
Senior Services News



A Newsletter
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Division of Senior Benefits and
Utilization Management

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August 2004

TO: All Nursing Facility (NF) Providers

SUBJECT: Distribution of 2005 Appropriated Funding (Supplemental Payment) to Nursing Facilities with High Medicaid Occupancy

PURPOSE: To inform NFs of the availability of additional Medicaid funding and to request prompt submission of Medicaid occupancy data

BACKGROUND: Pursuant to the New Jersey Appropriations Act for State Fiscal Year 2005, 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 the adjustments in Medicaid reimbursement methodology which became effective April 1, 1995.

ACTION: 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 the close of business on August 31, 2004. The "Facility Occupancy Statement" form, along with the appropriate documentation, must 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 June 30, 2004.
2. The number of Medicaid applicants residing in the NF for whom the NF anticipates payment for June 30, 2004.
3. The number of NF residents for whom the NF received Medicaid reimbursement prior to June 30, 2004 and for whom the NF billed Medicare for June 30, 2004, (not included in numbers 1 or 2 above).

NOTE: Please submit the lists 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:

$$E = A \text{ Medicaid Days} / T \text{ Medicaid Days} \times F$$

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, 2004. "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, 2005, and to the extent possible, DHSS will verify the accuracy of the completed surveys. Those facilities whose Medicaid occupancy rate on June 30, 2004 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, 2004 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 and adjusted in May 2005, based on verified data and actual Medicaid days paid for services rendered from July 1, 2004 through December 31, 2004 and a projection for the remainder of the fiscal year. No adjustment will be made if the revised maximum rate varies from the interim maximum rate by \$0.05 or less.

The new per diem rate that each facility receives will be considered final and not subject to further adjustment.

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, 2004. Any concerns raised after April 1, 2004 regarding this per diem add-on will not be considered.

ANY NURSING FACILITY THAT FAILS TO SUBMIT THE FACILITY OCCUPANCY STATEMENT BY AUGUST 31, 2004, 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 6/30/04
(INCLUDING PATIENTS ON LEAVE): _____
- 2) # OF MEDICAID APPLICANTS AND APPROVED BENEFICIARIES RESIDING IN THE FACILITY FOR WHOM
THE FACILITY ANTICIPATES PAYMENT FOR 6/30/04: + _____
(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 6/30/04, FOR WHOM THE FACILITY BILLED MEDICARE FOR 6/30/04, 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 IF ANY OF THE STATEMENTS MADE BY ME IN THIS REPORT AND THE ACCOMPANYING DOCUMENTS ARE FALSE, I MAY BE SUBJECT TO PUNISHMENT, INCLUDING BUT NOT LIMITED TO SUSPENSION, DEBARMENT OR DISQUALIFICATION FROM THE NEW JERSEY MEDICAID PROGRAM AND THE OTHER PROGRAMS ADMINISTERED IN WHOLE OR IN PART BY DMAHS IN ACCORDANCE WITH N.J.A.C. 10:49-11.1(d)22.

SIGNED _____ DATE _____
(Administrator/Executive Officer)

NAME AND TITLE _____
Please Print or Type

**This form must contain an original signature and must be completed and returned to DHSS no later than 08/31/04.
The form must be completed with a pen and there can be no erasures on, or changes to, the data and/or the form.**

Please submit forms to:

**FELIX ALMANZOR, DIRECTOR
OFFICE OF NURSING FACILITY RATE SETTING AND REIMBURSEMENT
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 715
TRENTON, NJ 08625-0715**