NYAHSA
2010 Financial Managers Annual Conference

Department of Health September 15, 2010

Nursing Home Discussion Topics

- Update of Status of 2002 Rebasing Rates
  - September 8, 2010 DAL
  - CMS Approvals
- MDS Submissions
- 2009 Cost Reports ~ 2011 Capital Rates
- Other Rate Setting Activities
- 2010-11 Enacted Budget Provisions
  - Carve Out of Prescription Drugs
  - Assessments Amnesty
  - Bed Hold Payments
  - Appeals Cap and Negotiated Settlements
  - Value Based Purchasing /Pricing Methodology
- Federal Reform

Status of Nursing Home Rates
Effective April 1, 2009 (Rebasing Rates)

- On January 13, 2010, the Department released to providers draft initial rebasing rates effective April 1, 2009, May 1, 2009 and January 1, 2010

- The initial January 13, 2010 rates reflect:
  - 2002 Rebasing Provisions (enacted 2006)
  - Medicaid Only Case Mix Adjustments (enacted 2007)
    - January 2009 Case Mix
  - $210 million cap (spending increase over 2008-09)
  - The elimination of 2008 and 2009 trends
  - 2009 Capital (April 1 and May 1, 2009 Rates)
    2010 Capital (January 1, 2010 Rates)

Status of Nursing Home Rates
Effective April 1, 2009 (Rebasing Rates)

- The UPL calculation is still under review by CMS
  - January 22, 2010 UPL calculation submitted to CMS
  - January 27, 2010 CMS requested back-up for calculations
  - February 1, 2010 DOH submitted requested backup/details of UPL calculations to CMS
  - July 13, 2010 CMS submitted 9 pages of questions to DOH
  - August 13, 2010 DOH submitted responses to questions
- CMS approval of other SPAs (e.g., the $210 million spending cap) is contingent upon CMS approval of UPL
- Publication date of rates remains uncertain
- Facilities continue to be paid their March 31, 2009 rates

Draft Preliminary Update of the Initial Rates Released on September 8, 2010

- To help facilities plan for impact of the rates and retroactive rate adjustments, the Department released an informal, informational update to the January 13, 2010 initial rates on September 8, 2010 via DAL and HPN
- The Draft Preliminary Updated Rates reflect the following modifications:
  - Statewide WEF and Peer Groups recalculated to correct for programming/calculation errors
  - Health Recruitment and Retention payments added back to 2002 allowable costs
  - Updated rate add-ons (e.g., criminal background checks, Measles and Rubella, Hepatitis B and dementia grants)
  - Updated cost reports for several facilities that properly filed 2002 costs reports
  - Errors in calculation of manual rates corrected
  - PRI schedule for 128 facilities which includes the processing of held PRIs
  - Modifications to costs for IGT payments for a few public facilities
  - Case mix calculation has been corrected to account for rounding errors
  - Costs for Hospital Based Facilities have been properly down trended
  - Other facility specific issues

Draft Preliminary Update of the Initial Rates Released on September 8, 2010

- The Draft Preliminary Updated Rates **DO NOT** reflect the impact of:
  - Case mix adjustments for July 1, 2009
  - Case mix adjustments for January 1, 2010
  - The processing of appeals that have or will occur subsequent to the production of the initial rates
    - **As a result of $210 million cap, such adjustments will have an impact on both facility specific rates and all nursing home rates**
  - The 2009 banking adjustment
  - 2009 Financially Disadvantaged payments
- Depending on the timing of CMS approvals, many or all of these rate adjustments may be reflected in the published rates

Upon CMS Approval

- DOH will submit rates to DOB for approval
- DOH will publish rates
- Facilities will have 120 days to submit appeals of the published rates
  - Appeals must be submitted via the Electronic Appeals Submission System
  - PHL Section 2808 (11)
    - Operating appeals limited to errors made by the Department
    - Revisions to 2002 Cost Reports for operating purposes may NOT be resubmitted (section 2808 PHL)
- Based on advice of counsel, appeals submitted on May 13, 2010 under January 13, 2010 initial rates will be deleted from EAS system
- Following release of published rates DOH will hold Webinar
  - September 8, 2010 DAL Questions submitted via NFRates@health.state.ny.us will be addressed

