



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

October 2, 2009

Re: Important Changes to the Eligibility Criteria
for Financially Disadvantaged Payments

Dear Administrator:

The purpose of this letter is to notify all Residential Health Care Facilities of:

- The modifications made to the eligibility criteria and formula for calculating the distribution of Financially Disadvantaged Payments (FDPs), and
- New provisions that require facilities to file written Restructuring Plans with the Commissioner.

The modifications to the FDP formula were made to better target the most financially disadvantaged facilities, and to encourage such facilities to assess their business practices by developing plans that serve as a roadmap for achieving long term financial stability and ensuring the delivery of quality long term health care services.

Upon approval by CMS of the State Plan Amendment (SPA) relating to the Financially Disadvantaged Program, the Department expects to transmit a Dear Administrator Letter to those facilities that will receive 2009 Financially Disadvantaged Payments under the new eligibility requirements. That notification will provide additional details about where to send the required Restructuring Plans and other information described below.

Modifications to the FDP Calculation

The modifications to the FDP Program were enacted with the 2009-10 Budget by Chapter 58 of the Laws of 2009, Part D, Section 8 and are effective April 1, 2009 (i.e., beginning with the 2009 Financially Disadvantaged Payments). A copy is attached for your reference. The primary changes to the FDP formula modify the eligibility criteria by:

- Increasing the Medicaid utilization eligibility criteria from 50 percent or more to 70 or more,
- Targeting eligibility to facilities with the highest negative operating margins (i.e., facilities that are placed in the top two quartiles when ranked by their calculated negative operating margin for the applicable three year period),
- Increasing the maximum distribution under the FDP from \$400,000 to \$1,000,000 (the total amount authorized is \$30 million annually for the FDP),

- Permitting facilities with positive operating margins in the most recent year of the applicable three year period to remain eligible for FDPs, and
- Limiting eligibility for FDPs to non-public residential health care facilities. Instead, public facilities will receive Upper Payment Limit payments of up to \$300 million in 2009-10, and up to \$150 million in each of the fiscal year 2010-11 and 2011-12.

Requirements for Submitting Restructuring Plans

Facilities determined to be eligible for FDPs are required to submit to the Commissioner a written Restructuring Plan with the following criteria:

- Facilities that receive an FDP of more than \$400,000 are required to submit Restructuring Plans within 60 days of the receipt of its first FDP for the applicable year;
- Facilities that receive an FDP of \$400,000 or less are required to submit Restructuring Plans within 120 days of the receipt of its first FDP for the applicable year.

The Commissioner may extend these due dates for a period of no more than 30 days to a facility that can satisfactorily demonstrate that such an extension is necessary and warranted.

Restructuring Plans shall include:

- A detailed description of the steps the Financially Disadvantaged (FD) facility will implement to improve operational efficiencies and align its expenditures with its revenues.
- A projected schedule of quantifiable benchmarks to be achieved by implementing the Restructuring Plan.
- A schedule of periodic reports to be submitted to the Commissioner describing the progress the facility has made in implementing its Restructuring Plan and meeting benchmarks.
- Restructuring Plans should include the retention of a qualified Chief Restructuring Officer (CRO) to assist in the development and implementation of the Plan. However, facilities that can satisfactorily demonstrate that a CRO is not essential to implementing the objectives of its Restructuring Plan may request, in writing, that this requirement be waived by the Commissioner. This request must be included in the Restructuring Plan.

Please be advised that facilities that fail to submit acceptable Restructuring Plans will be precluded from receiving further rate adjustments for the applicable year and will no longer be eligible for future distributions of FDPs. In addition, facilities that fail to make substantial progress in implementing its Restructuring Plan or achieving the benchmarks provided by the Plan will no longer be eligible to participate in the FD Program and may be required to repay some or all of the FDPs received.

Suggested Contents of Restructuring Plans

The following provides elements for inclusion in a complete Restructuring Plan. The level of detail and elements included should be commensurate and consistent with the severity of the financial condition of the facility, and the projected timeframes (short or long term) required to successfully implement the Plan and achieve fiscal stability.

