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

January 13, 2010

Subject: 2002 Rebasing Rates
Effective April 1/May 1, 2009

Dear Administrator:

This letter provides formal notice that the Medicaid rates for your facility effective for the periods April 1, 2009 through April 30, 2009 and May 1, 2009 through December 31, 2009 ("April 1/May 1, 2009 Medicaid Rates") are now available on the Health Provider Network (HPN). With the completion of these rates, the Department is now able to complete the Upper Payment Limit calculation required by the Centers for Medicare and Medicaid Services (CMS) for the approval of State Plan Amendment(s). **Therefore, please be advised the April 1/May1 2009 rates are being provided as "notice" rates and will not be processed for payment (i.e., published) until all approvals have been received from both CMS and the New York State Division of the Budget (NYSDOB).**

The rates are all-inclusive for health care services provided at your facility, and reflect:

- 2002 Rebasing provisions implemented by Chapter 109 of the Laws of 2006, as modified and effective April 1, 2009 as provided by Chapters 2 and 58 of the Laws of 2009, pending receipt of all CMS and NYSDOB approvals.
- The application of the relative resource groups system of patient classification (RUG-III) employed by the Federal Government, effective April 1, 2009.
- Medicaid only case mix adjustments in accordance with Chapter 58, of the Laws of 2007, effective April 1, 2009.
- Chapter 58 of the Laws of 2009 requires rates for the April 1, 2009 through March 31, 2010 period include proportional adjustments which reflect 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 that result in an increase of total statewide Medicaid rates (excluding capital rates) that are no more or no less than $210 million. The proposed SPA amendment now before CMS implementing the $210 million provision has, in accordance with Federal Public Notice requirements, a May 1, 2009 effective date. Thus, the Department calculated Medicaid rates effective April 1, 2009 through April 30, 2009 that do not reflect this adjustment, and Medicaid

rates effective May 1, 2009 through December 31, 2009 that adjust such rates 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 April 1, 2009 rates that reflect the impact of rebasing and Medicaid only case mix. The rate adjustment to adjust spending to the required $210 million amount is reflected as the "scale back adjustment" on the May 1, 2009 rate sheet.

- Base year cost reports, for 2002 or subsequent base years as appropriate, re-filed and certified by April 15, 2009. The information contained in such cost reports has been included in the calculation of the statewide peer group prices, New York State Specific Weights for the 53 Group RUG-III Classification System, and the facility's rate, as applicable.

REBASING PROVISIONS

The April 1/May1, 2009 Medicaid rate methodology continues to employ 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.

The following information provides a summary of the rate setting methodology for the April 1/May 1, 2009 rates.

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 2002 base year allowable costs from the 2002 cost report adjusted for inflation. The operating component of the rate for facilities which currently 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 2003-2009 (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 to 2007 to the facility's December 31, 2008 operating component 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 2-2(b)(i).

Real Property Taxes and Payment in Lieu of Taxes (PILOT): 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. Real Estate tax expenses reflected in the operating component will be eliminated (PHL §2808 2-b(b)(i)).

- 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 2007 RHCF-4 cost report or other such report used as the basis to establish the real property component of the 2009 rate.

Adjustments to the Direct Component of the Operating Component: The direct component of the April 1/May 1, 2009 rates is subject to case mix adjustment through the application of the relative resource utilization groups system of patient classification (RUG-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 April 1/May 1, 2009 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, to the April 1/ May 1, 2009 rate year case mix. For the April 1/May 1, 2009 rates the January 28, 2009 Census Roster MDS data is used for the case mix adjustment.

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) 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.

As enacted in the 2009/2010 Executive Budget, effective April 1, 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.

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 the April 1, 2009 rates are; for the base 90 percent of each mean direct and indirect price, and for the ceiling 115 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 2009 (and thereafter) 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 2009 (and thereafter) 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 is employing the formula used by the National Institute of Health to calculate a resident's BMI of: Weight-lbs/ (Height-inches {squared}) *703

Because 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 2009 (and thereafter) 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 2009 per diem add-on the TBI-Extended Care Residents have been identified from Section S of the 2009 MDS data.

  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 prevent duplicate 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. The Hepatitis B vaccination adjustment per diem included in the April 1/May1, 2009 rates is a continuation of the Hepatitis B per diem from the facility's January 1, 2009 rate.

Measles and Rubella Immunization Adjustment: The Measles and Rubella Immunization adjustment per diem included in the April 1/May 1, 2009 rates is a continuation of the Measles and Rubella Immunization per diem from the facility's January 1, 2009 rate.

Criminal Background Checks: The criminal background check adjustment in the April 1/May 1, 2009 rates is a continuation of the criminal background check per diem from the facility's January 1, 2009 rate.

Dementia Grants: The dementia grant adjustment per diem in the April 1/May 1, 2009 rates is a continuation of the dementia grant per diem from the facility's January 1, 2009 rate.

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

- Effective April 1/May 1, 2009 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 April 1/May 1, 2009 rates is the Part B offset from the facility's January 1, 2009 rate downtrended to 2007. **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.

Trend Factor: Pursuant to Chapter 109 of the Laws of 2006, the rebased rates are trended from 2002 to 2009 using the Consumer Price Index (CPI) as adjusted by legislative amendments. For purposes of down trending where applicable, the CPI was applied.