Two Year Impact of Rates
Draft Preliminary Update Released September 8, 2010
(Effective April 1, 2009)

$ Millions Impacts Compare to 3.31.09 Rate Paid Today	**Draft Preliminary Update to January 13 , 2010 Rates**
Rebasing	$928
Medicaid Only	($477)
Net Impact of Rebasing and Medicaid only	**$450**
Scale Back to $210 Million	($240)
Rebasing Impact with Med only and Scale Back	$210
Impact of Elimination of 2008 and 2009 Trend	($198)
Net Impact of Rebasing and Trend	$11
Net Impact of Rebasing and Trend Elimination for Two Years (2009-10 and 2010-11)	$22
Impact of "Banking Adjustment" for Trend Applicable to January, February, March of 2009 **(NOT REFLECTED IN SEPTEMBER 8, 2010 DAL RATES)**	($54)
Two Year Net Impact Including Banking Adjustment	($32)

Two Year Impact of September 8, 2010 Draft Preliminary Update of Rates

(Effective April 1, 2009)

- The impact of the rates varies significantly across individual facilities, regions and sponsorship
- 302 or 47% of facilities are negatively impacted by $488 million
- 54 or 48% of financially distressed facilities are negatively impacted by $85 million
- 224 facilities that currently have negative operating margins are negatively impacted by $75 million
- 104 facilities that are negatively impacted by $255 million will move from a positive to a negative operating margin
- High cost public facilities (that otherwise receive the benefit UPL payments) receive the bulk of the benefit of the new rates ($91 million)
  - Results in a shift of the source of funding from the counties to the State by reducing UPL payments
  - Proprietary and Voluntary Facilities incur losses ($85 million and $39 million)

Almost One-Half of Nursing Homes are Negatively Impacted with $215 million of the Reduction Concentrated Downstate

(Rates Effective April 1, 2009)

NYPHRM Region	#	Winner	#	Loser	#	Two Year Impact
CENTRAL	34	45,377,024	15	(14,450,719)	49	30,926,305
LONG ISLAND	28	36,465,113	49	(100,883,141)	77	(64,418,029)
NEW YORK CITY	58	134,511,675	120	(286,159,424)	178	(151,647,749)
NORTHEASTERN	38	58,879,599	17	(6,241,322)	55	52,638,277
NORTHERN METROPOLITAN	54	69,145,347	40	(34,645,931)	94	34,499,417
ROCHESTER	40	42,990,237	11	(9,783,219)	51	33,207,018
UTICA	38	33,466,906	18	(12,858,013)	56	20,608,893
WESTERN	46	35,710,846	32	(23,859,857)	78	11,850,989
Total	**336**	**$456,546,747**	**302**	**($488,881,626)**	**638**	**($32,334,879)**

Public Facilities Receive the Bulk of the Overall Benefits of New Rates

(Rates Effective April 1, 2009)

Sponsorship	#	Winner	#	Loser	Total	Two Year Impact
Proprietary	144	154,482,837	173	(239,568,338)	317	(85,085,501)
Public*	42	119,522,464	5	(27,737,578)	47	91,784,886
Voluntary	150	182,541,446	124	(221,575,710)	274	(39,034,264)
Total	**336**	**$456,546,747**	**302**	**($488,881,626)**	**638**	**($32,334,879)**