An assessment of the facility's existing financial condition may include:

- Any financial information that is more recent than the latest cost report filed with the Department, including statements of monthly cash flow, a listing of accounts payable and accounts receivable, and overdue liabilities, including outstanding State liabilities;
- An assessment of the major factors that have contributed to financial distress or instability;
- Whether over the past three years the facility has used external assistance to identify or recommend changes to improve its operations/financial condition and the recommendations and status of those efforts;
- A copy of the current budget, and an assessment of actual and projected performance under the budget;
- The impact of equity withdrawals or transfers of assets;
- Payer mix of patients, occupancy statistics, identification of special needs patients;
- The receipt of State and/or Federal grants, including HEAL grants; and
- The status of recent pending or recently approved CON application(s) and the impact of these plans on the financial stability and condition of the facility.

The Plan should contain a strategic overview and include key detailed elements of actions/plans to be taken to achieve fiscal stability. The projected impact of the actions/plan on the facility's current economic condition and a projected schedule for implementing those actions/plans should be included. In developing the elements of the Plan, include consideration of the following:

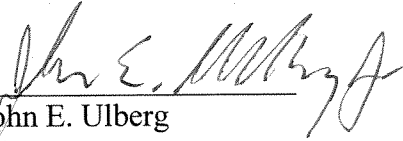
- Revenue improvements and expense reductions ;
- An identification of short and long term solutions to any issues that prevent fiscal stability;
- Marketing plans, including, the facility's competitive strengths and weaknesses and the community's perception of the facility and relations with other community health care providers (why do patients come to your facility? why do patients go to a competing facility?);
- Pending or anticipated CON initiatives;
- The bed size and utilization of your facility both now and any future planned changes;
- The financial status and potential of other services provided by the facility;
- The potential for exploring other community-based long term care options;
- Investments or/changes to capital structure, including debt and potential for refinancing
- Contractual relations with payers; and
- Employee benefit obligations.

The projected impact of the actions/plan on the facility's current economic condition and a projected schedule for implementing those actions/plans should be included. Each key element of the plan should have identifiable and measurable objectives and benchmarks for implementing and achieving the intended goal of the action/plan.

The Plan should identify key facility personnel responsible for plan development and implementation, along with any external resources that are expected to be required. As discussed above, external resources may include the retention of a CRO.

The Department views the FDP program as a partnership and collaborative process. If you have any questions, please contact the Bureau of Long Term Care Reimbursement at 518.474.1057 or the Office of Long Term Care at 518.402.5673.

Sincerely,



John E. Ulberg
Director

Division of Health Care Financing



Mark Kissinger
Deputy Commissioner
Office of Long Term Care

Chapter 58, Laws of 2009
Amendments to Financially Disadvantaged Program

Part D

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1 21. (a) Notwithstanding any inconsistent provision of law or regu-
2 lation to the contrary, for the purposes specified in subdivision nine-
3 teen of this section, the commissioner shall adjust medical assistance
4 rates of payment established pursuant to this article for services
5 provided on and after October first, two thousand four through December
6 thirty-first, two thousand four and annually thereafter for services
7 provided on and after January first, two thousand five, to include a
8 rate adjustment to assist qualifying facilities pursuant to this subdivi-
9 sion, PROVIDED, HOWEVER, THAT PUBLIC RESIDENTIAL HEALTH CARE FACILI-
10 TIES SHALL NOT BE ELIGIBLE FOR RATE ADJUSTMENTS PURSUANT TO THIS SUBDI-
11 VISION FOR RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE.

12 (b) Eligibility for such rate adjustments shall be determined on the
13 basis of each residential health care facility's operating margin over
14 the most recent three-year period for which financial data are available
15 from the RHCF-4 cost report or the institutional cost report. For
16 purposes of the adjustments made for the period October first, two thou-
17 sand four through December thirty-first, two thousand four, financial
18 information for the calendar years two thousand through two thousand two
19 shall be utilized. For each subsequent rate year, the financial data for
20 the three-year period ending two years prior to the applicable rate year
21 shall be utilized for this purpose.

