NYAHSA | New York Association of Homes & Services for the Aging

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M E M O R A N D U M

TO: RHCF Members

FROM: Darius Kirstein, Senior Policy Analyst

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DATE: October 5, 2010

SUBJECT: **Annual Budget Guidance for 2011**

ROUTE TO: Administrator, CFO

ABSTRACT: NYAHSA provides members with critical budgeting guidance and tools.

Introduction

With many facilities immersed in developing their calendar year (CY) 2011 financial projections, NYAHSA is providing members this guidance on key areas to consider in the budgeting process. We seem to say it every year, but it is certainly worth reiterating for 2011, this is the most challenging budget process our nursing homes have ever encountered. The concern arises out of the combination of ongoing uncertainty regarding 2009 and 2010 rates, the anticipated implementation of regional pricing, serious concerns over the state's fiscal year (FY) 2011-2012 looming budget deficit, and the transition to MDS 3.0.

Economic Trends

One area of uncertainty that is outside of anyone's control is the general state of the economy. Year-to-date (YTD) through August of 2010, the consumer price index-urban (CPI-U) as measured by the Bureau of Labor Statistics (BLS) is shown in the following table:

Table 1.

Consumer Price Index - All Urban Consumers (CPI) YTD 2010									
Month	Jan	Feb	March	April	May	June	July	August	YTD
CPI	2.63%	2.14%	2.31%	2.24%	2.02%	1.05%	1.24%	1.15%	1.85%

Source: Bureau of Labor Statistics (www.bls.gov)

The Health Care Reform Act (HCRA) mandates that the CPI-U is used as the proxy for setting trend factor adjustments for nursing homes, adult day health care, and home care. In a normal year, the Department of Health (DOH) sets the trend factor for the coming year based on the mid-August CPI projection as issued by the Congressional Budget Office (CBO). At the end of the year, DOH then reconciles the projected trend factor with the actual CPI as determined by the BLS. This methodology is predicated on a basic assumption that the CPI will increase from one year to the next.

As of this writing, the BLS YTD CPI through August is 1.85 percent. Current CBO projections are as follows:

Table 2.

Consumer Price Index - All Urban Consumers (CPI) Current CBO Projections

Year	2010	2011
CPI	0.80%	1.20%

Source: Congressional Budget Office (www.cbo.gov)

In theory, the 1.2 percent CBO projection should represent the trend factor that will be used for Medicaid rate adjustments effective January 1, 2011. However, 2005 marks the last year in which nursing homes received their full trend factor adjustment and the 2008 through 2010 trend factors have been eliminated as part of state budget cuts.

All indications are that the state is projecting a further double digit budget deficit for state FY 2011-2012. Therefore, NYAHSA is recommending that members do not budget a trend factor. The recent negative 1.1 percent FMAP adjustment only reinforces the need to consider a zero trend. Even if the November "hotline rates" show a trend factor due to the mandated rate setting methodology, it is unlikely that any trend initially applied would not be subject to some reduction or complete elimination.

Adult Day Health Care rates will be issued simultaneously with the nursing home rates, according to DOH, and the same trend factor reductions apply to both.

- ***Note on FMAP***

The final 2010-11 State Budget (Chapter 313 of the Laws of 2010) requires across the board reductions to most undisbursed general fund and state special revenue aid to localities appropriations (including Medicaid, school aid, social services, etc) commencing on September 16, 2010. These provisions were enacted to address financial plan deficiencies related to

reductions to the enhanced Federal Medical Assistance Percentage (FMAP) authorized by Congress. Based on this recently enacted statute, the State is implementing a 1.1% across the board reduction to all Medicaid payments that are processed on or after September 16, 2010. The reduction will remain in effect through March 31, 2011. Services exempt from the reduction include:

1) Payments whereby Federal law precludes such reduction, including:
    - Federally Qualified Health Center services;
    - Health services provided to Native Americans who reside on reservations and receive services at one of four tribal clinics affiliated with the federal Indian Health Program;
    - Supplemental Medical Insurance - Part A and Part B;
    - State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
    - Any local share cap payment required by the Federal medical assistance percentage (FMAP) increase legislation;
    - Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program settlement agreement;
    - Hospice services; and
    - Services provided to American citizen repatriates.

