Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

June 20, 2011

Subject: Medicaid "Rebasing Rates" and "Remediation Rates" Effective April 1, 2009

Dear Administrator:

The purpose of this letter is to formally advise you that new Medicaid rates for your residential health care facility have been promulgated and are now available on the Health Commerce System (HCS). As summarized immediately below and described in more detail throughout this Dear Administrative Letter (DAL), the rates described herein are effective for rate periods April 1, 2009, May 1, 2009, July 1, 2009, January 1, 2010, April 1, 2010, and January 1, 2011 (generally referred to in this DAL as the "Rebasing Rates") and for certain providers, rates effective May 1, 2011 and June 1, 2011 (generally referred to in this DAL as the "Rebasing Remediation Rates") and are all-inclusive rates for health care services provided at your facility. "Rates provided herein" reflect both the "Rebasing Rates" and the "Rebasing Remediation Rates."

April 1, 2009 Rates

- 2002 Rebasing provisions (Chapter 109 of the Laws of 2006, as amended)
- MDS / RUGs-III patient classification system and Medicaid Only Case mix and RUGs-III which reflect January 2009 MDS Data (Chapter 109 of the Laws of 2006, as amended and Chapter 58 Laws of 2007)
- Elimination of the 2008 and 2009 trend factor adjustments
- 2009 Capital rates

Note: Rates Effective April 1, 2009 do not reflect a "scale back" adjustment

May 1, 2009 Rates

- April 1, 2009 rates modified to include an 11-month "scale back" adjustment

July 1, 2009 Rates

- May 1, 2009 rates modified to reflect July 2009 MDS Data
- "Scale back" adjustment updated

January 1, 2010 Rates

- July 1, 2009 rates modified to reflect January 2010 MDS Data
- "Scale back" adjustment updated
- "Banking" trend adjustment for the final 2009 trend factor applicable to the first quarter of 2009
- 2010 Capital rates

April 1, 2010 Rates

- January 1, 2010 rates modified to reflect a 12-month "scale back" adjustment

January 1, 2011 Rates

- April 1, 2010 rates modified to reflect the elimination of the "banking" trend adjustment only – all other applicable adjustments will be made in future rate publications

May 1, 2011 Rates

- January 1, 2011 rate modified to include a Remediation payment (Rebasing Remediation Rates) – **Applicable only to those homes eligible to receive a Remediation Payment**

June 1, 2011 Rates

- May 1, 2011 rate modified to remove the Remediation payment – **Applicable only to those homes eligible to receive a Remediation Payment**

REBASING PROVISIONS

As discussed in more detail below, the Medicaid rate methodology applicable to the Rebasing Rates employs a modified pricing system, which combines the aspects of a pure pricing system with the principles of a cost-based system. The direct and indirect components of the rate utilize portions of both systems, by comparing a facility's allowable operating costs to a base (minimum) and ceiling (maximum) price. The facility receives the higher of the base price or its cost up to the ceiling price.

Updating the base year: Effective April 1, 2009, the base year for the operating component of the rate (the sum of direct, indirect and non-comparable components) is the base year allowable costs from the 2002 cost report (i.e., reports filed and properly certified by April 15, 2009) adjusted for inflation. The operating component of the rate for facilities which have a rebased rate which utilizes a cost report subsequent to 2002 is based on the allowable costs from the applicable base year cost report adjusted for inflation. (PHL §2808(2-b)(b)(i)).

- Allowable operating costs from the 2002 cost report, after application of the appropriate traceback percentage, are used to calculate the direct, indirect and non-comparable components of the rate. The allowable operating costs for facilities with rates based on a base year that is subsequent to 2002 have been down trended from the base period to 2002 using the applicable Consumer Price Index (CPI) for the period. The base year costs for all facilities, 2002 or applicable down trended base costs, have been trended forward by the CPI, as adjusted by Legislative amendments for the period 2003-2010 (see ***Trend Factor*** for additional details).

- ***Hold Harmless Provision:*** Facilities which do not benefit from the use of the 2002 base year or subsequent base year are held harmless. To determine if a facility is held harmless, the Department compared the facility's 2002 base year or subsequent base year operating component (the sum of the direct, indirect and non-comparable component) trended using applicable trend factors (see ***Trend Factor*** for additional details) to the operating component in effect December 31, 2008 without the 2008

trend factor. The facility receives the higher of these two operating components. Facilities receiving the equivalent of their 2008 operating component without the 2008 trend factor are held harmless. In addition, the 2008 rate will not be lowered by the value of the productivity and efficiency expenditures as provided by PHL §2808(2-b)(b)(i).