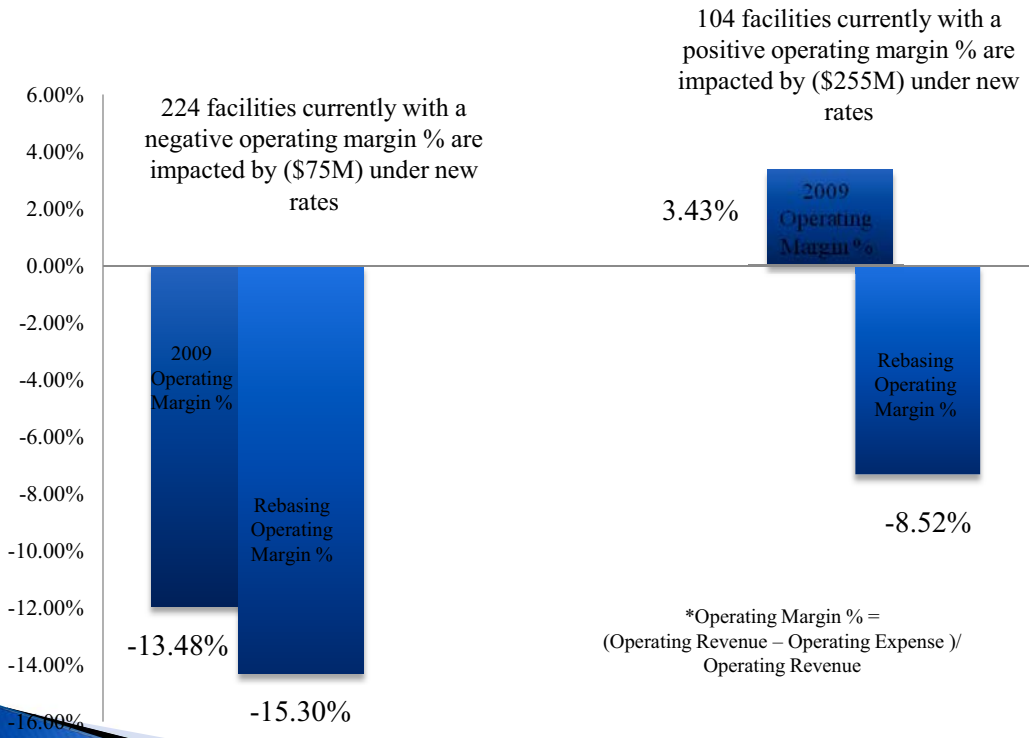
*The $91.7 million net increase in rates to public facilities is supported by federal and state resources and will result in commensurate reduction in Public UPL payments. Accordingly, $35 million in Medicaid spending will shift from the counties to the state.

158 Facilities Across the State Will Experience Losses of More than 5% of Revenue which Could Jeopardize Access or May Result in Potential Closures Using 2009 Cost Report Data

	Impact Greater than or Equal to -5% of Operating Revenue			Impact of Rebasing Between -4.9% & +4.9% Operating Revenue			Impact Greater than or Equal to +5% of Operating Revenue		
Sponsor	# Nursing Homes	Impact	Average Operating Margin*	# Nursing Homes	Impact	Average Operating Margin	# Nursing Homes	Impact	Average Operating Margin
CENTRAL	8	(12,578,471)	-16.31%	23	2,387,352	-0.09%	21	41,117,424	7.02%
LONG ISLAND	26	(80,714,051)	-7.79%	50	(16,875,637)	0.04%	12	33,171,660	5.59%
NEW YORK CITY	81	(246,744,543)	-16.91%	93	(19,546,428)	-0.53%	37	114,643,221	9.10%
NORTHEASTERN	4	(2,997,763)	-3.88%	29	268,483	-2.24%	26	55,367,558	-0.11%
NORTHERN METROPOLITAN	13	(24,636,412)	-14.67%	62	538,879	-4.17%	29	58,596,949	7.11%
ROCHESTER	6	(8,142,498)	-13.07%	25	3,066,387	0.87%	27	38,283,128	9.65%
UTICA	7	(9,965,571)	-19.70%	23	305,855	-3.83%	27	30,268,609	9.09%
WESTERN	13	(16,751,850)	-11.30%	43	(1,265,343)	-3.35%	25	29,868,182	4.62%
Total	**158**	**($402,531,158)**	**-14.38%**	**348**	**($31,120,451)**	**-1.67%**	**204**	**$401,316,730**	**6.75%**
# Beds	**31,175**			**50,494**			**34,940**		

