Senior Services News

A Newsletter Published by the
N.J. Dept. of Health & Senior Services
Division of Senior Benefits & Utilization Management

Volume 10 No. 3 **August 2006**

TO: **All Nursing Facility (NF) Providers – For Action**
Route to Financial Officers and Nursing Home Administrators

SUBJECT: **Distribution of State Fiscal Year 2007 Appropriated Funding to Nursing Facilities with High Medicaid Occupancy**

PURPOSE: **To inform NFs of additional Medicaid funding and to request accurate submission of Medicaid occupancy data by August 31, 2006**

BACKGROUND: Pursuant to the New Jersey Appropriations Act for State Fiscal Year 2007, the New Jersey Medicaid program will distribute a maximum of $18 million to those NFs whose Medicaid patient day occupancy level is at, or above, 75%. Each such facility will receive an interim distribution through a prospective per diem rate adjustment. No NF will receive a total allocation greater than the amount lost, due to adjustments in Medicaid reimbursement methodology, which became effective April 1, 1995.

ACTION: **All NF providers must complete and return the attached form by August 31, 2006.** To ensure the proper identification of eligible facilities whose Medicaid patient occupancy levels are at, or above, 75%, it is imperative that each NF accurately complete and promptly return the enclosed "Facility Occupancy Statement" form, along with the appropriate documents, by close of business on August 31, 2006. The "Facility Occupancy Statement" form, along with the appropriate documentation should be sent by certified mail to the Office of Nursing Facility Reimbursement at the address provided on the bottom of the form. **Special Care Nursing Facilities (SCNFs) must submit separate forms for each independent special care unit.**

The "Facility Occupancy Statement" form requests three critical items of information:

1. The number of Medicaid beneficiaries for whom the NF received Medicaid reimbursement for services rendered on June 30, 2006.

2. The number of Medicaid applicants and approved beneficiaries residing in the NF for whom the NF anticipates payment for services rendered on June 30, 2006.

3. The number of NF residents, for whom the NF received Medicaid reimbursement prior to June 30, 2006 and for whom the NF billed Medicare for services rendered on June 30, 2006 (not included in numbers 1 or 2 above).

NOTE: Please submit a list of patient names with Medicaid numbers, if available. Please do not submit Social Security numbers!

The prospective per diem rate adjustments will be calculated according to the following formula:

E = A Medicaid Days/T Medicaid Days * F

Where "E" is the entitlement for a specific nursing facility resulting from this allocation; "A Medicaid Days" is an individual nursing facility's reported Medicaid days on June 30, 2006. "T Medicaid Days" is the total reported Medicaid days for all affected nursing facilities and "F" is the total amount of State and federal funds to be distributed. No NF will receive a total allocation greater than the amount lost, due to adjustments in Medicaid reimbursement methodology, which became effective April 1, 1995.

Before April 30, 2007, DHSS will verify the accuracy of the completed surveys. After April 30, 2007, no verification will be done. Those facilities whose Medicaid occupancy rate on June 30, 2006 has been verified at 75% or greater will remain qualified for the final reconciliation process.

If a nursing facility has incorrectly identified its Medicaid occupancy on the survey form for June 30, 2006 and is found to be below 75%, the amount of the overpayment, will be recouped immediately at 100%.

The per diem add-on for the entire State fiscal year will be recalculated in May 2007, based on verified data and actual Medicaid days paid for services rendered from July 1, 2006 through December 31, 2006 and a projection for the remainder of the fiscal year. The new per diem rate that each facility receives will be considered final and not subject to further adjustment. No adjustment will be made if the revised maximum rate varies from the interim maximum rate by $0.05 or less.

Any concerns that an interested party may have should be brought to the attention of the Department of Health and Senior Services, Office of Nursing Facility Rate Setting and Reimbursement, PO 715, Trenton, NJ 08625-0715, prior to April 1, 2007. Any concerns raised after April 1, 2007 will not be considered.

ANY NURSING FACILITY THAT FAILS TO SUBMIT THE FACILITY OCCUPANCY STATEMENT BY AUGUST 31, 2006, SHALL NOT BE ELIGIBLE FOR THIS SUPPLEMENTAL PAYMENT.

RETAIN THIS NEWSLETTER BEHIND THE NEWSLETTER TAB
(BLUE TAB MARKED "5")

FACILITY OCCUPANCY STATEMENT
STATE OF NEW JERSEY
DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF NURSING FACILITY RATE SETTING AND REIMBURSEMENT

UNISYS PROVIDER NUMBER: _____ FACILITY NAME: _____

1) # OF MEDICAID BENEFICIARIES FOR WHOM THE FACILITY RECEIVED PAYMENT FOR SERVICES RENDERED ON 6/30/06 (INCLUDING PATIENTS ON LEAVE): _____

2) # OF MEDICAID APPLICANTS AND APPROVED BENEFICIARIES RESIDING IN THE FACILITY FOR WHOM THE FACILITY ANTICIPATES PAYMENT FOR SERVICES RENDERED ON 6/30/06: + _____
(Please submit a list of patient names with Medicaid numbers, if available. **Please do not submit Social Security numbers.)**

3) # OF NURSING FACILITY RESIDENTS FOR WHOM THE FACILITY RECEIVED MEDICAID REIMBURSEMENT PRIOR TO 6/30/05, AND FOR WHOM THE FACILITY BILLED MEDICARE FOR SERVICES RENDERED ON 6/30/06, NOT INCLUDED IN # 1 or #2 ABOVE: + _____
(Please submit a list of patient names with Medicaid numbers, if available. **Please do not submit Social Security numbers.)**

TOTAL : **=** **_____**

I CERTIFY THAT THE INFORMATION PROVIDED ON THIS STATEMENT AND WITHIN THE ACCOMPANYING DOCUMENTS IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT FRAUD OR CONCEALMENT WILL BE PUNISHABLE UNDER FEDERAL OR STATE LAW OR BOTH.

SIGNED _____ DATE _____
(Administrator/Executive Officer)

NAME AND TITLE _____
Please Print or Type

THIS FORM, WITH AN ORIGINAL SIGNATURE, MUST BE COMPLETED AND RETURNED TO DHSS NO LATER THAN 08/31/06
THE FORM MUST BE COMPLETED WITH A PEN AND THERE CAN BE NO ERASURES OR CHANGES TO THE DATA/FORM.

Please submit completed forms to:

JOHN ASH, DIRECTOR
OFFICE OF NURSING FACILITY RATE SETTING AND REIMBURSEMENT
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO 715
TRENTON, NJ 08625-0715