Adjustments to the Direct Component of the Operating Component

Case Mix: The direct component of the Rebasing Rates is subject to case mix adjustment through the application of the relative resource utilization groups system of patient classification (RUGs-III) employed by the Federal Government with regard to payments to skilled nursing facilities pursuant to Title XVIII of the Federal Social Security Act (Medicare). (See the Minimum Data Set section for additional details).

The direct component of the Rebasing Rates is subject to case mix adjustments required to be made in January and July of each calendar year (as amended under current law – please see NOTE below) . The direct component of the Rebasing Rates, the higher of the base price or facility cost up to the ceiling price, is adjusted by the percentage change in case mix from the base period case mix (2002 or subsequent base period as applicable) to the rate year case mix, and is further adjusted to reflect a Medicaid Only Case Mix as required by PHL§2808(2-b)(g). The following table shows which Census Roster date and scheduled case mix update is applicable to the Rebasing Rates described herein.

Effective Date of Rate	Scheduled Case Mix (Census Roster Date)
April 1, 2009	January 1, 2009 (January 28, 2009)
May 1, 2009	January 1, 2009 (January 28, 2009)
July 1, 2009	July 1, 2009 (July 29, 2009)
January 1, 2010	January 1, 2010 (January 27, 2010)
April 1, 2010	January 1, 2010 (January 27, 2010)

The January 1, 2011, May 1, 2011 (if applicable to your facility) and June 1, 2011 (if applicable to your facility) rates included herein will reflect the January 1, 2010 case mix. As indicated in the May 26, 2011 Nursing Home Webinar, the Department anticipates releasing July 1, 2010 rates and April 1, 2011 rates, and modified January 1, 2011 rates, April 1, 2011 rates, May 1, 2011 (if applicable to your facility) and June 1, 2011 (if applicable to your facility) that will reflect the scheduled July 1, 2010 case mix adjustment in September 2011.

NOTE: Pursuant to Chapter 58 of the Laws of 2010 and Chapter 59 of the Laws of 2010, the case mix adjustments for January 2011 and July 2011 applicable to Rebasing Rates in effect during those periods have been eliminated.

For additional information regarding the calculation of case mix and RUGs-III please see "ADDITIONAL CASE MIX - MINIMUM DATA SET INFORMATION."

Therapy Costs: The direct operating component includes allowable therapy costs and associated overhead costs. Administrative overhead costs related to Pharmacy Services, the costs of non-prescription drugs, supplies and associated overhead is reflected in the non-comparable component of the rate (PHL §2808 (2-b)(b)(v)).

- Overhead expenses from the relevant indirect cost accounts are reallocated to the physical, occupational, and speech therapy direct cost accounts. The basis of the allocation is determined by the costs and statistics from a facility's base year cost report. For example, net square feet is the statistic (Exhibit J of the RHCF-4, ICR Exhibit 19 statistics for RHCF-2 filers) associated with Plant Maintenance. Five hundred net square feet of a facility's 50,000 net square feet is allocated to the physical therapy department, or one percent of the total net square feet. Thus, one percent of the plant maintenance allowable costs, net of all associated adjustments and allocations, is the overhead amount allocated from the plant maintenance account to the physical therapy account.

- The method to allocate fiscal and administrative service cost accounts, which do not have an associated statistic as reported on Exhibit H of the RHCF-4, is explained by the following example. Assume total reported physical therapy cost less associated capital is $200,000. The total reported facility costs, less capital as identified on line 001, 002 and 003 of Exhibit H are $16,000,000. Finding the percentage of therapy cost to total is: $200,000/$16,000,000 = 1.25%. Thus, 1.25% of allowable fiscal and administrative costs, net of all associated adjustments and reallocations, is the overhead amount allocated to the physical therapy account. The administrative services overhead applicable to the pharmacy account is similarly calculated and reimbursed as a portion of the non-comparable component.

- The cost for medicine cabinet drugs, as reported on Schedule 6 of the RHCF-4, is used to determine the amount of non-prescription drugs which is reimbursed through the non-comparable component of the rate.

