasing rates not subject to January 2011 or July 2011 case mix adjustments
 - However, case mix data for these periods may be used in the pricing methodology

2010 Cost Reports ~ 2011 Capital

- ▶ 2010 Cost Reports Cost were due July 29, 2011
- ▶ For second consecutive year, time allotted to file nearly doubled from 60 days to about 120 days
- ▶ More time is working – only 41 facilities did not meet the July 29, 2011 due date
 - Late filers subject to penalties – Medicaid rate reduced by two percent beginning on the first day of the calendar month following the original due date of the report and continuing until the last day of the calendar month in which the report is properly filed.
- ▶ Department anticipates releasing 2012 initial capital rates November 2, 2011

2009 FD Payments & Restructuring Plans

- ▶ 81 homes received 2009 FD Payments
- ▶ Statute enacted in 2009 requires facilities that receive FD Payments to Submit Restructuring Plans
- ▶ Plans were due
 - August 22, 2011 (if FD payment \$400,000 or more)
 - October 21, 2011 (if FD payment less than \$400,000)
- ▶ Failure to submit/implement Plan disqualifies Facility from future participation in FD program and requires the recoupment of FD payments
- ▶ Restructuring Plans should reflect steps facility will take to improve operational efficiency, align revenues with expenditures, with schedule of benchmarks for implementation and periodic reports to DOH
 - See October 2, 2009 DAL posted on the HCS for additional information

Negotiated Appeals Settlement Program

- PHL Section 2808(17)(b) authorizes the Department to:
 - Enter into negotiated agreements with nursing homes to resolve multiple pending rate appeals
 - Use the proceeds of settlement agreements to reduce/offset outstanding liabilities (e.g., cash receipts assessments, Medicaid liabilities) due to the Department
 - Prioritize the processing of settlement agreements with nursing homes experiencing financial difficulties

Authorization for the Appeals Settlement Program

- **Every nursing home is eligible to participate in the Program**
- Consistent with the statute and to effectively manage the Program, the Department will process Appeal Settlements in Phases
 - The first several Phases of the Program will focus on NHs experiencing financial difficulties - 118 homes that were eligible for 2009 Financially Disadvantaged Funding and had negative operating margins of 5% or more
 - Phase I is now underway - 50 homes were invited to participate (July 29, 2011 DAL)
- The statutory authority for the Program does **not** expire, and will remain an important, collaborative tool for the Department and NHs to eliminate the back log of appeals

Objectives of the Settlement Program

- ▶ Important element of the Department's efforts to reform the reimbursement methodology and transition to a transparent pricing methodology
- ▶ Eliminates the backlog of appeals
 - Process **ALL** outstanding appeals for facilities that participate in the Program
- ▶ Fosters collaboration and exchange of information between the Department, the Nursing Home and its consultants
 - Streamlines the processing of appeals by sharing estimates and eliminating burdensome paperwork
 - Finalizes appeals in a Settlement Agreement, eliminating the re-appeal of processed appeals
- ▶ Improves the overall financial condition of facilities – particularly in the early Phases of the Program which focus on homes facing financial challenges

Key Elements of Finalized Settlement Agreements

- ▶ Resolve **ALL** outstanding, timely filed appeals on file with the Department
- ▶ Calculate the **actual value** of each outstanding appeal
 - The value of all appeals must be calculated in accordance with rate setting methodology established by statute and regulation and use documented and certified information
- ▶ Negotiate the estimated value of appeals for which limited information is available to both the NH and the Department
 - Negotiated amounts (e.g. where limited information is available) **must** be supported by a reasonable methodology and appropriate supporting information
 - Rebasings, APCs, Budget-to-Cost Based Appeals, and New Rates will **not** be part of the settlement process but will be processed under the traditional approach at the same time as the settlement.

Key Elements of Finalized Settlement Agreements

- ▶ Negotiated Settlement Agreement
 - Agreement is signed by all parties - the NH, the Department and OMIG
 - Provides for resolution/disposition of All Outstanding Appeals
 - Provides appeals are not subject to adjustment on audit or administrative or judicial review
 - Specifies the disposition of each item of each appeal for example, approved or partially approved \$ amount, appeal has already been processed

The Settlement Process

- ▶ Upon completion of settlements for Phase I homes that choose to participate, the Department will initiate Phase II, and will continue until every home has the opportunity to participate
- ▶ The Department will process settlements, generally in the order in which Letters of Interest are received
- ▶ If the appeals cap is reached, the Department will continue to finalize settlements and will process them for payment (in the order they were finalized) as room becomes available
 - The cap grows to \$80 million in 2012-13

Sprinklers

- ▶ The Centers for Medicare and Medicaid (CMS) have mandated all nursing homes be equipped with supervised automatic sprinkler systems by **August 13, 2013**
- ▶ MRT Initiative – Explore options (e.g., consolidated financings) to help homes secure financing (could involve DASNY) and to keep costs down
- ▶ DOH has been working with Associations to identify NHs that are facing financial challenges and may have difficulty securing financing
- ▶ Status – Based on preliminary data approximately:
 - 307 homes are sprinkler compliant
 - 121 homes are involved in CON process
 - 141 homes have indicated they are not sprinkler compliant but have not (to date) become engaged in CON process

Reimbursement and Billing Procedures for Medicaid Facilities Who Provided Assistance During Storms

- ▶ **General Principles:**
 - Medicaid intends on paying claims in a timely fashion to avoid cash flow issues for healthcare facilities as a result of this emergency
 - Payments will be developed using policies and existing state plan methodologies where applicable to develop fair and equitable payments for both evacuated and receiving facilities related to patient care
 - We are working with CMS to assist us in developing payment policies
- ▶ Provider impact survey – assess the scope of damage
- ▶ Additional information will be provided in the coming weeks