

April 4, 2012

Subject: Informational 2012 Nursing Home Rates

Dear Administrator:

The purpose of this Dear Administrator Letter (DAL) is to provide you additional details about the informational nursing home rates for residential health care facilities and supporting documentation (Attachments 1 through 5) that have been posted to the Health Commerce System (HCS) on April 4, 2012.

The non-capital components of the informational rates reflect the new Statewide Pricing Reimbursement Methodology and other provisions authorized by Section 2808 2-c of the Public Health Law (PHL), effective for rate periods beginning on January 1, 2012. The rates described herein are subject to approval by the Centers for Medicare and Medicaid Services (CMS) and the Division of the Budget, and until such approvals are received, are being provided for informational purposes only.

The Department is continuing to work as expeditiously as possible with CMS to approve the applicable State Plan Amendment. Upon the receipt of all required approvals, the Department will issue a DAL notifying nursing homes that the rates have been approved and posted to the HCS, and processed to eMedNY for payment.

The non-capital components of the informational rates for non-specialty facilities reflect the elements of the new Statewide Pricing Reimbursement Methodology. The non-capital components of the informational rates for specialty facilities reflect new rates of payment which are the rates of payment in effect for such specialty facilities on January 1, 2009. Specialty facilities include facilities or discrete units of facilities described in PHL §2808 2-c (c). The capital component of the informational rates for all facilities reflects the preliminary capital rate transmitted to you on November 2, 2011.

The New Pricing Methodology (Non Capital Component of the Rates for Non-Specialty Facilities)

The operating component of the rates for non-specialty facilities is a price that consists of the sum of the direct, indirect and non-comparable components.

Peer Groups

The following peer groups will be utilized to calculate the direct and indirect price components of the rates:

- Statewide Peer Group, which includes all non-specialty facilities

- HBF +300 Bed Peer Group, which includes free-standing facilities with certified bed capacities of 300 beds or more and all hospital-based facilities
- -300 Bed Peer Group, which includes all free-standing facilities with certified bed capacities of less than 300 beds

Direct Component of the Price

The direct component of the price shall be a blended rate that is equal to:

- 50% of the Statewide Direct Price, and
- 50% of either:
 - the Direct HBF +300 Bed Peer Group Price or
 - the Direct -300 Bed Peer Group Price

The peer group prices are calculated using allowable operating costs and statistical data for the direct component of the price as reported in each non-specialty facility's cost report, each non-specialty facility's cost report that is in the HBF +300 Bed Peer Group, or each non-specialty facility's cost report that is in the -300 Bed Peer Group Price, as applicable, for the 2007 calendar year, reduced by an allowable costs percent reduction, and divided by total 2007 patient days. Please see the Appendix for a description of the allowable cost centers used to calculate the direct prices and the allowable costs percent reduction.

The direct component of the price for non-specialty facilities that are in the HBF +300 Bed Peer Group is shown in the table below. See supporting documentation Attachment 1.

Rates Effective January 1, 2012	HBF+ 300 Bed Peer Group Direct Component of the Price				
	Statewide Direct Price (a)	50% of Statewide Direct Price (b)	Direct HBF +300 Bed Price (c)	50% of Direct HBF +300 Bed Price (d)	Total Direct Component of Price for HBF +300 Bed Peer Group (b)+(d)
Medicare Ineligible Price and Medicare Part D Eligible Price	\$105.79	\$52.90	\$117.48	\$58.74	\$111.63*
Medicare Part B Eligible Price, Medicare Part B and Part D Eligible Price	\$104.34	\$52.17	\$115.94	\$57.97	\$110.14

*Total does not add due to rounding

The direct component of the price for non-specialty facilities that are in the -300 Bed Peer Group is shown in the table below. See supporting documentation Attachment 1.