Peer Group Ceilings: For the purpose of computing peer group cost ceilings for both the direct and indirect components of the operating component of the rate, facilities are grouped by the following peer groups (PHL §2808(2-b)(b)(vi)):

- Free-standing facilities with less than 300 certified beds
- Free-standing facilities with 300 or more certified beds
- Hospital-based facilities

In addition, peer group ceilings for both the direct and indirect components of the operating component of the rate are calculated for the following specialty unit/facilities:

- Discrete AIDS
- Ventilator Dependent
- Traumatic Brain Injury
- Behavioral Intervention

Pediatric specialty unit/facilities continue to be exempt from peer group ceiling adjustments.

The Department limited the number of facilities included in the peer group ceiling calculation by removing facilities at or above the 97th percentile and at or below the 3rd percentile prior to the calculation of each peer group ceiling identified above.

Ceiling adjustment for all public facilities, and non-public facilities with fewer than 80 beds: Public facilities, and non-public facilities with fewer than 80 certified beds, which have direct or indirect costs over the ceiling receive a rate add-on of 50% of the difference between the facility specific direct (or indirect) cost per day and the direct (or indirect) ceiling cost per day (PHL §2808(2-b)(b)(xi)).

Corridors for each Direct and Indirect Statewide Mean Price: Pursuant to statute (PHL §2808(2-b)(b)(vii)) the methodology to establish corridors around each statewide direct and indirect mean price is to:

- Establish a base that is no less than 85 percent and no greater than 90 percent of each mean direct and indirect price
- Establish a ceiling that is no greater than 115 percent and no less than 110 percent of each mean direct and indirect price
- Realize a total financial impact of the application of the ceiling that is substantially equal to the total financial impact of the application of the base.

The corridors established for all the rates described herein are for the base 90 percent of each mean direct and indirect price, and for the ceiling 114.7 percent of each mean direct and indirect price.

2009 Per Diem Add-ons and Applicable Base Year Allowable Cost Adjustments: The operating component of the rate is adjusted to reflect per diem add-ons of:

- $8.00 per day trended from 2006 to the applicable rate year for each resident using the relevant MDS data who:

  ✓ Qualifies under both the RUG-III impaired cognition and the behavioral problems categories or

  ✓ Has been diagnosed with Alzheimer's disease or dementia, and is classified in the RUG-III reduced physical functions A, B, or C categories, or

  ✓ Is classified in the RUG-III behavioral problems A or B categories; and has an activities of daily living index score of ten or less. (PHL §2808(2-b)(b)(viii))

- $17.00 per day trended from 2006 to the applicable rate year for each resident whose Body Mass Index (BMI), using the relevant MDS data, is greater than thirty-five (35). (PHL §2808(2-b)(b)(ix). Residents with a BMI greater than 35 have been identified using the weight and height data from the relevant MDS data. The Department has employed the formula used by the National Institute of Health to calculate a resident's BMI of: (Weight-lbs/ (Height-inches {squared}))*703

As a result of reporting problems with the weight and height data used to calculate a resident's BMI the Department has imposed the following limits to more accurately identify residents who quality for the BMI adjustment:

- ✓ Height must equal at least 48 inches
- ✓ Weight cannot be greater than 825 lbs.
- ✓ Calculated BMI must be greater than 35 and less than 100

- $35.41 per day ($25.00 trended from 1996 to 2006) trended from 2006 to the applicable rate year for each resident identified as Traumatic Brain Injury – Extended Care (TBI-Extended Care) (PHL§2808(2-b)(b)(iii). For the applicable base year allowable cost adjustment the TBI-Extended Care Residents have been identified by matching the applicable year Patient Review Instrument (PRI) data submitted by each facility. For the per diem add-on the TBI-Extended Care Residents have been identified from Section S of the MDS.

An adjustment to remove the cost of residents eligible for the enhanced reimbursement add-ons identified above was made to the applicable base year cost to eliminate double reimbursement.