2) Payments that are funded exclusively with federal and/or local funds, including:
    - Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
    - Certified public expenditure payments to the NYC Health and Hospital Corporation;
    - Certain disproportionate share payments to non-state operated or owned governmental hospitals; and
    - Services provided to inmates of local correctional facilities.

Beginning in Cycle 1727 (check date 9/27/10 with a release date of 10/13/2010), the Medicaid check or EFT amount will reflect the 1.1% reduction. Paper remittances will display the actual reduction amount as a recoupment identified by Financial Reason Code 'FCF' and the corresponding description of 'FMAP CONTINGENCY FUND'. Similarly, the 835 electronic remittances will carry the reduction amount in the PLB segment with the qualifier J1.

On March 31, 2011, the Director of the Budget shall calculate the difference, if any between the actual closing balance in the General Fund on March 31, 2011 and the closing balance projected by the Division of the Budget in the 2010-11 Financial Plan. Please refer to:

http://publications.budget.state.ny.us/budgetFP/2010-11FinancialPlanReport.pdf.

If the actual closing balance is in excess of the projected balance, the amount of the difference will be used to uniformly reimburse the across-the-board reductions taken pursuant to the FMAP

Contingency Allocation Plan. In this event, the State will return funds to providers as soon as practical following the receipt of all necessary Federal approvals.

As information becomes available, it will be posted on the Department's website: http://www.health.ny.gov/health_care/state/fmap_contingency_plan. Additional questions should be submitted to the following electronic mailbox: **b1191@health.state.ny.us**. Responses to questions will be posted on the Department's website at the address above.

Projecting Medicaid Rates

The best strategy for members to project their Medicaid rates for next year is to use a series of tools that NYAHSA has developed specifically for our members. The following facts should be kept in mind:

A. For many homes, rebased rates (in effect from 4/1/09 through 6/30/11) are likely to be lower than those shown in the "notice" rate sheets released in January of 2010.
B. Regional pricing is scheduled to be implemented on July 1, 2011 yet the final methodology is unknown. While individual home circumstances will vary, for many voluntary homes and for most public, hospital-based and 300+ bed homes, the regional rate is likely to be lower than their rebased rate.
C. A number of retroactive reconciliations that may have serious financial impact are still pending.

Please note that while this guidance is based on the most currently available information, the many unknowns and potential changes make any rate calculations rough estimates only. If you have questions or need assistance in calculating rate projections, please contact Darius Kirstein at dkirstein@nyahsa.org.

1. Rebased Rates

a. **Timing:** The Medicaid State Plan Amendment that includes rebasing is pending CMS (Centers for Medicare and Medicaid Services) approval. DOH has responded to follow-up questions from CMS and is requesting a quick response. While DOH says there has been no suggestion that CMS is unwilling to approve, the timing remains uncertain. Once the state receives approval, the state Division of the Budget needs to sign off on the rates and they need to be programmed into the payment system, a process that is likely to take 6 weeks from start to facility payment.

b. **Amounts:** Since DOH made the rate sheets available to nursing homes in January of 2010, the rates have undergone a number of corrections and updates. The largest changes were updates to peer group means for vent and hospital-based homes (see table below). However, since the annual statewide cost of rebasing (when compared to total Medicaid nursing home spending in the previous 12 months) is capped at $210 million, any increase in the calculated rates means that scale-back amounts

increase as well. The scale-back amount appears on line 14 of the first page of the rate packet dated 5/1/2009 and is a key figure that will impact the net benefit that a home will see from rebasing.

Starting with the notice rate sheets released in January, 2010, homes can refine their rebased rate estimates by: 1) recalculating their rates to reflect their facility-specific CMI changes; and, 2) increasing their scale-back amounts based on the increase in statewide cost of rebasing.

Table 3.