*Operating Margin % = (Operating Revenue – Operating Expense)/ Operating Revenue

Over One Half of Nursing Homes will Remain or Become Financially Unstable Under the New Rates



MDS Submissions

- MDS submissions have been finalized for:
  - July 2009
  - January 2010
- July 2010 submission
  - Census Date: July 28, 2010 (All Residents in house, Regardless of Payer)
  - Upload Period: October 4, 2010 – October 15, 2010
- Effective October 1, 2010 CMS will be transitioning to MDS 3.0
  - As required by statute, New York State will continue to employ the 53 Group RUG-II Classification System
  - Questions about conversion to 3.0 and August DAL can be directed to mds3@health.state.ny.us

Case Mix Changes ~ Statewide Changes for July 1, 2009 and January 1, 2010

Statewide CMI	January 1, 2009	July 1, 2009	% Change Jan 2009 to July 2009	January 1, 2010
All Payer	1.0602	1.0972	3.489%	1.1056
Medicaid Only	0.9381	1.0045	7.078%	1.0104

- April 1, 2009 rebasing rates reflect the January 1, 2009 case mix (0.9381)
- Statute requires the rates to be updated to reflect case mix changes (e.g., July 1, 2009 and January 1, 2010 Case Mix), subject to $210 million spending cap

2009 Cost Reports ~ 2011 Capital

- 2009 Cost Reports Cost were due July 31, 2010
- Time allotted to file nearly doubled from 60 days to over 100 days
- 589 or 94 percent of facilities filed on time
- 39 facilities did not meet the July 31, 2010 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 2011 initial capital rates November 1, 2010

Other Rate Setting Activities

Rate Set	Projected Schedule/Status
2009 Financially Disadvantaged Payments	CMS Approval: Pending DAL Letter: October 2, 2009 Legislative Changes and Restructuring Plan Requirements
2009 UPL Payments Public Facilities	CMS Approval: Pending
2008 Cash Receipts Assessments Reconciliation	Projected Date to DOB: December 1, 2010 Will include appeals for 2002-2007 reconciliations and roll over of reconciled rates
2010 Financially Disadvantaged Payments	CMS Approval: Pending
2011 Initial Capital Rates	November 1, 2010
Adult Day Health Care Rates	Will be released with April 1, May 1, 2009 and Jan 2010 Rates Will reflect the elimination of 2008 and 2009 trends and zero trend for 2010

Financially Disadvantaged Payments

- 2009 Legislation Modified Calculation and Provided for Restructuring Plans
- Modifications 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
- State Plan Amendment (UPL calculation) now before CMS

2010-11 Enacted Budget
Shift Prescription Drugs to Fee-for-Service

- Enacted legislation shifts the reimbursement of prescription drugs for NH patients from the Medicaid rate to the Medicaid Pharmacy fee-for-service program.
- The bulk of prescription drug costs are already carved out of the rate because they are paid for by Medicare Part D
- Medicare ineligible and Medicare Part B eligible rates will be revised to remove the cost of prescription drugs and will be covered by fee-for-service program and billed directly to Medicaid by dispensing pharmacy
- "Heads Up" DAL issued on August 30, 2010
  - Pharmacies that supply prescription drugs to nursing homes need to be enrolled in the Medicaid program
- The Department is currently working with CMS to receive the State Plan approvals - Anticipated effective date on or about October 1, 2010
- Detailed information regarding the implementation date of this change will be provided in future Dear Administrator Letters.

