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MEMORANDUM

TO: RHCF Members

FROM: Darius Kirstein, Senior Policy Analyst

DATE: January 13, 2010

SUBJECT: **Nursing Home Medicaid Rates Now Available**

ROUTE TO: Administrator, CFO

ABSTRACT: 2009-10 nursing home Medicaid rate sheets have been posted on the HPN.

Introduction

Earlier today, the Department of Health (DOH) sent nursing home HPN Coordinators an e-mail announcing that nursing home Medicaid rate packets for 4/1/09 and 1/1/10 are available for download from the Health Provider Network (HPN). The rate packets are each comprised of three PDF documents and are accompanied by “*Dear Administrator*” letters (DALs) that provide details of the rate calculations.

The rates are based on 2002 costs, utilize the rebasing methodology enacted in 2006 and incorporate the change to a Medicaid-only case-mix index based on RUG-III. Facilities with base years newer than 2002, have their base year costs de-trended to 2002 for purposes of corridor comparisons and re-trended to the rate year. Specialty facility/unit rates are included and the impact of eliminating the occupancy adjustment factor is reflected in the rates for AIDS facilities/units.

The operating component of the rates is constrained to ensure that the total statewide increase is \$210 million when compared to current rates. The DAL reminds providers that approvals from the Centers for Medicare and Medicaid Services (CMS) and the Division of the Budget are required prior to payment of these rates. NYAHSA will be monitoring this situation closely.

Accessing the Rates

To download the rates from the HPN:

1. log in at <https://commerce.health.state.ny.us>;

2. Click on “Programs” under the INFO BY TOPIC heading;
3. Click on “Division of Health Care Financing” under the heading “Office of Health Insurance Programs”; and
4. Under the heading “Nursing Homes” click on “Nursing Home Rate Sheets 4/1/2009 and Forward.”

The DALs are attached as Attachments [1 \(for 4/01/09\)](#) and [2 \(for 1/1/10\)](#).

A previous DAL providing detailed instruction on how to file appeals via the HPN may be accessed [here](#). Please keep in mind that based on recent legislation, DOH will only accept operating component appeals for the correction of computational errors or omissions of data based on information previously submitted. No updates or corrections to the operating component of the rate that would require the re-filing of a cost report is permitted.

Rate Review Webinar

NYAHSa and our JATF colleague associations are sponsoring two Webinars to review the new rate sheets that will be conducted by staff of DOH’s Bureau of Long Term Care Reimbursement. The Webinars will provide a review of the rate sheets and an opportunity for participants to submit questions electronically and have these questions addressed during the DOH presentation.

DOH has promised to post the answers to all submitted questions on the HPN subsequent to the events. An archived version of the Webinar itself will be posted on our Web site.

The Webinars are scheduled for:

Friday, January 15th, 1 to 3 PM and Tuesday, January 19th, 1 to 3 PM

The Webinars are free to NYAHSa members but space is limited to one line per facility and registration is required.

To register, access the appropriate link below and follow the instructions provided.

January 15th: http://www.hanys.org/events/?event_id=189

January 19th: http://www.hanys.org/events/?event_id=190

We urge facilities to ensure that the proper software is installed on their computers prior to the event. Members are encouraged to submit questions in advance to dkirstein@nyahsa.org. Please enter “Webinar Question” in the subject line.

Major Changes Since the Previous Issuance

The rate sheets are organized in a similar way as the rebased notice rates issued in December 2008 that were subsequently invalidated by legislation delaying rebasing until 4/1/09. The new rate sheets incorporate a variety of updates, including recalculated peer group means, new CMI figures and the constraint to \$210 million of the statewide spending increase of the net impact of

rebasings and the imposition of a Medicaid-only CMI. Major changes from the December 2008 rate sheet issuance are highlighted below.