22 (c) Each facility's operating margin for the three-year period shall
23 be calculated by subtracting total operating expenses for the three-year
24 period from total operating revenues for the three-year period, and
25 dividing the result by the total operating revenues for the three-year
26 period, with the result expressed as a percentage. For hospital-based
27 residential health care facilities for which an operating margin cannot
28 be calculated on the basis of the submitted cost reports, the sponsoring
29 hospital's overall three-year operating margin, as reported in the
30 institutional cost report, shall be utilized for this purpose. All
31 facilities with negative operating margins calculated in this way over
32 the three-year period shall be arrayed into quartiles based on the
33 magnitude of the operating margin. Any facility with a positive operat-
34 ing margin for the most recent three-year period, a negative operating
35 margin that places the facility in the quartile of facilities with the
36 smallest negative operating margins, a positive total margin in the most
37 recent year of the three year period, or an average Medicaid utilization
38 percentage of fifty percent or less during the most recent year of the
39 three-year period shall be disqualified from receiving an adjustment
40 pursuant to this subdivision, PROVIDED, HOWEVER, THAT FOR RATE PERIODS
41 ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, SUCH DISQUALIFICATION:

42 (I) SHALL NOT BE APPLIED SOLELY ON THE BASIS OF A FACILITY'S HAVING A
43 POSITIVE TOTAL MARGIN IN THE MOST RECENT YEAR OF SUCH THREE-YEAR PERIOD;

44 (II) SHALL BE EXTENDED TO THOSE FACILITIES IN THE QUARTILE OF FACILI-
45 TIES WITH THE SECOND SMALLEST NEGATIVE OPERATING MARGINS; AND

46 (III) SHALL ALSO BE EXTENDED TO THOSE FACILITIES WITH AN AVERAGE MEDI-
47 CAID UTILIZATION PERCENTAGE OF LESS THAN SEVENTY PERCENT DURING THE MOST
48 RECENT YEAR OF THE THREE-YEAR PERIOD.

49 (d) For each facility remaining after the exclusions made pursuant to

50 paragraph (c) of this subdivision, the commissioner shall calculate the
51 average annual operating loss for the three-year period by subtracting
52 total operating expenses for the three-year period from total operating
53 revenues for the three-year period, and dividing the result by three,
54 PROVIDED, HOWEVER, THAT FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOU-
55 SAND NINE, THE AMOUNT OF SUCH AVERAGE ANNUAL OPERATING LOSS SHALL BE
56 REDUCED BY AN AMOUNT EQUAL TO THE AMOUNT RECEIVED BY SUCH FACILITY
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1 PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (A) OF SUBDIVISION TWO-B OF
2 THIS SECTION. For this purpose, for hospital-based residential health
3 care facilities for which the average annual operating loss cannot be
4 calculated on the basis of the submitted cost reports, the sponsoring
5 hospital's overall average annual operating loss for the three-year
6 period shall be apportioned to the residential health care facility
7 based on the proportion the residential health care facility's total
8 revenues for the period bears to the total revenues reported by the
9 sponsoring hospital, AND SUCH APPORTIONED AVERAGE ANNUAL OPERATING LOSS
10 SHALL THEN BE REDUCED BY AN AMOUNT EQUAL TO THE AMOUNT RECEIVED BY SUCH
11 FACILITY PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (A) OF SUBDIVISION
12 TWO-B OF THIS SECTION.

13 (e) [Each] FOR PERIODS PRIOR TO APRIL FIRST, TWO THOUSAND NINE, EACH
14 such facility's qualifying operating loss shall be determined by multi-
15 plying the facility's average annual operating loss for the three-year
16 period as calculated pursuant to paragraph (d) of this subdivision by
17 the applicable percentage shown in the tables below for the quartile
18 within which the facility's negative operating margin for the three-year
19 period is assigned.