2010-11 Enacted Budget
2010 Cash Assessment Amnesty Program

- Only outstanding liabilities for periods prior to January 1, 2009 are eligible for Amnesty
  - Monthly obligations that have already been paid by the facility or recouped from Medicaid cycle checks are NOT eligible
- Interest and penalty will be waived for outstanding principal amounts that are paid after April 1, 2010 and before December 1, 2010
- Partial payments will be applied chronologically to the oldest monthly principal amounts
  - Interest and penalties are waived only for those months paid in full
- Liabilities (even those estimated by the Department) are not subject to revision or correction
- Facilities that want to participate in the Amnesty Program are required to send a letter of intent to the Bureau of HCRA Operations and Financial Analysis and indicate the date of expected payment
- Upon receipt of the intent letter, the Department will determine the amount of principal eligible for amnesty and information on how to make the required payments

2010-11 Enacted Budget
Reduce Payments for Bed-Holds

- Annual limits for both hospitalization (14 days) and therapeutic leave (10 days)
- Payments for reserved bed days will be made at 95 % of Medicaid rate
- DAL letters, questions and answers issued July 19 and August 13, 2010
- Questions can be submitted to bedres@health.state.ny.us

2010-11 Enacted Budget
Rate Appeals and Negotiated Settlements

- PHL §2808(17) caps annual amount of rate appeals at $80 million for SFY 2010-11
- Authorizes Commissioner to:
  - Prioritize rate appeals for facilities that are facing significant fiscal hardship
  - Expedite processing of backlog of outstanding appeals by entering into negotiated settlements
    - Settlement payments to facilities may be offset by outstanding amounts owed to the State (i.e., assessments)

Value Based Purchasing ~ Effective July 1, 2011

- July 1, 2011 – New Value Based Purchasing Methodology Takes Effect
  - ❖Initial rates due 60 days in advance of July 1, 2011 ~ May 1, 2011
  - ❖State Plan Amendments and CMS Approval Required

- Elements of Value Based Purchasing statute include:
  - ❖ Pricing Methodology for Operating Component of Rate
    - 2007 Base Year – base year updated no less frequently than every six years
    - Regional /Statewide Price, rather than facility specific rates
    - Continuation of MDS Case Mix – 53 RUG Groups
    - Continuation of Medicaid Only Case Mix
  - ❖Quality Incentive Pool or Pools
  - ❖Multi –Year Transition Payments to mitigate significant swings in rates and facilitate ability of NHs to plan

Refining Value Based Purchasing Methodology Principles of Medicaid Reimbursement Reform

Medicaid rates should:

- 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

Federal Health Care Reform

Patient Protection and Affordable Care Act (PPACA)
Health Care and Education Reconciliation Act (HCERA)

- On May 13, 2010, Governor Paterson established the Governor's Health Care Reform Cabinet
- The Cabinet consists of representatives from 15 state agencies, including DOH, and is charged with:
  - Advising and making recommendations to the Governor on the State's role in implementing PPACA and HCERA
  - Managing all aspects of Federal reform in collaboration with an external advisory committee comprised of 37 health care industry and advocacy organizations
- DOH has 6 internal Implementation Workgroups that provide support to the Governor's Cabinet, of which Long Term Care Reform is an integral part

Federal Health Care Reform

- Encourages states to explore new provider payment models (e.g., Value-Based Purchasing Methodology consistent with Federal reforms)
- Allows states to utilize Federal waiver/state plan flexibility to restructure their LTC systems and gain enhanced FMAP
- Establishes a "medical home" and coordinated case management model for enrollees with chronic care conditions (Sec. 2703)
  - Challenge of high cost patients with no care coordination ~ 51% of patients with chronic illnesses have no assigned primary care physician based on prior 2-years ambulatory use
  - Medical home would encourage the development of cost effective care management
  - Financial Arrangements include monthly care coordinate fee; risk arrangements and cost savings sharing incentives
  - Qualifies for 90% Federal Medical Assistance Percentage (FMAP)

Federal Health Care Reform

- Facilitate nursing home transparency, accountability and quality improvement (Sec. 6101-6102; 6105 and 6201)
  - Improve financial disclosure to include facility ownership type
  - Implement compliance and ethics programs
  - Mandate additional reporting of data to Medicare NH Compare Website
  - Require participation in national criminal background check program for direct care staff