Hepatitis B Vaccine: Pursuant to statute (PHL §2808(2-b)(b)(iii)) the operating component of the rate is adjusted for the costs of Hepatitis B vaccination based upon data reported in the RHCF-2 or RHCF-4. The Hepatitis B vaccination adjustment per diem included in the April 1, 2009 through December 31, 2009 rates is a continuation of the Hepatitis B per diem from the facility's January 1, 2009 rate. The 2010 adjustment included in rates effective January 1, 2010 through December 31, 2010 is calculated as follows: the lower of the 2008 vaccine expense reported by the facility or the reported number of inoculations given to employees in 2008 multiplied by the facility's average cost per vial capped at $128.50 for a three vial series, divided by estimated 2010 patient days. This per diem can be found on Line 15A of the face page of the rate sheet.

Measles and Rubella Immunization Adjustment: In accordance with Section 415.26 of Part 415 of the Commissioner's Administrative Rules and Regulations all employees are required to be properly immunized against rubella and all employees born after January 1, 1957 are required to be properly immunized against measles. The Measles and Rubella Immunization adjustment per diem included in the April 1, 2009 through December 31, 2009 rates is a continuation of the Measles and Rubella Immunization per diem from the facility's January 1, 2009 rate. Reimbursement to facilities for their allowable rubella and measles vaccine expense for rate year 2010 and included in rates effective January 1, 2010 through December 31, 2010 is based upon data reported in the 2008 RHCF-2 or RHCF-4. The 2008 reported expenses are divided by estimated 2010 patient days. This per diem can be found on Line 1 of Schedule 5A of the rate sheet.

Criminal Background Checks: In accordance with Section 402.10 of Part 402 of the Commissioner's Administrative Rules and Regulations facilities are required to review the criminal history record of employees who are hired on or after September 1, 2006 and who provide direct care or supervision to residents. The criminal background check adjustment in

the April 1, 2009 through December 31, 2009 rates is a continuation of the criminal background check per diem from the facility's January 1, 2009 rate. Reimbursement to facilities for costs associated with criminal background checks for 2010 and included in rates effective January 1, 2010 through December 31, 2010 is based upon data reported in the 2008 RHCF-2 or RHCF-4. The 2008 reported expenses are divided by estimated 2010 patient days and are capped at $110.00 per background check. This per diem can be found on Line 3 of Schedule 5A of the rate sheet.

Dementia Grants: Rates for certain facilities include a dementia grant award to improve the care and treatment of nursing facility residents with dementia. The dementia grant adjustment per diem in the April 1, 2009 through December 31, 2009 rates is a continuation of the dementia grant per diem from the facility's January 1, 2009 rate. The 2010 rates include reimbursement for the portion of the award applicable to 2010. For these facilities, the per diem to reimburse this award can be found on Line 2 of Schedule 5A of the rate sheet.

AIDS Occupancy Factor: Effective April 1, 2009 (Chapter 58 of the Laws of 2009) the occupancy factor has been eliminated from the operating component of the rate for a facility that is designated as an AIDS facility or as having an AIDS discrete unit.

Wage Equalization Factor (WEF): The WEF is utilized to compensate for wage differences in various regions across the State.

- For the Rates provided herein, the WEF has been calculated based on employee compensation as reported in the 2002 and/or subsequent 2002 base year RHCF cost report.
- The WEF calculation includes salaries and fringe benefits for Registered Nurses (RNs), Licensed Professional Nurses (LPNs), Certified Nursing Aides (Aides), Therapists, and Therapist Aides.
- The regional corridors are established pursuant to statute and adhere to a statewide value of ten percent.
- The Department limited the number of facilities included in the WEF calculation by removing facilities at or above the 95th percentile and at or below the 5th percentile prior to the calculation of the WEF.

Part B and Part D Adjustments: The Part B offset amount in the Rates provided herein is the Part B offset from the facility's January 1, 2009 rate reduced by the 2008 and 2009 trend factors. The Part D offset is calculated by removing the cost of prescription drugs from the facility's allowable cost as well as from the associated peer group to determine the allowable direct component excluding the cost of drugs and comparing the results of this calculation with the allowable direct component with the cost of drugs. The difference in these two calculations is the amount of the Part D offset.

Other Rebasing Provisions: Public Health Law §2808(2-b)(c) provides that no less than 65% (and no more than 75%) of the additional Medicaid reimbursement received by a nursing home that is attributable to the Rebasing provisions related to the 2002 base year costs, are to be used for Recruitment and Retention purposes (R&R). Such funds must be expended for

the benefit of non-supervisory workers or any worker with direct resident care responsibility or for purposes authorized under the Nursing Home Quality Improvement Demonstration Program (PHL §2808-d).