20 i. For a facility located in a county with a total population of two
21 hundred thousand or more as determined by the two thousand U.S. Census:

22 First Quartile (lowest operating margins): 30 percent
23 Second Quartile: 15 percent
24 Third Quartile: 7.5 percent

25 ii. For a facility located in a county with a total population of fewer
26 than two hundred thousand as determined by the two thousand U.S. Census:

27 First Quartile (lowest operating margins): 35 percent
28 Second Quartile: 20 percent
29 Third Quartile: 12.5 percent

30 (f) The amount of any facility's financially disadvantaged residential
31 health care facility distribution calculated in accordance with this
32 subdivision shall be reduced by the facility's estimated rate year bene-
33 fit of the two thousand one update to the regional input price adjust-
34 ment factors authorized pursuant to FORMER subdivision seventeen of this
35 section as amended by section 24 of part C of chapter 58 of the laws of
36 2004, OR AS AUTHORIZED BY SUBDIVISION SEVENTEEN-A OF THIS SECTION, AS
37 ADDED BY SECTION 56 OF PART C OF CHAPTER 58 OF THE LAWS OF 2007, if any,
38 PROVIDED, HOWEVER, THAT SUCH REDUCTION SHALL NOT BE APPLIED WITH REGARD
39 TO RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE. After all
40 other adjustments to a facility's financially disadvantaged residential
41 health care facility distribution have been made in accordance with this
42 subdivision, the amount of each facility's distribution shall be limited
43 to no more than four hundred thousand dollars during the period October
44 first, two thousand four through December thirty-first, two thousand

45 four and [during any subsequent annual rate period], ON AN ANNUALIZED
46 BASIS, FOR RATE PERIODS THROUGH MARCH THIRTY-FIRST, TWO THOUSAND NINE,
47 AND NO MORE THAN ONE MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO
48 THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND NINE AND FOR
49 EACH ANNUAL RATE PERIOD THEREAFTER.

50 (g) The adjustment made to each qualifying facility's medical assist-
51 ance rate of payment determined pursuant to this article shall be calcu-
52 lated by dividing the facility's financially disadvantaged residential
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1 health care facility distribution calculated in accordance with this
2 subdivision by the facility's total medical assistance patient days
3 reported in the cost report submitted two years prior to the rate year,
4 provided however, that such rate adjustments for the period October
5 first, two thousand four through December thirty-first, two thousand
6 four shall be calculated based on twenty-five percent of each facility's
7 reported total medical assistance patient days as reported in the appli-
8 cable two thousand two cost report. Such amounts shall not be reconciled
9 to reflect changes in medical assistance utilization between the year
10 two years prior to the rate year and the rate year.

11 (h) The total amount of funds to be allocated and distributed as
12 medical assistance for financially disadvantaged residential health care
13 facility rate adjustments to eligible facilities for a rate period in
14 accordance with this subdivision shall be thirty million dollars for the
15 period October first, two thousand four through December thirty-first,
16 two thousand four and thirty million dollars [for annual] ON AN ANNUAL-
17 IZED BASIS FOR rate periods on and after January first, two thousand
18 five THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT AND THIRTY
19 MILLION DOLLARS ON AN ANNUALIZED BASIS ON AND AFTER JANUARY FIRST, TWO
20 THOUSAND NINE. The nonfederal share of such [total shall be fifteen
21 million dollars which] RATE ADJUSTMENTS shall be paid by the state, with
22 no local share, from allocations made pursuant to paragraph (hh) of
23 subdivision one of section twenty-eight hundred seven-v of this [chap-
24 ter] ARTICLE. In the event the statewide total of the ANNUAL rate
25 adjustments determined pursuant to paragraph (g) of this subdivision
26 varies from [thirty million dollars] THE AMOUNTS SET FORTH IN THIS PARA-
27 GRAPH, each qualifying facility's rate adjustment shall be proportion-
28 ately increased or decreased such that the total OF THE ANNUAL rate
29 adjustments made pursuant to this subdivision is equal to [thirty
30 million dollars] THE AMOUNTS SET FORTH IN THIS PARAGRAPH on a statewide
31 basis.

32 (i) This subdivision shall be effective if, and as long as, federal
33 financial participation is available for expenditures made for benefici-
34 aries eligible for medical assistance under title XIX of the federal
35 social security act for the rate adjustments determined in accordance
36 with this subdivision.