Direct & Indirect Peer Group Means

	DIRECT COMPONENT		INDIRECT COMPONENT	
Peer Group	Jan 2010 Rate Sheets	March 2010 Interim	Jan 2010 Rate Sheets	March 2010 Interim
Small FS	102.07	104.18	51.16	51.37
300+ FS	119.52	123.70	60.96	61.47
HB	119.93	120.97	64.79	72.83
VENT	219.97	275.49	60.25	81.38
AIDS	177.26	187.83	88.84	91.84

Note: Figures shown are preliminary, point-in-time figures that may have changed further since March 2010

c. **Scale-back:** The scale-back is a proportional reduction in each home's Medicaid funding based on the percentage of total nursing home Medicaid spending that home represents. For example, if a home's rate multiplied by annual Medicaid days represents 1% of total Medicaid spending, the facility-specific scale-back amount for that home would be 1% of the total statewide scale-back amount.

Due to technical reasons, the scale-back amount that appears on the rate sheets dated 05/01/2009 is an annual amount divided by 11 months worth of days (i.e., no scale-back will be reflected in the 4/1/09 through 4/30/09 rates, but the scale-back attributable to that period will be incorporated in the scale-back amounts applied for the rest of the year.) To arrive at an annual Medicaid revenue projection, it may be easier to calculate scale-back estimates based on a 12 month (365 day) year. To convert the scale-back amount shown on your 05/01/2009 rate sheet to a 365 day figure, multiply it by .9167 (11/12ths).

This initial scale-back amount was based on DOH's initial rate calculations which suggested that the net annual statewide increase from rebasing was $375 million, meaning that -$165 million in scale-back adjustments were needed to arrive at the $210 million cap. Since that time, corrections, rate revision and statewide CMI

growth have ballooned that amount. Based on information released by DOH, more recent figures suggest that the net statewide cost of rebasing using a 1/1/09 case mix is $460 million, meaning that the scale-back for the 4/1/09 through 6/30/09 rate period should be calculated using a -$250 million statewide amount. To update the scale-back estimate for your home for this three month period, multiply your scale-back amount by 1.52.

Beginning July 1, 2009, rates will be updated to reflect the CMI based on July 2009 census rosters. DOH projects that the 7 percent statewide increase in CMI seen in July 2009 increases the cost of rebasing by $275 million. Because the cost is already at the $210 cap, the entire $275 million must be subtracted using the scale-back, in effect doubling the scale-back calculated in the previous step. To estimate the scale-back that will be applied to your rate effective 7/1/09, multiply the scale-back from the previous paragraph by 2.1. Based on our work as well as DOH indications, there has been very slight statewide growth in CMI after the large increase from 1/1/09 to 7/1/09, meaning that you can use this new scale-back estimate with no further adjustments for rates through 6/30/2011.

d. CMI: To estimate the impact on your rate of case mix changes at your facility, use NYAHSA's *CMI Change Template* (attached to the e-mail). Pleas note that there are two separate templates: one for public and small homes, one for non-public and 80+ bed homes. Model the CMI for each census roster date (July 2009, January 2009, July 2010) to arrive at updated rates, then subtract the appropriate scale-back amount.

2. Regional Pricing

Regional pricing is scheduled for implementation on 7/1/2011. The legislative language leaves the details of the methodology up to the discretion of DOH. Members of the nursing home reimbursement workgroup (which includes NYAHSA along with other associations and consumer representatives) have expressed concerns and have provided suggestions on making the methodology more workable. With a new administration coming to Albany after November's elections, we continue to have hope that we can either eliminate or at least improve the troublesome aspects of regional pricing.

While no methodology has been finalized, the most recent discussions utilized NYPHRM regions but incorporated a facility-specific WEF that helped recognize wage differences in both the direct and indirect components. While we do not have reliable estimates of WEF-inclusive rates, members can construct a rough estimate of their rate by using the chart below. Legislation calls for regional prices to be based on 2007 costs. Since each

annual trend factor has been eliminated since 2007, no trend factor adjustments are needed.

The regional all-payer CMIs listed below are based on 2007 data. (Please note that DOH will calculate RUG category weights for 2007 that will differ from the 2002 weights, but your home's latest CMI should provide an adequate basis for this estimate.) Divide your home's Medicaid-only CMI from January 2010 by the regional average CMI shown. Multiply this figure by the regional average direct component to arrive at your home's estimated direct component.