SCALE BACK PROVISIONS

Chapters 58 of the Laws of 2009 and 2010 and Chapter 59 Laws of 2011 requires rates for the April 1, 2009 through March 31, 2010 period include proportional adjustments to ensure that the impact of the rebasing provisions of Chapter 109 of the Laws of 2006 and Medicaid only case mix implemented by Chapter 58 of the Laws of 2007 do not result in an increase in aggregate total expenditures (excluding capital rates and prior to trend adjustments) that is no more or no less than $210 million.

The effective date of the State Plan Amendment related to this provision, in accordance with Federal Public Notice requirements, is May 1, 2009. Thus, the April 1, 2009 through April 30, 2009 rates provided herein do not reflect this adjustment. The rates effective May 1, 2009 through March 31, 2010 are adjusted such that the aggregate adjustment in rates in effect for April 1, 2009 through March 31, 2010 result in aggregate Medicaid expenditures that are no more or no less than $210 million. The proportional adjustments to such rates were determined using each facility's proportionate share of their estimated Medicaid revenue from the applicable rates that reflect the impact of rebasing and Medicaid only case mix.

Those Chapter Laws also provide that annual rates for the April 1, 2010 through March 31, 2011 and April 1, 2011 through March 31, 2012 do not reflect an increase or decrease from the aggregate total expenditures calculated above for the April 1, 2009 through March 31, 2010 period.

The rate adjustments implemented to adjust spending to the required amount is reflected as the "scale back adjustment" on the applicable rate sheets. The final calculated scale back adjustments are not subject to subsequent correction or reconciliation.

Trend Factor: Pursuant to Chapter 109 of the Laws of 2006, the rebased rates are trended from 2002 to the applicable rate year using the Consumer Price Index (CPI) as statutorily amended. For purposes of down trending where applicable, the full CPI was applied.

Percent	2003 Final CPI	2004 Final CPI	2005 Final CPI	2006 Final CPI	2007 Final CPI	2008 Final CPI	2009 Initial CPI	2009 Final CPI	2010 Initial CPI
CPI	2.30	2.70	3.40	3.20	2.80	3.8	3.10	-0.40	1.70
CPI (As Amended)	2.30	2.70	3.40	2.95	2.10	0	0	0	0

The rates provided and effective as described herein reflect the statutory elimination of the 2008, 2009 and 2010 trend factors. The rates applicable to the 2010 calendar year (effective January 1, 2010 and April 1, 2010) reflect a per diem adjustment to prospectively reimburse the difference between the initial 2009 trend factor paid in the rate effective January 1, 2009 through March 31, 2009 and the final 2009 trend factor. This adjustment is commonly referred to as the "banking" adjustment.

The January 1, 2011 rates reflect the elimination of the 2009 "banking" adjustment and no other trend or other rate adjustments. As indicated in the May 26, 2011 Nursing Home Webinar the Department anticipates releasing rate adjustments that will reflect applicable 2011 trend factor and other adjustments in September 2011.

REMEDIATION RATES

As discussed in the May 26, 2011 Nursing Home Webinar, the Department and the Nursing Home Associations worked collaboratively to develop a Remediation Plan to mitigate the adverse impacts of the Rebasing Rates. Only nursing homes eligible for a Remediation Rebasing payment will receive a per diem add-on that will be reflected in rates effective May 1, 2011 through May 31, 2011. Facilities eligible for the Rebasing Remediation payment will also receive a rate, effective June 1, 2011, that will remove that per diem add-on. The Remediation Rebasing payments are authorized by Section 2808(2-d) of the PHL.

Facilities eligible for Remediation Rebasing payments include those facilities that have experienced a net reduction (as determined by the Commissioner) in their rate for the period April 1, 2009 through March 31, 2011 as a result of:

- The 2002 rebasing methodology,
- Medicaid-only case mix methodology, and
- The application of the proportional adjustments (i.e., the "scale back") required by the aggregate expenditure limits imposed by Chapter 58 of the Laws of 2009 as amended.

In determining the net reduction, the impact of case mix adjustments applicable to July 2010, and Medicaid rate adjustments for appeals and patient review instrument (PRI) case mix updates processed for payment after October 19, 2010 have been disregarded.