37 (J) FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, RESIDEN-
38 TIAL HEALTH CARE FACILITIES WHICH ARE OTHERWISE ELIGIBLE FOR RATE
39 ADJUSTMENTS PURSUANT TO THIS SUBDIVISION SHALL ALSO, AS A CONDITION FOR
40 RECEIPT OF SUCH RATE ADJUSTMENTS, SUBMIT TO THE COMMISSIONER A WRITTEN
41 RESTRUCTURING PLAN THAT IS ACCEPTABLE TO THE COMMISSIONER AND WHICH IS
42 IN ACCORD WITH THE FOLLOWING:

43 (I) SUCH AN ACCEPTABLE PLAN SHALL BE SUBMITTED TO THE COMMISSIONER
44 WITHIN SIXTY DAYS OF THE FACILITY'S RECEIPT OF RATE ADJUSTMENTS PURSUANT
45 TO THIS SUBDIVISION FOR A RATE PERIOD SUBSEQUENT TO MARCH THIRTY-FIRST,
46 TWO THOUSAND EIGHT, PROVIDED, HOWEVER, THAT FACILITIES WHICH ARE ALLO-
47 CATED FOUR HUNDRED THOUSAND DOLLARS OR LESS ON AN ANNUALIZED BASIS SHALL

48 BE REQUIRED TO SUBMIT SUCH PLANS WITHIN ONE HUNDRED TWENTY DAYS, AND
49 FURTHER PROVIDED THAT THESE PERIODS MAY BE EXTENDED BY THE COMMISSIONER
50 BY NO MORE THAN THIRTY DAYS, FOR GOOD CAUSE SHOWN; AND

51 (II) SUCH PLAN SHALL PROVIDE A DETAILED DESCRIPTION OF THE STEPS THE
52 FACILITY WILL TAKE TO IMPROVE OPERATIONAL EFFICIENCY AND ALIGN ITS
53 EXPENDITURES WITH ITS REVENUES, AND SHALL INCLUDE A PROJECTED SCHEDULE
54 OF QUANTIFIABLE BENCHMARKS TO BE ACHIEVED IN THE IMPLEMENTATION OF THE
55 PLAN; AND

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1 (III) SUCH PLAN SHALL REQUIRE PERIODIC REPORTS TO THE COMMISSIONER, IN
2 ACCORDANCE WITH A SCHEDULE ACCEPTABLE TO THE COMMISSIONER, SETTING FORTH
3 THE PROGRESS THE FACILITY HAS MADE IN IMPLEMENTING ITS PLAN; AND

4 (IV) SUCH PLAN MAY INCLUDE THE FACILITY'S RETENTION OF A QUALIFIED
5 CHIEF RESTRUCTURING OFFICER TO ASSIST IN THE IMPLEMENTATION OF THE PLAN,
6 PROVIDED, HOWEVER, THAT THIS REQUIREMENT MAY BE WAIVED BY THE COMMIS-
7 SIONER, FOR GOOD CAUSE SHOWN, UPON WRITTEN APPLICATION BY THE FACILITY.

8 (K) IF A RESIDENTIAL HEALTH CARE FACILITY FAILS TO SUBMIT AN ACCEPTA-
9 BLE RESTRUCTURING PLAN IN ACCORDANCE WITH THE PROVISIONS OF PARAGRAPH
10 (J) OF THIS SUBDIVISION, THE FACILITY SHALL, FROM THAT TIME FORWARD, BE
11 PRECLUDED FROM RECEIPT OF ALL FURTHER RATE ADJUSTMENTS MADE PURSUANT TO
12 THIS SUBDIVISION AND SHALL BE DEEMED INELIGIBLE FROM ANY FUTURE RE-AP-
13 PPLICATION FOR SUCH ADJUSTMENTS. FURTHER, IF THE COMMISSIONER DETERMINES
14 THAT A FACILITY HAS FAILED TO MAKE SUBSTANTIAL PROGRESS IN IMPLEMENTING
15 ITS PLAN OR IN ACHIEVING THE BENCHMARKS SET FORTH IN SUCH PLAN, THEN THE
16 COMMISSIONER MAY, UPON THIRTY DAYS NOTICE TO THAT FACILITY, DISQUALIFY
17 THE FACILITY FROM FURTHER PARTICIPATION IN THE RATE ADJUSTMENTS AUTHOR-
18 IZED BY THIS SUBDIVISION AND THE COMMISSIONER MAY REQUIRE THE FACILITY
19 TO REPAY SOME OR ALL OF THE PREVIOUS RATE ADJUSTMENTS.