Rates Effective January 1, 2012	- 300 Bed Peer Group Direct Component of the Price				
	Statewide Direct Price (a)	50% of Statewide Direct Price (b)	Direct -300 Bed Price (c)	50% of Direct -300 Bed Price (d)	Total Direct Component of Price -300 Bed Peer Group (b)+(d)
Medicare Ineligible Price and Medicare Part D Eligible Price	\$105.79	\$52.90	\$99.30	\$49.65	\$102.54*
Medicare Part B Eligible Price, Medicare Part B and Part D Eligible Price	\$104.34	\$52.17	\$97.90	\$48.95	\$101.12
*Total does not add due to rounding					

WEF Adjustments to the Direct Component of the Price

The direct component of the prices reported above is further adjusted by a wage equalization factor (WEF). The WEF adjustment is calculated using cost and statistical data reported in each non-specialty facility's 2009 cost report as described below. The WEF is a blended adjustment that is equal to 50% of a Facility Specific Direct WEF and 50% of a Regional Direct WEF.

The Facility Specific Direct WEF

The Facility Specific Direct WEF is calculated as follows:

$$1 \div ((\text{Facility Specific Wage Ratio} \div \text{Wage Index}) + (\text{Facility Specific Non-Wage Ratio}))$$

See supporting documentation Attachment 3A.

The Facility Specific Wage Ratio is calculated by dividing facility-specific total salaries and fringes related to direct cost centers for nursing administration (013), activities program (014), social services (021), transportation (022), physical therapy (039), occupational therapy (040), speech/hearing therapy (041), pharmacy (042), central service supply (043), and residential health care facility (051) by total direct operating expenses from such cost centers.

The Wage Index is calculated by dividing facility specific labor costs per hour by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing therapy (041) and residential health care facility (051).

The Facility Specific Non-Wage Ratio is calculated by subtracting from 1 the Facility Specific Wage Ratio.

Regional Direct WEF

A Regional Direct WEF is calculated for each of the 16 WEF regions. The regions are defined by county geographic boundaries and such geographic boundaries are the sole factor considered in determining which WEF region a facility is located in. Please see the Appendix for a defined list of each of the 16 regions.

The Regional Direct WEF uses the same cost centers as used in the Facility-Specific Direct WEF but is instead calculated for each Region as follows:

$$1 \div ((\text{Regional Wage Ratio} \div \text{Regional Wage Index}) + \text{Regional Non-Wage Ratio})$$

See supporting documentation Attachment 3 and 3B.

The Direct WEF adjustment to the direct component of the price for facilities for which 2009 cost report data is unavailable or insufficient to calculate the WEF as described above will be equal to 100% of the applicable regional WEF.

Case Mix Adjustments to the Direct Component of the Price

The direct component of the price is subject to case mix adjustments. The case mix adjustment for the direct component of the prices effective January 1, 2012 and contained herein, is calculated by dividing January 2011 Medicaid only case mix data by the all-payer case mix for the base year 2007. See supporting documentation Attachments 1 and 5.

The all payer case mix for base year 2007 is a blend of:

- 50% of the Statewide case mix for all facilities, and
- 50% of the case mix for either:
 - the Direct HBF +300 Bed Peer Group Price or
 - the Direct -300 Bed Peer Group Price

Subsequent case mix adjustments to the direct component of the price for rate periods effective after January 1, 2012 shall be made in July and January of each calendar year and shall use Medicaid-only case mix data applicable to the previous case mix period. For example, rates effective July 1, 2012 will reflect January 2012 Medicaid-only case mix data, rates effective January 1, 2013 will reflect July 2012 Medicaid-only case mix data, etc.

Case mix adjustments to the direct component of the price for facilities for which facility specific case mix data is unavailable or insufficient shall be equal to the base year case mix of the peer group applicable to such facility.

