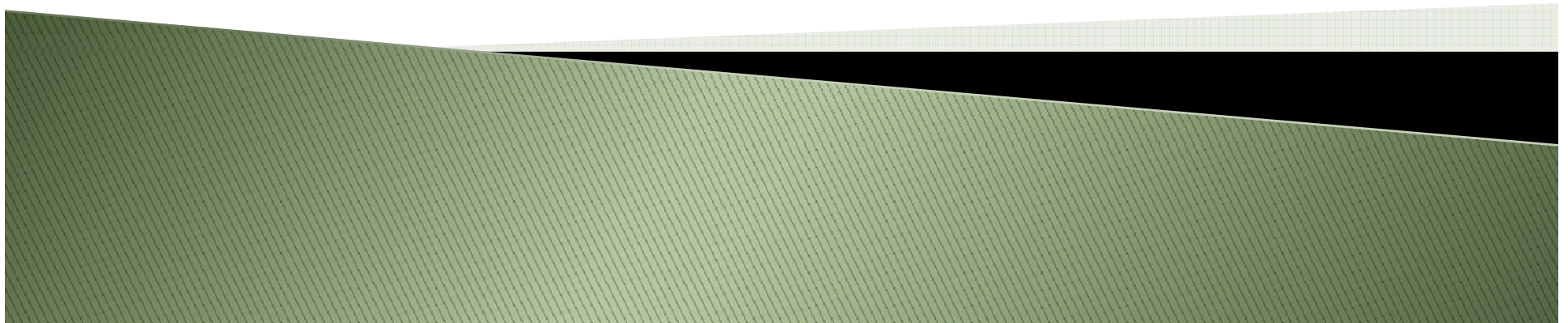


NYAHSA
2009 Annual Conference
for Financial Managers

Department of Health

August 27, 2009



January 28, 2009

Census Roster Upload

- ▶ Initial MDS Census Roster upload in April 2009 identified 150 facilities that failed to file MDS data with Federal database resulting in a significant number of residents that could not be matched to the census roster.
- ▶ DOH policy on unmatched residents is a default to both the lowest RUG III case mix and Medicaid.
 - This would have resulted in a significant reduction in case mix / Medicaid rate for these facilities.
- ▶ To address this issue, DOH notified ALL facilities that they would have until June 5, 2009 to submit MDSs to the Federal database prior to a **one time** re-upload of their census roster for matching to MDS data.
- ▶ The deadline for re-upload was June 24, 2009, of the 150 facilities:
 - 116 facilities successfully matched 100% of their residents
 - 34 facilities did not successfully match 100% of their residents

July 29, 2009 Census Roster Upload

- ▶ Facilities will upload the July 29, 2009 census roster beginning October 5, 2009 and ending October 16, 2009.
- ▶ Facilities are reminded that must have successfully filed MDS data with the Federal/State database for every resident on the July 29, 2009 census roster in accordance with CMS filing requirements.
- ▶ Facilities should be aware that the one time re-upload provided for the January 28, 2009 census roster **will not be repeated for any future MDS Census Dates**

Calculating Base Year MDS Case Mix

- ▶ Based upon Work Group/JATF discussions Department intended to employ Mid-Point methodology ~ thought to minimize the overstatement of case mix related to Medicare patients
- ▶ Methodology would apply to base year full house case mix for April 1, 2009 rates which uses 2002 base year, and April 1, 2010 regional pricing rates which uses 2007 base year
- ▶ JATF (NYAHS, NYSHFA, HANYS) and Department have been discussing other alternative approaches, Department is in process of calculating and evaluating JATF proposed alternative – will impact programming and production of April 1, 2009 rates