Section 2808(2-d) of PHL authorizes total Rebasing Remediation payments of $276.6 million, of which $221.3 million are to be allocated to eligible facilities as described below. The remaining $55.3 million of payments are to be distributed to the same eligible facilities in the same proportion that the $221.3 million of payments are allocated.

a) Facilities that met the following criteria will receive a per diem add-on that is equal to 100 percent of the net reduction calculated as described above.
   - ✓ Facilities eligible for Financially Disadvantaged distributions for the 2009 period;
   - ✓ Non-public facilities whose total operating losses equal or exceed five percent of total operating revenue and whose Medicaid utilization equals or exceeds seventy percent (based on either their 2009 cost report or their most recently available cost report, as determined by the Commissioner); or
   - ✓ Facilities or distinct units of facilities providing services primarily to children under the age of twenty-one, will receive a supplemental payment that is equal to 100 percent of the net reduction determined above.

b) Facilities other than eligible facilities described in paragraph (a) will receive a per diem add-on equal to 50 percent of their net reduction.

c) Facilities described in paragraph (b), which after the application of the rate adjustments described in paragraph (b) remain subject to a net reduction in their inpatient Medicaid revenue that is in excess of two percent (as measured with regard to the non-capital components of facility inpatient rates in effect on March 31, 2009 computed prior to the application of trend factor adjustments attributable to the 2008 and 2009 calendar years) will receive a per diem rate add-on that has been further adjusted such that their net reduction does not exceed two percent.

d) Facilities described in paragraph (c) which experienced a net reduction in their inpatient rates of more than $6 million over the period April 1, 2009 through March 31, 2011 as a result of the application of proportional adjustments (i.e., the "scale back") will receive a per diem rate add-on that has been further adjusted to reduce their net reduction to zero.

The Rebasing Remediation payments described herein will not be subject to subsequent adjustment or reconciliation.

CAPITAL RATES

The following table indicates the effective date of the capital rate that is applicable to the effective date of the all inclusive rates provided herein. For your reference the cost report used to calculate the capital rate has been provided.

Effective Date of Rate	Applicable Capital Rate
April 1, 2009	January 1, 2009 (2007 Cost Report) (See September 16, 2009 DAL)
May 1, 2009	January 1, 2009 (2007 Cost Report)
July 1, 2009	January 1, 2009 (2007 Cost Report)
January 1, 2010	January 1, 2010 (2008 Cost Report)
April 1, 2010	January 1, 2010 (2008 Cost Report)

The capital component of the rate continues to reflect property taxes and/or payments in lieu of property taxes reported in the facility's cost report two years prior to the rate year. In accordance with (PHL §2808(2-b)(b)(i)), real estate tax expenses reflected in the operating component will be eliminated.

- The capital component of the rate is computed to reflect the full value, after application of the appropriate traceback percentage, of real estate taxes and payments made in lieu of real estate taxes as reported in the applicable cost report used to calculate the real property component of the rate.

The rate of return on net investment for 2010 is 0.19% based upon the 26 week U.S. Treasury bill rate in effect on September 10, 2009 in accordance with Part 86-2.28.

The rate of return on real property equity, calculated pursuant to Part 86-2.21 is 4.33 % for 2010.

The rate used to calculate the threshold for working capital as 9.25%

The January 1, 2011, May 1, 2011 (if applicable to your facility) and June 1, 2011 (if applicable to your facility) rates included herein will reflect the January 1, 2010 capital rate. As indicated in the May 26, 2011 Nursing Home Webinar, the Department anticipates releasing modified January 1, 2011 rates (and other 2011 rates with various effective dates) that will reflect the 2011 Capital Rates (which are calculated using the 2009 cost reports) in September 2011.

ADDITIONAL CASE MIX - MINIMUM DATA SET INFORMATION

Base Year Minimum Data Set (MDS): Effective April 1, 2009 Medicaid rates are subject to case mix adjustments through application of the relative resource utilization groups system of patient classification (RUG-III) employed by the Federal Government for payments to skilled nursing facilities pursuant to Title XVIII of the Federal Social Security Act (Medicare). The reimbursement system will employ the MDS 2.0 or subsequent revisions as approved by the CMS. The reimbursement system employs the 53 Group RUG-III Classification System model version 5.20.