Indirect Component of the Price

The indirect component of the price shall be a blended rate that is equal to:

- 50% of the Statewide Indirect Price, and
- 50% of either:
 - the Indirect HBF +300 Bed Peer Group Price or
 - the Indirect -300 Bed Peer Group Price

The peer group prices are calculated using allowable operating costs and statistical data for the indirect component of the price as reported in each non-specialty facility's cost report, each non-specialty facility's cost report that is in the HBF +300 Bed Peer Group, or each non-specialty facility's cost report that is in the -300 Bed Peer Group Price, as applicable, for the 2007 calendar year, reduced by an allowable costs percent reduction, and divided by total patient 2007 patient days. Please see the Appendix for a description of the allowable cost centers used to calculate the direct prices and the allowable costs percent reduction.

The indirect component of the price for non-specialty facilities that are in the HBF +300 Bed Peer Group is shown in the table below. See supporting documentation Attachment 1.

	HBF+ 300 Bed Peer Group Indirect Component of the Price				
Rates Effective January 1, 2012	Statewide Indirect Price (a)	50% of Indirect Price (b)	Indirect HBF +300 Bed Price (c)	50% of Indirect HBF +300 Bed Price (d)	Total Indirect Component of Price for HBF +300 Bed Peer Group (b)+(d)
Price	\$53.15	\$26.58	\$61.54	\$30.77	\$57.35

The indirect component of the price for non-specialty facilities that are in the -300 Bed Peer Group is shown in the table below. See supporting documentation Attachment 1.

	- 300 Bed Peer Group Indirect Component of the Price				
Rates Effective January 1, 2012	Statewide Indirect Price (a)	50% of Indirect Price (b)	Indirect -300 Bed Price (c)	50% of Indirect -300 Bed Price (d)	Total Indirect Component of Price -300 Bed Peer Group (b)+(d)
Price	\$53.15	\$26.58	\$48.49	\$24.25	\$50.82*
*Total does not add due to rounding					

WEF Adjustments to the Indirect Component of the Price

The indirect component of the prices reported above is further adjusted by a wage equalization factor (WEF). The WEF adjustment is calculated using cost and statistical data reported in each non-specialty facility's 2009 cost report as described below. The WEF is a blended adjustment that is equal to 50% of a Facility Specific Indirect WEF and 50% of a Regional Indirect WEF.

Facility Specific Indirect WEF

The Facility Specific Indirect WEF is calculated as follows:

$$1 \div ((\text{Facility Specific Wage Ratio} \div \text{Wage Index}) + \text{Facility Specific Non-Wage Ratio}).$$

See supporting documentation Attachment 3C.

The Facility Specific Wage Ratio is calculated by dividing facility-specific total salaries and fringes related to indirect cost centers for fiscal services (004), administrative services (005), plant operation and maintenance (006), grounds (007), security (008), laundry and linen (009), housekeeping (010), patient food service (011), cafeteria (012), non-physician education (015), medical education (016), housing (018), and medical records (019), by total indirect operating expenses for such cost centers.

The Wage Index is calculated by dividing facility specific labor costs per hour by labor costs per hour for RNs, LPNs, aides and orderlies, therapists and therapist aides for all facilities from cost centers physical therapy (039), occupational therapy (040), speech/hearing (041) and residential health care facility (051).

The Facility Specific Non-Wage Ratio is calculated by subtracting from 1 the Facility Specific Wage Ratio.

Regional Indirect WEF

A Regional Indirect WEF is calculated for each of the 16 WEF regions. The regions are defined by county geographic boundaries and such geographic boundaries are the sole factor considered in determining which WEF region a facility is located in. Please see the Appendix for a defined list of each of the 16 regions.

The Regional Indirect WEF uses the same cost centers as used in the Facility-Specific Indirect WEF but is instead calculated as follows for each Region:

$$1 \div ((\text{Regional Wage Ratio} \div \text{Regional Wage Index}) + (\text{Regional Non-Wage Ratio}))$$

See supporting documentation Attachment 3 and 3D.

The Indirect WEF adjustment to the indirect component of the price for facilities for which 2009 cost report data is unavailable or insufficient to calculate the WEF as described above will be equal to 100% of the applicable regional WEF.