Add this to the appropriate regional average indirect component shown below, then add your home's estimated non-comparable component (please contact dkirstein@nyahsa.org if you would like an estimate of your allowable 2007 non-comp costs). Finally, add your projected 2011 capital component to complete the rate. Note that these rates are prior to any Part D or B offsets and assume a uniform ceiling reduction across all regions. You may want to adjust the direct component down by the Part D offset shown on your rate sheet for a better simulation of your dual eligible rate. (By the time regional rates take effect, prescription drugs will have been removed from the rate, reducing the direct component and making the Part D offset obsolete).

Table 4.

Estimated Regional Direct & Indirect Means, Mean CMI

NYPHRM Region	Direct	Indirect	2007 All Payer Mean CMI
Central	$109.06	$55.57	0.89
Long Island	147.72	64.31	0.95
New York City	140.21	68.41	0.92
Northeastern	117.33	57.23	0.86
No. Metropolitan	132.63	67.34	0.90
Rochester	118.51	56.94	0.84
Utica	98.81	54.81	0.86
Western	116.55	56.56	0.96

Source: DOH preliminary estimates of mean costs, NYAHSA CMI analysis

3. Trend Factor Reconciliation

Homes face two trend factor reconciliations: one to reconcile the first three months of 2009, and one that will reconcile rates from 4/1/09 to the present.

A. The reconciliation for 1/1/09 through 3/31/09 will reduce the trend factor for that period from 2.1 percent to -1.4. To estimate the impact, multiply your 1/1/09

operating component by -3.5 percent and multiply this figure by Medicaid days billed during this period.

B. Since 4/1/09, Medicaid rates that homes have been receiving include trend factors that should have been removed. While these overpayments can be viewed as an advance on rebasing that helps cash flow, members should be aware that they will be subject to recoupment. Although the reconciliation from old rates to rebased rates is likely to be done in a single transaction, it may be easier to think of rebasing and tend reconciliation as two separate actions, especially since DOH benefit estimates of rebasing were calculated from the trend-less rates.

The trend factors that should have been removed effective 4/1/09 include a 1.17 percent trend for 2008, 2.1 percent trend for 2009 and a bump in the roll factor attributable to 2008 banking. They total approximately -4.3 percent. To estimate the impact, multiply the 1/1/09 operating component by -4.3 percent, then multiply this amount by the Medicaid days billed since 4/1/09.

- ***Additional Reconciliations***

Members should also keep in mind that there are the following additional Medicaid rate reconciliations that need to be considered:

1. 2007 and 2008 rebasing transition payments; and
2. 6 percent cash receipts assessment reimbursement payments for 2008 and forward.

The 2002 base year update grew out of the efforts of the Joint Association Task Force (JATF), comprised of NYAHSA and the other statewide associations, to deal with the devastating financial impact of continuing to base nursing home reimbursement on a base year which was well over two-decades old. The base year update was passed by lawmakers in 2006 and included a phase in period. During this phase in period, providers received 2007 and 2008 transition payments based on a percentage of the total projected benefit from the base year update.

These were originally based on early projections, and DOH has signaled their intention to eventually reconcile the dollars using actual rates with updated CMI data. Part of the process of reconciling the add-on includes recalculating rates based on the re-filed 2002 cost reports submitted to DOH as part of the original 2009 hotline process. DOH has not given a timeframe for this reconciliation, which will redistribute the $305 million in funding paid over these two years from facilities that were overpaid to those that were underpaid based on updated costs and facilities' 2009 CMI adjustments. While this is essentially a CY 2009 rate issue, providers need to keep this in mind because the actual cash flow impact may not occur until next year.

Financially Disadvantaged Funding

The final 2009-10 state budget reconfigured program eligibility and grant amounts, and added restructuring plan requirements as a condition to receive continuing funding under this program.