For facilities with a 2002 base year cost report a 2002 MDS database was developed using a four quarter mid-point methodology which identified each resident's MDS by the assessment reference date (ARD) closest to the mid-point of each quarter. For facilities with a base year cost report subsequent to 2002 an MDS database was developed using a four quarter mid-point methodology which identified each resident's MDS by the ARD closest to the mid-point of each quarter matching the 12 month ('off- year') cost report period.

If more than one MDS was identified for a resident within a quarter, the MDS with the ARD closest to the mid-point was selected. In cases where two MDS submissions for the same resident were an equal distance from the mid-point, the earlier MDS with an ARD before the mid-point was selected. This methodology was used for all four quarters of the applicable base year, 2002 or off-year and the resulting quarterly 'counts' were added together, consequently the MDS 'counts' in the base year data for rates effective 2009 may contain more MDS counts than beds.

Each facility's base year MDSs are RUGed, using the 53 Group RUG-III Classification System, Index Maximization, and New York State specific weights resulting in each facility's 'frozen' base year MDS case mix index.

Residents eligible for specialty unit/facility reimbursement for discrete AIDS, Ventilator Dependent, Traumatic Brain Injured, and Behavioral Intervention are identified by matching the frozen base year MDS data to the applicable year Patient Review Instrument (PRI) data submitted by each facility. Residents eligible for the enhanced reimbursement "add-on" for Traumatic Brain Injured – Extended Care are also identified by matching the frozen base year MDS data to the applicable year PRI data submitted by each facility.

In addition, the Department agreed to refine the Mid-Point methodology described above to identify MDS records by payer and to weight such MDS records using the relationship of Medicare and all other days as reported in the Residential Health Care Facility (RHCF) cost

report for the 'base year'. This adjustment was made in response to a request by the Joint Association Task Force (which collectively includes the New York State Health Facilities Association-NYSHFA, New York Association of Homes and Services for the Aging-NYAHSA, and Healthcare Association of New York State-HANYS) to address an over sampling of Medicare MDS that may result in an overstatement of the base year case mix.

New York State Specific Weights for 53 Group RUG-III Classification System: New York State specific weights have been developed that reflect New York State wages and fringe benefits reported in 2002. The resulting individual RUG weights were then increased by the statutory amounts for residents in the impaired cognition A, impaired cognition B, and reduced physical function B categories.

The data used to determine the relative weights was developed using the 2002 base year MDS database, the Federal staffing minutes for RNs, LPNs, Aides, Therapists, and Therapist Aides for each RUG group from the 1995 and 1997 time study, and the statewide dollar per hour for all the job categories listed above from the 2002 Medicaid cost reports.

Each RUG category is assigned an index score that represents the amount of nursing time and rehabilitation treatment time associated with caring for the residents who qualify for the groups.

The methodology to determine the relative weight of each RUG group is as follows:

- Determine the number of residents per RUG category using MDS Hierarchical scoring
- Multiply total minutes by statewide average dollar per minute resulting in the overall average cost
- Multiply the overall average cost by the resident count of MDSs and add all five staffing levels together to calculate the total staffing cost per resident
- Divide the total staffing cost per resident by the resident counts to determine an average cost per resident
- The relative weight is determined based on each RUG category's average cost as compared to the total average cost

AUDITS

As a reminder, please note that cost reports submitted for the 2002 calendar year or any subsequent year used to determine the operating component of the April 1, 2009 rate will be subject to audit through December 31, 2014. (PHL §2808(2-b)(d)).

ADULT DAY HEALTH CARE (ADHC) RATES

Information applicable to ADHC rates effective on or after April 1, 2009 will be provided in a separate DAL.

APPEALS

Operating Rate Appeals: Facilities are reminded that effective April 1, 2009, statute provides the Department will only review operating rate appeals for the correction of computational errors or omissions of data by the Department in determining the operating rate based upon information submitted to the Department prior to the computation of the rate. This applies to all administrative operating appeals submitted to the Department on or after April 1, 2009,

regardless of the period they pertain to. Thus, all operating appeals submitted under the timeframes provided in this DAL must be in accordance with these provisions. Operating rate appeals submitted that are not in accordance with these provisions are invalid.

Facilities are also reminded that effective April 1, 2009 the Department will not consider any revisions made to a facility's annual cost report (regardless of the year the cost report applies to) for operating adjustment purposes later than the due date established by the Commissioner. Thus, revisions to the 2002 or subsequent base period cost report, which was due April 15, 2009, will not be accepted by the Department.