Medicare Part D Offset

The rate sheets reflect a recalculated Medicare Part D offset based on 2002 (or subsequent base year) prescription drug costs. For most facilities, this offset is higher than prior to rebasing and higher than the offset displayed in the December 2008 rebased notice rates. Because DOH had not finalized the new Part D offset at the time that the December 2008 rebased notice rates were issued, those rate sheets still displayed the pre-rebasing Part D offset.

Case-Mix Index (CMI)

The largest difference from the previous rate calculations is the incorporation of a Medicaid-only CMI adjustment. Schedule 4 of the new rate sheet provides a breakdown of base year and current CMIs and change percentages that are applied to the direct component. Further in the packet, members will find schedules displaying the calculation of the CMI along with resident counts by MDS RUG category. While members should be able to validate the 2009 counts to their January 2009 census roster submission, the base year MDS summary sheet will reflect DOH's mid-point methodology which is difficult for facilities to replicate.

Additionally, most facilities will find that their base year "frozen" CMI in these rates will be noticeably lower than that shown in the December 2008 notice rates. This is due to the adjustment that DOH applied to correct for the oversampling effect that caused Medicare MDSs to have a larger impact than warranted on the CMI in their original calculation. DOH applied a weighing factor (based on reported base year Medicare and non-Medicare days) to resident counts which explains the unusually high patient count numbers shown on the Frozen Facility MDS Summary schedule.

A lower base year CMI results in a larger percent increase in CMI from base year to current year, seemingly increasing each facility's rate. However, these rate increases may be illusory, because the total statewide annual benefit is constrained to \$210 million.

Both sets of rates reflect the CMI collected during the January 2009 roster submissions. Subsequently, rates effective 7/1/09 through 3/31/10 will be updated using the July 2009 roster submissions. Members are cautioned to keep in mind that because of the \$210 million constraint, a facility that experienced growth in its Medicaid-only CMI from January 2009 to July 2009 may not necessarily see an increase in its rate.

Constraining Payments to \$210 Million

Legislation passed in 2009 requires the statewide annual increase of rebasing (net of the impact of implementing a Medicaid-only CMI) to be \$210 million. The calculated impact of rebasing and Medicaid-only CMI (using January 2009 roster submissions) is \$375 million, meaning that rates must be reduced by \$165 million to conform to the \$210 million figure. DOH achieves this by proportionalizing the \$165 million reduction to all facilities based on their estimated Medicaid revenue.

More specifically, DOH calculates estimated Medicaid revenue for each facility by multiplying the 4/1/09 rate less capital by a facility's 2008 Medicaid days. This annual Medicaid revenue estimate is divided by estimated statewide Medicaid revenue for all nursing homes. The resulting percentage is multiplied by \$165 million to compute the facility-specific reduction to meet the \$210 million constraint. Note that this methodology results in a reduction for every facility and is a change from the methodology the department had originally intended to use.

Hold-Harmless Provision

The 2006 rebasing legislation provides a hold-harmless provision meant to mitigate the impact of rebasing for homes that would see a rate decrease. The Medicaid-only CMI is not part of the hold-harmless, nor is the effect of an increase in a facility's Part D offset.

DOH calculates the hold-harmless provision by comparing a facility's existing operating rate (defined as the sum of the direct, indirect and non-comparable components of the 3/31/09 rate minus the 2008 and 2009 trend factors) to the rebased operating rate calculated using an all-payer CMI. If the existing operating component is higher, DOH starts with that figure and adjusts down to reflect the impact of moving to a Medicaid-only CMI.

Note that any adjustments to the rate (e.g., dementia, TBI, Medicare Part D offset, etc.) are excluded when the hold-harmless test is done, meaning that a hold-harmless facility may see a decrease in their rate even prior to the application of the Medicaid-only impact.

We urge members to review their rates and seek clarifications as needed. If you have questions regarding the rates or information in this memo, please contact Darius Kirstein at dkirstein@nyahsa.org or by phone on 518-449-2707, ext. 104; or Patrick Cucinelli, pcucinelli@nyahsa.org or by phone on ext. 145.