	2003 Final CPI	2004 Final CPI	2005 Final CPI	2006 Final CPI	2007 Final CPI	2008 Initial CPI	2009 Initial CPI
CPI	2.30	2.70	3.40	3.20	2.80	2.30	3.10
CPI w/Legislative Amendments	2.30	2.70	3.40	2.95	2.10	0	0

Capital Rates - RHCF-4 & RHCF-2 Filers: The capital component of the April 1/May 1, 2009 rates reflect the same capital component as the January 1, 2009 "Hotline" rates which use the 2007 costs from the applicable 2007 RHCF-4 cost report for RHCF-4 filers or as allocated from the 2007 ICR for RHCF-2 filers. The January 1, 2009 "Hotline" rates were sent to facilities via a DAL dated September 16, 2009.

MINIMUM DATA SET

Base Year Minimum Data Set (MDS): Pursuant to statute, the 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 will also employ 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 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, consequently the MDS counts in the base year data used for rates effective 2009 contain more MDSs 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 by the portion of Medicare and all other days as reported in the Residential Health Care Facility (RHCF) cost reports. This adjustment is in response to a recent 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 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

It should be noted that the New York State specific weights have changed from the weights used in the 2009 rates provided with the DAL of December 8, 2008 due to the re-filing of 2002 cost reports by approximately twenty-five percent (25%) of the facilities.

MDS Data (2009 Forward) for Case Mix Adjustment to the Rate: PHL §2808 2-b(b)(ii) requires case mix adjustments be made in January and July of each calendar year. The Department has provided additional information in DALs detailing the policy and procedure for processing the MDS assessment data for Medicaid rate setting purposes for January and July of each calendar year.

The MDS data for the April 1/May 1, 2009 rates reflect the MDSs "culled" as a result of the statewide re-upload of the January 28, 2009 Census Rosters. The January 28, 2009 census roster re-upload was a ONE TIME RE-UPLOAD to avoid significant declines in rates that would have occurred for facilities that failed to timely file their Federal MDS data as required by CMS. Therefore, the Department again reminds facilities that they MUST file their MDS data in accordance with the timeframes established by CMS. The Department will notify facilities of the CMI adjustment for the July 29, 2009 census roster upload (rates effective July 1, 2009) under separate cover.

Statute requires that effective April 1, 2009 and forward that Case Mix adjustments be made for Medicaid residents only. Therefore the case mix adjustment used to calculate Medicaid rates effective April 1, 2009 and forward is based on the applicable facility census roster (January/July) MDS data for the case mix of a facility's Medicaid residents as reported on Section S of the MDS.

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 on the April 1, 2009 ADHC rates will be provided in a separate DAL.

APPEALS

Capital Rate Appeals: Since capital appeals related to the initial January 1, 2009 rates transmitted by the December 8, 2008 DAL remained valid the Department will not accept appeals to the 2009 capital component of the April 1/May 1, 2009 rates. The deadline for appeals to the capital component of the initial January 1, 2009 rates was April 15, 2009. In addition, for facilities that had a 2009 Hotline capital appeal processed the deadline to file appeals to the Hotline appeal was October 23, 2009. Therefore, the Department will also not accept any capital appeals to the Hotline appeals. Please note, however, that any capital appeal timely submitted in accordance with the above due dates will be "rolled" into the April 1/ May1, 2009 rates, if applicable, when processed.

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.

Facilities will have 120 days from the date of this letter to submit appeals to the April 1/May1, 2009 rates. As noted above the Department will not accept capital component appeals and will only accept 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 there will not be an accelerated administrative process ("Rate Hotline") to correct any errors for these rates. In addition the Department will not accept appeals to the MDS data used for either the base year "frozen" case mix or the MDS data "culled" as a result of the January 28, 2009 census roster submitted by the facility for the case mix adjustment effective in the April 1/May1, 2009 rates.

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

As indicated in the Department's March 3, 2009 DAL (available on the HPN), 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 HPN. Detailed instructions regarding initial access through the HPN 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 HPN is available ***only*** *for Freestanding facilities and Hospital-Based facilities filing on the RHCF-4 cost report.*

***APPEAL SUBMISSIONS FOR RHCF-2 FILERS* (Hospital-Based facilities filing on 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 APRIL 1/MAY 1, 2009 RATES

Email Address

To provide you assistance in understanding the methodology used to calculate your April 1, 2009 rates, and effectively manage and be responsive to the volume of inquiries the Department has established the following email address which we are requesting you use to submit questions and inquiries regarding the contents of this letter and the computation of your April 1/May 1, 2009 rates.

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

The Department will be conducting a "Webinar" to review the elements of the new 04/01/2009, 05/01/2009 and 01/01/2010 rates and rate methodology (2002 rebasing). The Webinar will provide a forum for facilities to participate in an educational seminar concerning the new rate methodology via the internet. After each portion of the Webinar questions may be posted electronically. Each of these questions will be answered as time allows during the Webinar, and answers to all questions will be posted on the Nursing Home section of the HPN as soon as possible. Due to the anticipated size of the audience and time constraints it will not be possible to take oral questions during the webinar.

Details of the Webinar, including the Web address, date, time and registration information will be provided in an email to facilities as soon as possible.

Sincerely,

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