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

150 State Street, Suite 301 Albany, New York 12207-1698 Telephone (518) 449-2707 Fax (518) 455-8908 Web www.nyahsa.org

M E M O R A N D U M

TO: RHCF Members

FROM: Dan Heim, Vice President for Public Policy
Darius Kirstein, Senior Policy Analyst

DATE: May 13, 2009

SUBJECT: **Nursing Home Medicaid Reimbursement Issues**

ROUTE TO: Administrator, CFO

ABSTRACT: Important updates on various Medicaid payment issues.

Introduction

As members are aware, there are a number of outstanding nursing home Medicaid reimbursement items. Late last week, the Department of Health (DOH) met with NYAHSA, NYSHFA, and HANYS to provide an update on the status of the department's efforts. NYAHSA has also been having other discussions with DOH staff on selected state budget provisions.

Furthermore, NYAHSA has been evaluating the state budget **and is considering potential legal action on a specific issue.** Finally, the newly expanded Nursing Home Reimbursement Workgroup held its first meeting on May 12th in Albany.

MDS Roster Submission

DOH reports that approximately 150 facilities across the state had one or more residents listed on their January 28, 2009 census roster for whom no MDS was filed. Most of these gaps were attributable to problems encountered when the facility originally tried to submit the MDS. In some cases the batch was submitted erroneously as a test batch; in some cases the submission was not accepted and never resubmitted.

DOH also identified several systemic errors in their programming that in some cases resulted in the wrong MDS being selected for residents listed on the Jan. 28th roster. DOH now believes that these issues, which had to do with Section T therapy time, older MDS resubmissions, and new admissions close to the Jan 28th date, have been resolved.

When an MDS match is unavailable, a resident defaults to the lowest RUG category and is presumed to be a Medicaid resident. DOH has been in contact with each facility that had any residents without an MDS match and has advised that missing MDSs should be re-filed with CMS.

In recognition that this is the first time that the MDS process is used and in light of the large number of facilities affected, DOH will, on a one-time basis for January 28, 2009 census date only download the MDS database a second time for all facilities. This will provide facilities that filed missing MDSs or made corrections to previously filed MDSs since March 18, 2008 (the previous MDS database download date) to have such submissions reflected in their case-mix calculation.

While this is a significant benefit for most facilities, it will require all homes to resubmit their Jan. 28th census roster. DOH will issue a "Dear Administrator" Letter (DAL) that will announce the timing and details of the resubmission.

January 2009 Medicaid Rates

DOH reports that the processing of 2009 capital hotline appeals is almost complete. This will allow staff to finalize the rate calculations for the first quarter of 2009 that will reflect a 1.5 percent 2008 trend factor "banking" adjustment, a 2008 trend factor of 1.17 and a 2009 trend factor of 2.1 percent. While all target dates are subject to change if delays are encountered, DOH plans to pay the 2009 first quarter rates by mid-summer.

April 2009 Medicaid Rates

Development of the April 2009 Medicaid rates still requires much work. Nearly 150 nursing homes re-filed their 2002 (or newer base year) cost reports by the April 15th DOH established deadline. This will require DOH to recalculate the statewide direct and indirect prices, as well as MDS RUG-III weights. The total additional funding that may be used to implement rebasing using a Medicaid-only case mix index (CMI) was legislatively set at $210 million. This constraint requires CMS approval.

While subject to change, DOH shared their current vision of how they plan to implement the $210 million constraint. DOH would calculate **annual Medicaid funding** for each facility using both the current and rebased rates. The current rate will reflect an all-payer PRI-based CMI, while the new rate will utilize a Medicaid-only MDS-based CMI.

To arrive at annual Medicaid funding using the **current** rate, they propose to multiply the 3/31/09 Part D eligible rate (excluding 2008 and 2009 trend factors) by Part D eligible Medicaid days and add it to the Part D ineligible rate multiplied by Part D ineligible days.

To arrive at annual Medicaid funding (unconstrained) using the **new** rate, they would multiply the new 2002-based Part D eligible rate by Part D eligible Medicaid days and add it to the new Part D ineligible rate multiplied by Part D ineligible days.

Subtracting the annual funding using the current rate from annual funding using the new rate will yield the impact of rebasing and moving to a Medicaid-only CMI. The impacts for all facilities

will be proportionately scaled up or down so that the statewide impact equals $210 million. Such proportional adjustments are not subject to reconciliation.

Reconciliation of Rebasing Transition Payments

DOH intends to use the same process described above to reconcile the 2007 and 2008 rebasing add-ons with one exception: the new rate will be calculated using an all-payer CMI. Instead of proportionalizing to $210 million, the statewide benefit will be scaled to the funding amounts distributed ($137.5 million in 2007 and $167.5 million in 2008). This process will redistribute the funding from facilities that were overpaid to those that were underpaid based on updated costs and facilities' 2009 CMIs.