These changes are subject to federal approval. Under these new provisions, the cap that any one facility can receive is raised to $1 million from $400,000. However, the total pool of dollars remains fixed at $30 million. The basic criteria for determining eligibility will remain the same, however the parameters for determining which facilities qualify will be narrowed. Therefore, the number of facilities qualifying will shrink. Funding for 2009 and 2010 has not been distributed, nor have any facilities been notified that they are eligible for these funds pending federal approval.

Bed Hold

The recent changes in bed hold, which essentially limit the number of paid days to 14 per resident per 12-month period for hospital stays (10 for therapeutic leave), obviously represent a reduction in revenue for those facilities that were billing for bed hold days under the old methodology. In addition, bed hold payments for the period of April 1, 2010 through July 19, 2010 will be retroactively reduced to the 95 percent level, reflecting the reduced reimbursement per diem for bed holds. Based upon individual facility policy in response to the new bed hold reimbursement, facilities will need to develop an analysis to determine the negative impact of the new process and budget accordingly.

IGT

Intergovernmental Transfer (IGT) payments for public facilities only are approved to continue through 2011 at a new statewide cap set at $300 million. While the law approves a cap of $300 million, the upper payment limit calculation (UPL) ultimately determines the amount of IGT funding available. With so many unknowns in other areas of the Medicaid rate, it is difficult to determine what the impact will be on the UPL. Conservatively, it is safe to assume that funding will remain at least level with 2007 at a statewide total of $150 million for 2010. NYAHSA recommends against assuming that the payment will double.

Medicare Part A

NYAHSA Doc. ID # n00004776 provides members with detailed information on Medicare Part A rates for federal FY 2011, starting October 1, 2010, including a regional breakdown on rates. The Centers for Medicare and Medicaid Services (CMS) issued the skilled nursing facility (SNF) prospective payment system (PPS) proposed rule on July 20th, 2010 with a comment period ending September 20, 2010. Once finalized, this rule will determine the Medicare Part A rates for SNFs for the federal fiscal year 2011 (FY 2011) beginning October 1, 2010 and running through September 30, 2011. Last year, CMS issued the programmatic portion of the federal fiscal year FY 2011 SNF PPS with the FY 2010 final rule.

The Patient Protection and Affordable Care Act

The passage of the *Patient Protection and Affordable Care Act* (ACA), also known as the Health Care Reform Act, also creates uncertainty in the FY 2011 proposed rates. CMS originally intended to concurrently implement the new MDS 3.0 and RUG-IV systems. The new RUG IV grouper logic and expanded 66 resource utilization groups are closely tied to the MDS 3.0. Whereas the MDS 3.0 remains on track to be implemented effective October 1,

2010, ACA delays the implementation of RUG-IV to no earlier than October 1, 2011. It is unclear as to how this disconnect between the two systems evolved out of the health care reform debate, and may represent an oversight by Congress.

To comply with ACA, CMS will base payment using the Minimum Data Set (MDS) 3.0 with a "hybrid" RUG III system that only incorporates two components of RUGs IV ("look-back" period and concurrent therapy provisions). Because CMS has not yet developed a grouper for this "hybrid" payment system, effective October 1, CMS will implement an interim payment system using the MDS 3.0 and the entire RUG- IV (the grouper that currently exists). Once the "hybrid" system is in place, CMS will retroactively adjust claims to be paid under the "hybrid" RUG-III system (HR-III). CMS expects the HR-III to be in place in no sooner than January of 2011.

Without additional Congressional action, however, Part A rates effective October 1, 2010 will be based on a hybrid system of the MDS 3.0 and the current RUG-III 53 grouper logic. The MDS 3.0/RUG-IV grouper, however, is the only one that is currently operational. CMS is unlikely to have in place the necessary "hybrid grouper (HR-III)" until after the first of the year. This means that the rates to be paid for the first quarter of FY 2011 would be interim rates and will have to be adjusted retroactively sometime in early 2011. In addition, programmatic changes such as the new requirements on concurrent therapy and the elimination of the hospital look-back period would also have to be implemented October 1, 2010, again, without the implementation of RUG-IV.

According to CMS, they are proceeding with the development of the HR-III. CMS states in the proposed rule: "Once the necessary infrastructure is in place, we will then retroactively adjust claims to reflect the HR-III system which incorporates RUG-IV's specific revisions on concurrent therapy and the look-back period within the framework of the existing RUG-53 system, along with the use of MDS 3.0."