Non-Comparable Component of the Price

The non-comparable component of the price is a facility-specific calculation. The non-comparable price is calculated using allowable operating costs and statistical data as reported in each facility's cost report for the 2007 calendar year divided by total 2007 patient days. See supporting documentation Attachment 2.

Please see the Appendix for a description of the allowable cost centers used to calculate the facility specific non-comparable price.

Per Diem Rate Adjustments for Certain Patients

The rate of a non-specialty facility which has the following types of residents, as determined by the January 2011 case mix data, includes the following per diem add-ons:

(1) A per diem add-on in the amount of \$8 for each patient that, (i) qualifies under both the RUG-III impaired cognition and the behavioral problems categories, or (ii) has been diagnosed with Alzheimer's disease or dementia, is classified in the reduced physical functions A, B, or C or in behavioral problems A or B categories, and has an activities of daily living index score of ten or less.

(2) A per diem add-on in the amount of \$17 for each patient whose body mass index is greater than thirty-five.

(3) A per diem add-on in the amount of \$36 for each patient requiring extended care for traumatic brain injury.

Subsequent adjustments to a facility's per diem rate add-on for such patients will be updated with the case mix adjustments made in July and January of each year (see "Case Mix adjustments to the Direct Component of the Price" for additional information). See supporting documentation Attachment 4.

Per Diem Transition Adjustments

The Pricing methodology reflects a five year transition period, which begins with rate year 2012. During each of the five years, facilities are eligible for a per diem rate adjustment. The purpose of the per diem adjustment is to mitigate significant swings in revenues and provide a smooth transition to pricing, which will be fully implemented in 2017.

The per diem transition adjustments are calculated to limit the difference between a facility's Medicaid revenue calculated under pricing (see (i) below) and a facility's Medicaid revenue, as calculated by their July 7, 2011 non-capital Medicaid rate (see (ii) below) to no greater than a percentage of the facility's current Medicaid Revenue received from their July 7, 2011 non-capital Medicaid rate (as transmitted to facilities in the DAL dated November 9, 2011).

For the 2012 rate year the percentage is 1.75%. The percentage is increased to 2.5% in 2013, 5% in 2014, 7.5% in 2015 and 10% in 2016.

(i) A facility's Medicaid revenue, calculated by summing the direct component, indirect component, and non-comparable components of the price in effect for each eligible facility on January 1, 2012, and multiplying such total by the facility's 2010 Medicaid days or the most recently available Medicaid days as of October 24, 2011 as determined by the Commissioner.

(ii) A facility's Medicaid revenue calculated by multiplying the facility's July 7, 2011 non-capital Medicaid rate (as transmitted to the facilities by the Department in a letter dated November 9, 2011) by the facility's 2010 Medicaid days or the most recently available Medicaid days as of October 24, 2011 as determined by the Commissioner and deemed not subject to subsequent reconciliation or adjustment.

Facilities which do not have a July 7, 2011 rate as described above shall not be eligible for the per diem transition adjustment described herein.

Specialty Facilities

Effective January 1, 2012, the non-capital components of the rate for specialty facilities shall be the rates in effect for such facilities on January 1, 2009, as adjusted for inflation and rate appeals, in accordance with applicable statutes. Such rates of payment in effect January 1, 2009 for AIDS facilities or discrete AIDS units with facilities shall be reduced by the AIDS occupancy factor, as described in section 12 of part D of chapter 58 of the laws of 2009.

Effective for rate periods on and after January 1, 2012, there will be no case mix adjustments to rates for specialty facilities.

Capital Rate

At this time, the Department anticipates that it will finalize the 2012 Capital Rates and publish those rates upon CMS approval of the Statewide pricing methodology.