Status of Filing of 2008 Cost Reports

- ▶ Over 500 facilities submitted properly filed 2008 Cost Reports by due date of July 17 (cost report)/July 24 (certifications)
- ▶ 52 Facilities Requested an Extension
- ▶ 65 Facilities Did Not File or Request an Extension
- ▶ 70+ Facilities filed certified cost reports but have an incomplete submission due to the failure to file related company financial statements – Department is contacting these facilities directly, statements need to be filed by September 2 to avoid penalty
- ▶ Department granted extension to September 2 (cost report), September 9 (certifications)
- ▶ Facilities that fail to meet Sept 2/Sept 9 deadline will be subject to two percent reduction in facility's Medicaid rate
 - ❖ Penalty is applied from the first day of the calendar month following the **original** due date of the report (i.e., August 1, 2009) and continuing until the last day of the calendar month in which the report is properly filed

Rate Setting Activities

Rate Set	Estimated Schedule/Status
2002 – 2007 Cash Receipts Assessments Reconciliation (Offsets Retro Payments)	To EMedNy: July 17, 2009 DAL Letter Dated: July 21, 2009
2008 Health Recruitment and Retention	To EMedNy: July 22, 2009 DAL Letter Dated: August 17, 2009
January 1, 2009 Rates + # Capital Hotlines	To EmedNY: Week of August 31 DAL Letter: Week of August 31
April 1, 2009 Rates	CMS Approval: Pending To DOB: Around October 1 ~20% 2002 Cost Reports Resubmitted 2002 Allowable Costs ~MDS Census Roster Resubmission ~Consideration for Revising Base Year MDS Case Mix Methodology

Rate Setting Activities

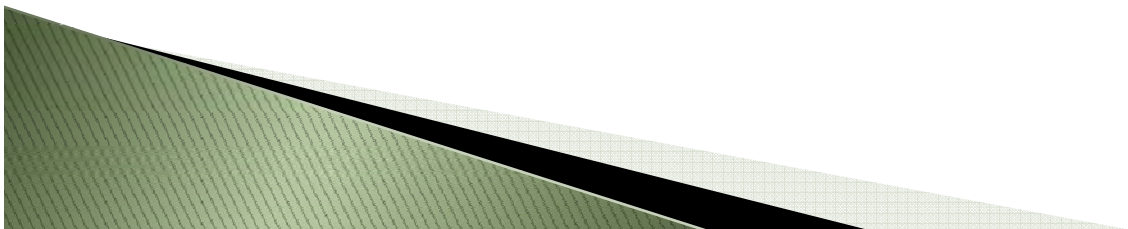
Rate Set	Estimated Schedule/Status
2009 Financially Disadvantaged Payments	CMS Approval: Pending DAL Letter: End of September Describing Legislative Changes To DOB: End of October/November
2009 UPL Payments Public Facilities	CMS Approval: Pending April 1 rates for computation
2010 Initial Capital Rates - 1.1.2010	DAL Letter: November 1, 2010
2008 Cash Receipts Assessments Reconciliation	Last Quarter of 2009
Reconcile 2007 and 2008 Transition Payments – Results in Redistribution of Payments	January 2010
2010 Initial Regional Pricing Rates Operating Component – 4.1.2010	DAL Letter: January 30, 2010

Appeals

- ▶ Staff resources are already constrained and will be impacted by retirements and hiring/fiscal constraints
- ▶ Electronic Submission System ~ Next Phase is to provide for electronic processing, will expedite processing
- ▶ The Department continues to process as many appeals as possible, with focus on 12 month cost reports, financially distressed facilities
- ▶ Department is continuing to evaluate options for addressing outstanding appeals – some issues may be addressed on Statewide basis
- ▶ Regional Pricing/New Legislation will reduce appeals

2009 Legislation ~ Cost Reports and Appeals for Operating Rate

- ▶ Effective April 1, 2009 , the Department will only review administrative rate appeals that relate to the operating component of the rate for the correction of computational errors or omissions of data by the Department based upon the information provided to the department prior to the computation of the rate
- ▶ The Department will not consider any revisions made to a facility's annual cost report for operating rate adjustment purposes later than the due date established by the Commissioner
- ▶ Applies to all non-capital related rate appeals that have not been submitted as of April 1, 2009 (regardless of what rate periods they pertain to)