With all that said, there is also reason to believe that CMS may be playing a waiting game in anticipation that Congress will act to redress the current situation and allow for the full implementation of both MDS 3.0 and RUG-IV on October 1, 2010, as originally intended. This would eliminate the need for the HR-III and the payment of interim rates. Inside sources believe that it is a matter of "when" and not "if" Congress makes this correction.

Part A Rate Analysis

CMS estimates that the FY 2011 Medicare Part A rate adjustments will increase payments to skilled nursing facilities by $542 million, as a result of a net 1.7 percent inflationary adjustment.

As noted above, most of the final rule for FY 2011 was released with the final rule for FY 2010. CMS intended, in part, to give providers ample time to prepare for the many changes accompanying the implementation of MDS 3.0 and RUG-IV. Therefore the current additional proposed rule deals primarily with rate issues.

The critical factors affecting FY 2011 Part A rates include:

- A Market Basket Index (MBI) of 2.3 percent; and

- A Market Basket Forecast Error (MBFE) adjustment of a negative 0.6 percent.

Therefore, the net result is the 1.7 percent increase in rates.

The proposed rule also details the requirement for a parity adjustment. As occurred in 2006 with the change from the 44 RUG grouper to the current 53 (RUG-53), CMS applied a parity adjustment to ensure that the change was budget neutral. Hence there was a retroactive recalibration of the rates (analogous to a case mix creep adjustment). The same will apply with the current programmatic changes. The law requires that the change from the current RUG-53 to the RUG-IV system with 66 groups be budget neutral on a system-wide basis, and may at some point require retroactive recalibration of the rates.

Two key programmatic areas that may significantly impact facility revenues are the changes related to concurrent therapy and the elimination of the hospital look-back period as detailed below.

The economic effect for both the RUG-IV and HR-III rules vary by type of provider and location. Nearly all facilities would experience an increase in payment under both systems. Under RUG-IV SNFs in urban areas would experience an average of 1.9% increase in payment, while rural facilities would experience an average of 0.7% increase. Under HR-III, SNFs in urban area would experience an average increase of 1.8%, while SNFs in rural areas would experience and average increase of 1.5%. Not-for-profit facilities will experience a slightly higher increase in payment relative to for-profit facilities. There is also a more detailed table of the economic impact to both the RUG-IV and HR-III rule.

MBFE

The annual update of the payment rates includes, as appropriate, an adjustment to account for market basket forecast error (MBFE). As described in the final rule for FY 2008, the threshold percentage that triggers an adjustment to account for market basket forecast error is 0.5 percentage point effective for FY 2008 and subsequent years. This adjustment takes into account the forecast error from the most recently available FY for which there is final data, and applies whenever the difference between the forecasted and actual change in the market basket exceeds a 0.5 percentage point threshold. For FY 2009 (the most recently available FY for which there is final data), the estimated increase in the market basket index was 3.4 percentage points, while the actual increase was 2.8 percentage points, resulting in a difference of -0.6 percentage points. Table 1 shows the forecasted and actual market basket amounts for FY 2008.

Table 5 - FY 2008 Forecast Error Correction for CMS SNF Market Basket

Index	Forecasted FY 2009 Increase	Actual FY 2009 Increase	FY 2009 Forecast Error Correction
SNF	3.4	2.8	-0.6

Source: CMS SNF PPS Proposed Rule for FY 2011

AAHSA Templates

AAHSA is providing members with three important Excel™ spreadsheet tools to use in navigating the upcoming rate changes. The template is available on the AAHSA Web site at: www.aahsa.org. Once on the AAHSA Web site and logged in, click on *Providers*; then click on *Nursing Homes*; then click on *Payment Rate Calculation Tools*.
The three templates members should refer to are:

- The template for calculating rates based on 66 groups and without the HR-III grouper;
- The template for calculating rates based on 53 groups with the HR-III grouper; and
- The template for converting from RUG-53 to RUG-66.