2008 Cost Report Software

Homes should have received a notice from DOH that changes to the RHCF-4 and RHCF-2 cost reports, including the addition of several new schedules, have been posted to the Health Provider Network (HPN) in draft form. The RHCF cost reporting software inclusive of these new schedules is expected to be available on May 18th. The changes were made available to providers as advance notice of the types of new data that they must report starting this year.

Changes to the cost report include:

- Detailed reporting of Medicaid days for residents eligible for Medicare Part D, Part B and both;
- A new schedule to collect agency staff and staff turnover data;
- A new schedule for hospital property allocations;
- A new schedule for allocating purchased and contracted services; and
- A new schedule for calculating Adult Day Health Care utilization.

Additional details and instructions regarding the new reporting requirements will be provided when the software is released. We urge members to take advantage of the advance posting of the new schedules to begin gathering the necessary information. Once the 2008 software is posted, facilities will have the standard 60 days to submit their cost reports.

2008 Recruitment and Retention Funding

DOH staff has completed its work on the 2008 recruitment and retention funding distribution schedule and the schedule is making its way through the rate setting approval process.

Financially Disadvantaged Funding

DOH staff has completed its work on the 2008 disadvantaged facility funding distribution schedule and the schedule is making its way through the rate setting approval process. The 2009-10 state budget reconfigured the program and added restructuring plan requirements as a condition to receive continuing funding. These changes are subject to CMS approval. Assuming timely approval, DOH hopes to distribute 2009 disadvantaged facility funding in October and plans to issue a DAL describing the program changes in late summer.

Assessment Reconciliation

The cash receipts assessment add-on reconciliation for the period 2002-07 has been completed. Preliminary results of the reconciliation indicate that there is an overall recoupment statewide. No timetable has yet been given by DOH with respect to finalizing facility-specific impacts.

PRIs

Work continues on final updates to the PRI database for the period 2003-06. At this time, a schedule has not been established for reissuance of rates based on these updates.

Asset Transfers/Equity Withdrawals

As previously reported, a provision in the 2009-10 budget legislation requires DOH prior approval for a voluntary not-for-profit facility to transfer funds from its balance sheet to another entity, if the transfers individually or in the aggregate would exceed three percent of the prior calendar year's Medicaid revenue. Facilities are required to make these requests to DOH in writing by certified or registered mail, and DOH will have up to 60 days to act on them. If a transfer is made without prior approval, DOH could require replacement of the withdrawn assets and also impose a penalty of up to 10 percent of any amount transferred without prior approval.

NYAHSA recently discussed this requirement in detail with DOH, and suggested a number of clarifications to the policy and its implementation. DOH plans to issue a DAL and request form to facilities very soon.

Potential Action on Rebasing Delay

As you are aware, the Deficit Reduction Plan enacted by state lawmakers in February 2009 delayed the implementation of rebasing from January 1, 2009 to April 1, 2009. This decision had the effect of cutting funding to facilities statewide by over $150 million, and effectively reducing rates to 2006 levels.

Early next week, NYAHSA's Executive Committee will be discussing the potential for a legal challenge to the delay in rebasing. We will advise you of the outcome of this discussion next week, and any specific actions that you should consider taking in response.

Nursing Home Reimbursement Workgroup

The nursing home reimbursement workgroup met on May 12th. NYAHSA is represented on the group by Board Member Laurie Jankowski (Niagara Lutheran Home & Rehab. Center, Buffalo) and Vice President for Public Policy Dan Heim. The group, which was convened several months ago to address a number of Medicaid reimbursement issues, has just been expanded to include consumers as well as representatives of regional provider associations.

NYAHSA is pleased to announce that four of the new regional representatives on the group are also from NYAHSA member organizations—Jim Dewhirst (The Friendly Home, representing the Rochester Association of Home and Services for the Aging); Norma Lewis (St. Luke Health Services, representing the LTC Executive Council of Central NY); Michael Osborne (Catholic Health System, representing the Western New York Association of Homes and Services for the

Aging); and Audrey Weiner (Jewish Home Lifecare, representing the Continuing Care Leadership Coalition).

The group is charged with overseeing development of the new value-based regional pricing methodology. DOH will be making a report on the workgroup's activities to the Legislature by December 15, 2009. During the May 12th meeting, DOH reviewed the legislation that authorized the regional pricing system, slated to take effect on April 1, 2010. Key issues that the workgroup will be considering were also discussed including the appropriate regions, determining allowable costs, addressing cost differences among facilities, specialty facility/unit rates, and establishing funding pools for quality and transition payments. The next meeting is being planned for June, with a focused discussion on determining allowable costs and developing a quality incentive pool. DOH also indicated that they would make 2007 cost and MDS data available to the workgroup during June for analytical purposes.

Conclusion

As shown by this extensive list of issues, DOH staff has a full agenda. Any timeframes noted above on the various rate revisions represent DOH's best (and in some cases most optimistic) estimates of completion. Members are cautioned that the timeframes noted are subject to change.

If you have questions regarding this information, please contact Darius Kirstein at 518-449-2707, ext. 104, or Patrick Cucinelli at ext. 145, or e-mail us at dkirstein@nyahsa.org or pcucinelli@nyahsa.org, respectively.

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