Capital Rate Appeals: The deadlines applicable to the 2009 capital rates have passed, thus the Department will not accept any appeals related to the 2009 capital rates.

Facilities have 120 days from the date of this letter to submit appeals to the rates provided herein. The Department will only accept capital component appeals and operating rate appeals for the correction of computational errors or omissions of data by the Department in determining the operating rate based upon information submitted to the Department prior to the computation of the rate. Please be advised that the Department will not accept appeals to the MDS data used to calculate case mix.

APPEAL SUBMISSIONS FOR RHCF-4 FILERS
(Freestanding facilities and Hospital-Based facilities filing the RHCF-4 cost report)

As indicated in the Department's March 3, 2009 DAL (available on the HCS), appeals submitted on or after April 15, 2009 by mediums other than the new **Electronic Appeals Submission (EAS) System** will not be accepted. The EAS is accessed through the HCS. Detailed instructions regarding initial access through the HCS were provided in the E-mail transmitting the above noted March 3, 2009 DAL.

The EAS System contains features to provide users with assistance, including links to frequently asked questions (FAQs), a User Guide (Help), and access to regulations related to Medicaid reimbursement for nursing homes (i.e., Title 10 of the New York Code of Rules and Regulations (10 NYCRR)). Most screens provide a small tool bar for the user, allowing creation of a new appeal or quick access to the "appeal search" mechanism.

Questions or issues regarding using the new EAS that cannot be resolved by the FAQs or Help links should be submitted via E-mail to the DOH's Bureau of Long Term Care Reimbursement at: nfrates@health.state.ny.us.

The new EAS System accessed through the HCS is available only for Freestanding facilities and Hospital-Based facilities filing the RHCF-4 cost report.

APPEAL SUBMISSIONS FOR RHCF-2 FILERS
(Hospital-Based facilities filing the RHCF-2 Cost Report)

Hospital-Based facilities filing on the RHCF-2 cost report MUST continue to submit appeal requests in hardcopy mailing to the Department. The appeal submission for RHCF-2 filers and any related information associated with the appeal **MUST** be forwarded to the following address:

Mr. John Gahan
Director
Bureau of Primary and Acute Care Reimbursement
Corning Tower Building, Room 1043
Empire State Plaza
Albany, New York 12237

RHCF-2 filers that file an appeal with the Bureau of Primary and Acute Care Reimbursement must provide the following information:

- A cover letter, signed by the Operator or Chief Executive Officer, containing a summary of the items of appeal.
- Supporting schedules or any other pertinent data must be included with the facility's appeal letter.

ASSISTANCE AND QUESTIONS REGARDING THE RATES CONTAINED HEREIN

May 26, 2011 NH Webinar

This presentation is available through the HCS and may be helpful to you as you review this DAL and your rates sheets.

To access the May 26, 2011 Webinar regarding Implementation of Nursing Home Rebasing and Other Budget Actions:

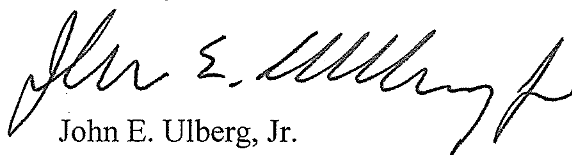
- Log on to the HCS
- Under the heading 'My Applications' select 'NF Cost Report'
- From the Nursing Home Cost Report, under the heading Webinar 2011, select May 26, 2011 Webinar - Implementation of Nursing Home Rebasing and Other Budget Actions

Email Address

To provide you assistance in understanding the methodology used to calculate rates provided herein, and effectively manage and be responsive to the volume of inquiries the Department has established the following email address: **nfrates@health.state.ny.us**. All email correspondence **should include the facility name in the subject line,** along with the operating certificate number, the sender's phone number, and question(s) in the body of the email.

Webinar
A joint Department-Nursing Home Association "Webinar" Presentation that will review the elements of the rates contained herein and the rate methodology (2002 rebasing) will be available for you to access at your convenience beginning on Wednesday, June 29, 2011. Instructions for accessing the Webinar will provided in an e-mail on or before June 29, 2011.

Sincerely,



John E. Ulberg, Jr.
Director
Division of Health Care Financing