2009 New Legislation ~ Financially Disadvantaged Payments

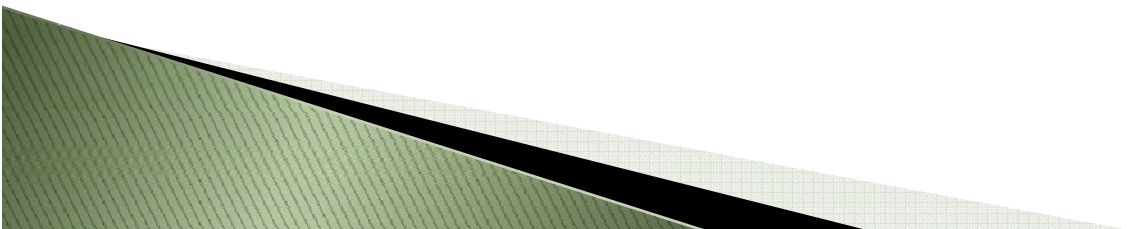
- ▶ **Changes to Financially Disadvantaged payments (\$30 million annually) target facilities most in need by:**
 - **Focusing on facilities with highest negative operative margins (top two quartiles)**
 - **Increasing Medicaid utilization requirement from 50% to 70%**
 - **Increasing the maximum payment from \$400,000 to \$1,000,000**
 - **Excluding public facilities that receive IGT payments**
- ▶ **Requiring a restructuring plan within 60 days of receipt of FD payments (120 days if payment is less than \$400,000)**
- ▶ **Plan 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**
- ▶ **Failure to submit/implement Plan disqualifies Facility from future participation in FD program/recoupment of FD payments**

Value Based Purchasing ~ Effective April 1, 2010

- ▶ April 1, 2010 – New Value Based Purchasing Methodology Takes Effect
 - ❖ Initial rates due 60 in advance of April 1 ~ January 30th

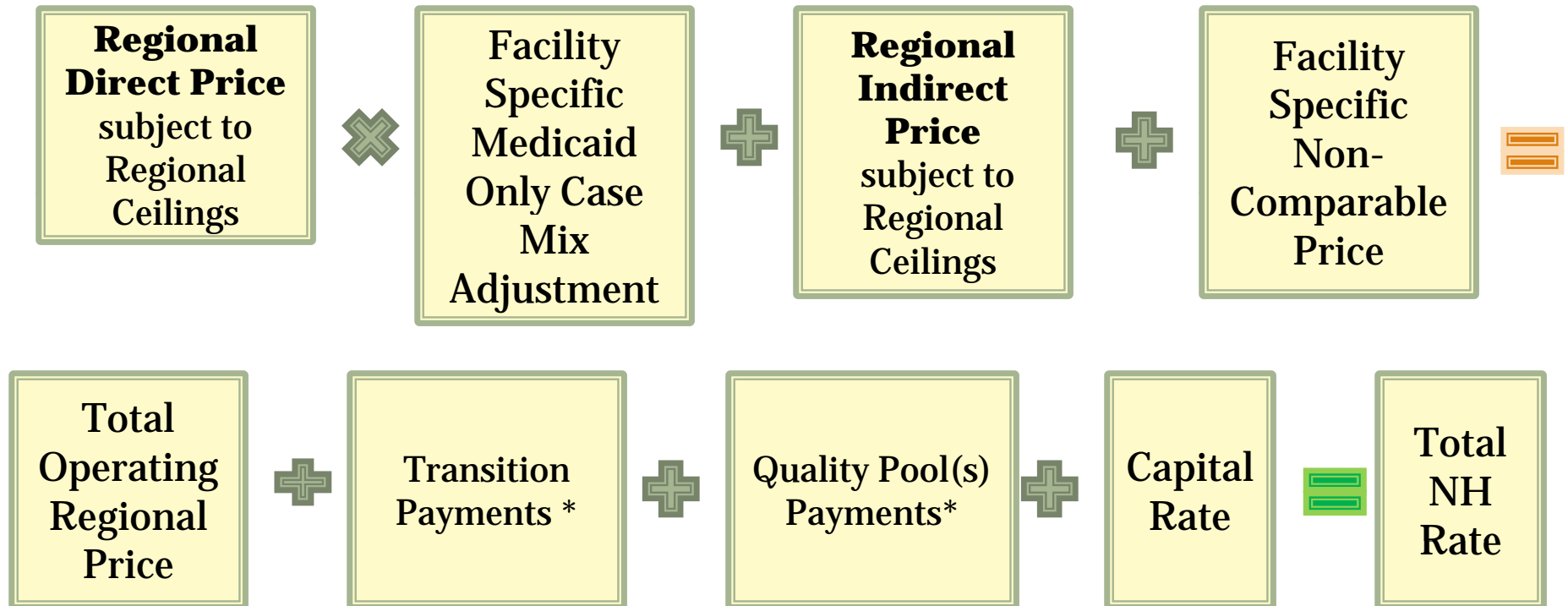
- ▶ Elements of Value Based Purchasing statute include:
 - ❖ Regional Pricing Methodology for Operating Component of Rate
 - 2007 Base Year – base year updated no less frequently than every six years
 - Regional, rather than facility specific rates
 - Continuation of MDS Case Mix – 53 RUG Groups
 - Continuation of Medicaid Only Case Mix
 - Does not apply to Specialties (March 31, 2010 rate in effect until alternative methodology can be developed with Industry Representatives/Work Group)
 - ❖ Quality Incentive Pool or Pools
 - ❖ Transition Payments