Appeals

Please be advised the Department is **not** accepting appeals related to the informational rates contained herein. If you believe your rate has a significant error and would like to relay this information to the Department, please send an email to the address provided in the Questions section of this DAL and in the subject line indicate Statewide Pricing Informational Rates. Upon the receipt of the required approvals from CMS and subsequent publication of the rates, facilities will have 120 days to appeal the published rates. Please note that those appeals will be subject to applicable statutory provisions, including, but not limited to, Public Health Law sections 2808(11) and 2808(17).

Questions and Scheduled Webinar

The Department will be hosting a Webinar to review the informational rate sheets and supporting documentation on **April 11, 2012 at 3:00 p.m.** If you have questions about your informational rate sheets please submit an email to nfrates@health.state.ny.us and indicate in the subject line of the email "Statewide Pricing Informational Rates." The Department will post questions and answers to the HCS and where practical, the Department will attempt to address answers to your questions during the Webinar.

To register for the webinar go to <https://www1.gotomeeting.com/register/348489433>.
After registering you will receive a confirmation email containing information about how to join
the Webinar. Please note the following System Requirements:

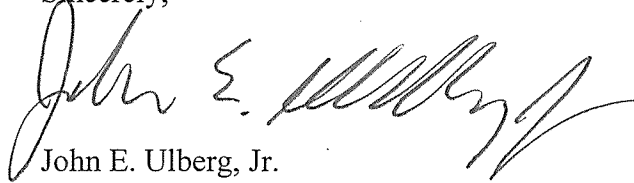
PC-based attendees

Required: Windows® 7, Vista, XP or 2003 Server

Macintosh®-based attendees

Required: Mac OS® X 10.5 or newer

Sincerely,



John E. Ulberg, Jr.
Medicaid Chief Financial Officer
Division of Finance and Rate Setting

Appendix

The following 16 regions are used to calculate the Regional Direct WEF and the Regional Indirect WEF.

- (1) Albany Region, consisting of the counties of Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady and Schoharie.
- (2) Binghamton Region, consisting of the counties of Broome and Tioga.
- (3) Central Rural Region, consisting of the counties of Cayuga, Cortland, Seneca, Tompkins and Yates.
- (4) Elmira Region, consisting of the counties of Chemung, Schuyler and Steuben.
- (5) Erie Region, consisting of the counties of Cattaraugus, Chautaugua, Erie, Niagara and Orleans.
- (6) Glens Falls Region, consisting of the counties of Essex, Warren and Washington.
- (7) Long Island Region, consisting of the counties of Nassau and Suffolk.
- (8) New York City Region, consisting of the counties of Bronx, Kings, New York, Queens and Richmond.
- (9) Northern Rural Region, consisting of the counties of Clinton, Franklin, Hamilton and St. Lawrence.
- (10) Orange Region, consisting of the counties of Chenango, Delaware, Orange, Otsego, Sullivan and Ulster.
- (11) Poughkeepsie Region, consisting of the counties of Dutchess and Putnam.
- (12) Rochester Region, consisting of the counties of Livingston, Monroe, Ontario and Wayne.
- (13) Syracuse Region, consisting of the counties of Madison and Onondaga.
- (14) Utica Region, consisting of the counties of Herkimer, Jefferson, Lewis, Oneida and Oswego.
- (15) Westchester Region, consisting of the counties of Rockland and Westchester.
- (16) Western Rural Region, consisting of the counties of Allegany, Genesee and Wyoming.

Allowable Cost Centers for the Direct Component of the Price

Allowable cost centers used to calculate the Direct Component of the Price include costs reported in the following functional cost centers on the facility's 2007 cost report (RHCF-4), or extracted from a hospital-based facility's 2007 cost report (RHCF-2) and the institutional cost report of its related hospital, from available certified cost reports as determined by the Commissioner, after first deducting costs attributable to specialty units, and the hospital by applying appropriate trace back percentages; and capital costs:

- (1) nursing administration (013);
- (2) activities program (014);
- (3) social services (021);
- (4) transportation (022);
- (5) physical therapy (039) (including associated overhead);
- (6) occupational therapy (040) (including associated overhead);
- (7) speech/hearing therapy (041) (Speech therapy portion only including associated overhead);

- (8) central service supply (043);
- (9) residential health care facility (051); and
- (10) pharmacy (042)(excluding costs allocated to non-comparables).