If any member has difficulty in accessing any of these tools please contact me and I will provide them for you, and I will be happy to walk through them with you.

Wage Index

CMS continues to utilize a hospital-based wage index in order to account for differences in regional wage levels. The wage index must be applied in a manner that does not result in aggregate payments that are greater or less than would otherwise be made in the absence of the wage adjustment. This is accomplished by applying a budget neutrality factor.

The labor related portion of the rate for FY 2011 is 69.31 percent, a decrease from 69.84 percent for the FY 2010 rates. The non-labor portion for FY 2011 is 30.69.

It is critical to keep in mind that 9 out of 14 New York wage index regions are seeing a decrease in the proposed wage indexes for FY 2011. As the following table shows, only the Elmira, Glens Falls, Poughkeepsie, Syracuse, and Utica areas are seeing a potential increase. A decrease in the wage index for a given region will act to offset the net MBI.

Table 6 Comparison of FY 2010 and FY 2011 Wages Indices

Year	ALBANY	BINGHAMTON	BUFFALO	ELMIRA	GLENS FALLS	ITHACA	KINGSTON
	WAGE INDEX	WAGE INDEX	WAGE INDEX	WAGE INDEX	WAGE INDEX	WAGE INDEX	WAGE INDEX
2011	0.8653	0.8719	0.9530	0.8445	0.8507	0.9842	0.9075
2010	0.8777	0.8780	0.9740	0.8341	0.8456	1.0112	0.9367
Difference	-0.0124	-0.0061	-0.0210	0.0104	0.0051	-0.0270	-0.0292
	NASSAU-	NEW YORK					
Year	SUFFOLK	METRO	POUGHKEEPSIE	ROCHESTER	SYRACUSE	UTICA	NON-URBAN
	WAGE INDEX	WAGE INDEX	WAGE INDEX	WAGE INDEX	WAGE INDEX	WAGE INDEX	WAGE INDEX
2011	1.2315	1.2955	1.1354	0.8595	0.9905	0.8471	0.8185
2010	1.2477	1.3005	1.1216	0.8724	0.9785	0.8460	0.8269
Difference	-0.0162	-0.0050	0.0138	-0.0129	0.0120	0.0011	-0.0084

Source: CMS Proposed SNF PPS FY 2011 Rule

- **Budget Neutrality Factor**

As noted above, the wage index must be applied in a manner that does not result in aggregate payments that are greater or less than would otherwise be made in the absence of the wage adjustment. This is accomplished by applying a budget neutrality factor. For FY 2011, that factor is 0.9997 (compared to 1.0010 for FY 2010).

Consolidated Billing

CMS is not making any changes to the listing of services excluded under consolidated billing for FY 2010.

AIDS Adjustment

Section 511 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* instituted a temporary128 percent increase in the PPS per diem payment for any SNF resident with an AIDS diagnosis code 042. (Please note that the 128 percent factor is applied by multiplying the base rate by a factor of 2.28, e.g., a base rate of $100 would increase to $228.) This add-on remains in effect until such time as CMS institutes an appropriate adjustment in the patient classification system that captures the additional cost of caring for these individuals. Since CMS has yet to do so, this add-on will continue for FY 2011.

MDS 3.0, RUG-IV and Other FY 2011 Changes

Following is a list of some of the most important programmatic provisions noted above, designed to provide an initial summary of the changes included in the rule issued last year:

- Implementation of MDS 3.0 is effective 10/1/10. Please note that with the recent New York Medicaid shift from the PRI to the MDS, this will likely have a significant impact on both Medicare and Medicaid.

- More focus on activities of daily living (ADL) scoring, with a standardized scale (0 to 16) among groups and the shift to RUG-IV with 66 groups (increasing from the current 53). There are a number of very detailed changes contained in the final rule and that providers will need to navigate as the situation continues to evolve. The following are the categories under RUG-IV:

  Rehabilitation Plus Extensive Services; Ultra High Rehabilitation; Very High Rehabilitation; High Rehabilitation; Medium Rehabilitation; Low Rehabilitation; Extensive Services; Special Care High; Special Care Low; and Clinically Complex.