- ▶ Total Spending No Greater than Prior Year Spending
- ▶ Workgroup Recommendations due December 15, 2009



Overview of Value Based Purchasing Methodology

2007 Base Year



Regional Pricing ~ Key Methodology Issues for Work Group to Consider

- ▶ **Regions (current model uses 8 NYPHRM regions)**
- ▶ **Ceiling adjustments to allowable costs**
- ▶ **Cost differentials among facility types**
- ▶ **Cost differentials related to direct care staffing among Public, Voluntary and Proprietary facilities ~ relationship to quality pool**
- ▶ **Special needs patients ~ Bariatric, Dementia, Behavioral rate per diem add-ons**
- ▶ **Relationship between costs and quality**
- ▶ **Establishment of quality care pool(s)**

Quality Incentive Pool ~Executive Budget Proposal

Staffing	Long Stay Measures MDS Resident Outcomes	Survey Scores
Total RN Hours + RN Agency Contracted Staff Hours/ Total Hours All Staff (RN, Agency Contract, LPN, Aides, Orderlies)	% of Residents Who Have/Had a Catheter Inserted and Left in their Bladder % of Residents with a Urinary Tract Infection % of Residents Who Lose Too Much Weight % of Residents Whose Need for Help with Daily Activities Has Increased % of Residents Whose Ability to Move About In and Around Their Room Got Worse	Re-Certification Survey Scores
Weight: 20%	Weight: Each Measure 12%, Category 60%	Weight: 20%
Source: Facility specific ASPEN (Automated Survey Processing Environment) data	Source: Facility specific Minimum Data Set (MDS)	Source: Facility Specific ASPEN data

- ▶ Focus competition for resources on quality and not costs
 - First year, 2010-11, reward highest quality achievers
 - Beginning in 2011-12 ~ Reward highest quality achievers and improvers
- ▶ Top 20% of Homes in Each Regional Area Office with Highest Quality Scores Awarded Share of Pool Distributed by Medicaid Patient Days

Transition Payments

- ▶ Provide assistance to help nursing homes to transition to Value Based Purchasing and to reconfigure service delivery to address changing health care priorities
- ▶ Nursing homes with Medicaid Utilization of 50% or more and that that have significant percentage reduction in Medicaid Revenue
 - Public Facilities that receive IGT payments are not eligible for Transition Funding
- ▶ Transition funds expected to be available over multi-year period
- ▶ Eligible facilities required to submit a report setting forth financial condition and plan for reforming and improving financial condition
~ after 2 years, a progress report must be submitted to receive additional funding