Case Mix Adjustments

Case mix adjustments are calculated by applying the relative Resource Utilization Groups System (RUGS-III) as published by the Centers for Medicare and Medicaid Services and revised to reflect New York State wage and fringe benefits, and based on Medicaid only patient data.

The New York State wages are used to determine the weight of each RUG. The cost for each RUG is calculated using the relative resources for registered nurses, licensed practical nurses, aides, therapists, and therapy aides and the 1995-97 federal time study. The minutes from the federal time study are multiplied by the New York average dollar per hour to determine the fiscal resources need to care for that patient type. This amount is multiplied by the number of patients in that RUG. RUG weights are assigned based on the distance from the Statewide average. The RUGS III weights are increased by the following amounts for the following categories of residents:

- (i) thirty minutes of certified nurse aide time for the impaired cognition A category;
- (ii) forty minutes of certified nurse aide time for the impaired cognition B category; and
- (iii) twenty-five minutes of certified nurse aide time for the reduced physical functions B category.

Allowable Cost Centers for the Indirect Component of the Price

Allowable costs for the indirect component of the price include costs reported in the following functional cost centers on the facility's 2007 cost report (RHCF-4), or extracted from a hospital-based facility's 2007 cost report (RHCF-2) and the institutional cost report of its related hospital, from available certified cost reports as determined by the Commissioner, after first deducting costs attributable to specialty units, and the hospital by applying appropriate trace back percentages; and capital costs.

- (1) fiscal services (004);
- (2) administrative services (005);
- (3) plant operations and maintenance (006) (with the exception of utilities and real estate and occupancy taxes);
- (4) grounds (007);
- (5) security (008);
- (6) laundry and linen (009);
- (7) housekeeping (010);
- (8) patient food services (011);
- (9) cafeteria (012);
- (10) non-physician education (015);
- (11) medical education (016);
- (12) housing (018); and
- (13) medical records (019).

Allowable Costs Percent Reduction

The allowable costs percent reduction is uniformly applied to the direct and indirect allowable costs of each facility to set a price that maintains the level of spending prescribed by the \$210 million nursing home cap and that allows gains and losses under the first year of pricing to be capped at 1.75% (see Transition Per Diem Adjustments for more information). The allowable costs percent reduction for rates effective January 1, 2012 is 19.545660%.

Allowable Cost Centers for the Non-Comparable Component of the Price

Allowable costs for the non-comparable component include costs reported in the following functional cost centers on the facility's 2007 cost report (RHCF-4), or extracted from a hospital-based facility's 2007 cost report (RHCF-2) and the institutional cost report of its related hospital, or from otherwise available certified cost reports as determined by the Commissioner, after first deducting costs attributable to specialty units, and the hospital by applying appropriate trace back percentages; and capital costs.

- (1) Laboratory services (031);
- (2) ECG (032);
- (3) EEG (033);
- (4) Radiology (034);
- (5) Inhalation therapy (035);
- (6) Podiatry (036);
- (7) Dental (037);
- (8) Psychiatric (038);
- (9) Speech and hearing therapy (041) (hearing therapy only, including associated overhead);
- (10) Medical directors office (017);
- (11) Medical staff services (044);
- (12) Utilization review (020);
- (13) Other ancillary services (045, 046, 047);
- (14) Costs of utilities associated with plant operations and maintenance; and
- (15) Pharmacy costs pertaining to administrative overhead and costs of non-prescription drugs and supplies.

Note: The Department is in the process of preparing additional supporting documentation that will provide facility specific allowable costs for each of the costs centers that are used in the calculation of the prices.