- The Look-Back period under RUG-IV is being modified to include only those services that are provided after SNF admission. Providers will still be able to code those services provided prior to admission to the SNF on the MDS 3.0 for care planning purposes.

- Therapy minutes during current therapy sessions will need to be allocated per patient. For example, under the current rules a one-hour concurrent therapy session with three patients is considered an hour of treatment for each. Under the new rules concurrent therapy is limited to a maximum of two patients and the grouper will automatically allocate the time evenly between each patient.

  This is a critical point to keep in mind. If for a period of one hour the therapist provides concurrent therapy to two patients, one hour of therapy time should be recorded on the MDS for each patient. The grouper will then automatically credit each resident for a half hour of therapy. If instead, a half hour is recorded for each resident, the grouper will only credit each for 15 minutes. This would have a significant negative impact on the rehab scoring for these residents.

- CMS will require the therapist to track and report the three different delivery modes of therapy: Independent, Concurrent (no more than 2 patients), and Group (2 to 4 patients). The reporting of group therapy remains unallocated as long as the patient limitation and supervision requirements are met.

- MDS 3.0 also eliminates therapy projections under section T. For short-stay residents who receive less than 5 days of treatment, an average would be used to assign a score. There is also a new short stay MDS classification which may be used.

- ***The standard logic that the rehab category offers better reimbursement that clinical is no longer the case under MDS 3.0/RUG-IV. Facilities will have to be more strategic is setting the ARD. In some cases, setting the ARD to better capture clinical scores may actually provide better reimbursement than the ARD which captures the most rehab.***

It is clear that there are significant fiscal impacts to consider in these FY 2011 changes. One example, the change in concurrent therapy provisions may dramatically change the cost formula for delivering therapy services. The elimination of the look-back and the shift in weighting from rehabilitation to clinical services are two more examples that warrant serious analysis in terms of financial impact.

NYAHSA is recommending that members budget their FY 2011 Medicare Part A revenue based on a assumption of MDS 3.0 combined with the RUG-IV 66 grouper logic.

Medicare Part B

In June, Congress acted to override a 21.2 percent decrease to the Medicare Physician Fee Schedule (MPFS) ancillary Part B rates, and implemented a 2.2 percent increase for the period from **June 1 through November 30, 2010**.

Additional details on the June 1 update are available on the CMS Web site at: https://www.cms.gov/PhysicianFeeSched/. The new conversion factor for services furnished during the time period of June 1 through November 30 is **$36.8729**.

To calculate Medicare Part B rates for selected therapy services please refer to the AAHSA Web site (www.aahsa.org) and click on *Providers*, then click on *Nursing Homes*, and then *Therapy Payment.* The Excel™ spreadsheet under *Medicare Part B Rate Calculation Tool June 1 – Nov. 30, 2010* has detailed instructions and easy to use drop down features for calculating Part B rates. If any member has difficulty accessing the spreadsheet or needs assistance please contact me.

The National Government Services (www.ngsmedicare.com) Web site has also been updated to reflect the new Part B rates. Simply log in under *Medicare Part B* as a *New York* provider and click on *Fee Schedules.* Here you will find the complete listing of all codes billed under Part B. For most organizations the *Par* amount applies. The general exception is for those providers who have not agreed to accept Medicare as payment in full and would bill the *Non-Par* amount.

It is uncertain at this time what will happen as of December 1, 2010 and into 2011. The best advice for NYAHSA members is to budget Medicare Part B revenue at a level amount with the current period.

Conclusion

As has been the case over the past few budget cycles, the best budgeting advice NYAHSA can offer is for members to be as conservative as possible in their financial projections, in response to the current circumstances. Of course, federal and state auditing activity will remain a serious cash flow and budgeting consideration as well, including ongoing OMIG audits. NYAHSA will continue to provide members with the latest information, training, and tools needed to help manage in these challenging times. In addition, please be assured that we will continue our strong advocacy work, hand in hand with our membership, in an ongoing effort to resolve these concerns.

Please contact us with any questions at dkirstein@nyahsa.org, or call 518-449-2707 ext. 104; or pcucinelli@nyahsa.org, or call ext. 145.

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