

Statewide Pricing Methodology for Nursing Homes

Effective date: 2/19/14

SUMMARY OF EXPRESS TERMS

This regulation establishes a new reimbursement methodology for the operating component of non-specialty residential health care facilities (nursing homes). The operating component of the price is based upon allowable costs and is the sum of the direct price, indirect price and a facility-specific non-comparable price. The direct and indirect prices are a blend of a statewide price and a peer group price. There are two peer groups: 1) all non-specialty hospital-based facilities and non-specialty freestanding facilities with certified beds capacities of 300 or more, and 2) non-specialty freestanding facilities with certified bed capacities of less than 300 beds. The direct price is subject to a case mix adjustment and a wage index adjustment. The new case mix adjustment methodology also contains mechanisms to safeguard the integrity of case mix data reporting. If reported case mix data indicates a change in the facility's case mix of more than five percent, the payment adjustment associated with the change over five percent may be held, pending an audit to verify the accuracy of the reported data. Also, facilities are required to formally certify to the accuracy of their case mix data reporting on an annual basis. The indirect price is subject to a wage index adjustment. Per-diem adjustments to the operating component of the rate include add-ons for bariatric, traumatic brain-injured (TBI) extended care, and dementia residents; adjustments for the reporting of quality data; and transition payments. Non-specialty facilities will transition to the price over a five-year period (2012-2016), with prices fully implemented beginning in 2017. The non-capital component of the rate for specialty facilities, which are not subject to the new reimbursement methodology, will be the rates in effect for such facilities on January 1, 2009.

Pursuant to the authority vested in the Commissioner of Health by section 2808 2-c of the Public Health Law, Subpart 86-2 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subpart 86-2 of title 10 of NYCRR is amended by adding a new section 86-2.40, to read as follows:

86-2.40. Statewide prices for non-capital reimbursement. The non-capital cost components of residential health care facility (“facility”) Medicaid rates for inpatient services for periods on and after January 1, 2012, shall be in accord with the following:

(a) “Specialty facilities” means those facilities or discrete units of facilities described in paragraph (c) of subdivision 2-c of section 2808 of the Public Health Law. Such facilities and such discrete units of facilities shall not be subject to the provisions of this section, other than subdivision (ad), and the costs and statistical data reported by such facilities and such discrete units of facilities shall not be included in the rate computations otherwise made pursuant to this section, and the term “facilities” as used in this section shall not be deemed to include such facilities.

(b) The operating component of rates shall be a price and shall consist of the sum of the direct, indirect and non-comparable price components.

(c) For purposes of calculating the direct and indirect price component of the rates, the following peer groups shall be established:

- (1) all facilities;
- (2) free-standing facilities with certified bed capacities of 300 beds or more and all hospital-based facilities as defined in 10 NYCRR 86-2.10(a)(13) (“HBF +300 bed”); and
- (3) all free-standing facilities with certified bed capacities of less than 300 beds (“-300 bed”).

(d) The direct component of the price shall consist of a blended rate, to be determined as follows:

- (1) 50% of the direct price which shall be based upon allowable operating costs and statistical data for the direct component of the price as reported in each facility's cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and
- (2) 50% of either:
 - (i) the direct price of HBF +300 bed facilities, which shall be based upon allowable operating costs and statistical data for the direct component of the price as reported by each hospital-based facility and each free-standing facility with certified bed capacity of 300 beds or more in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days, or

(ii) the direct price of -300 bed facilities, which shall be based upon allowable operating costs and statistical data for the direct component of the price as reported by each freestanding facility with certified bed capacity of less than 300 beds in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.

(e) (1) The direct component of the price for each peer group shall be as follows:

	Direct Component of the Price Medicare Ineligible Price, Medicare Part D Eligible Price (HBF +300 Bed Peer Group)				
Effective Date of Prices	Direct Price (a)	50% of 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)
January 1, 2012	\$105.79	\$52.90	\$117.48	\$58.74	\$111.63
January 1, 2013	\$111.82	\$55.91	\$124.17	\$62.09	\$117.99
January 1, 2014	\$116.58	\$58.29	\$129.46	\$64.73	\$123.02
January 1, 2015	\$117.94	\$58.97	\$130.97	\$65.49	\$124.46
January 1, 2016	\$118.48	\$59.24	\$131.57	\$65.79	\$125.03
January 1, 2017	\$119.02	\$59.51	\$132.17	\$66.09	\$125.59
	Direct Component of the Price Medicare Part B Eligible Price, Medicare Part B and Part D Eligible Price (HBF +300 Bed Peer Group)				
Effective Date of Prices	Direct Price (a)	50% of 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)
January 1, 2012	\$104.34	\$52.17	\$115.94	\$57.97	\$110.14
January 1, 2013	\$110.28	\$55.14	\$122.54	\$61.27	\$116.41
January 1, 2014	\$114.98	\$57.49	\$127.76	\$63.88	\$121.37
January 1, 2015	\$116.33	\$58.17	\$129.25	\$64.63	\$122.79
January 1, 2016	\$116.86	\$58.43	\$129.84	\$64.92	\$123.35
January 1, 2017	\$117.39	\$58.70	\$130.43	\$65.22	\$123.91

Direct Component of the Price Medicare Ineligible Price, Medicare Part D Eligible Price (-300 Bed Peer Group)					
Effective Date of Prices	Direct Price (a)	50% of Direct Price (b)	Direct -300 Bed Price (c)	50% of Direct -300 Bed Price (d)	Total Direct Component of Price for -300 Bed Peer Group (b)+(d)
January 1, 2012	\$105.79	\$52.90	\$99.30	\$49.65	\$102.54
January 1, 2013	\$111.82	\$55.91	\$104.95	\$52.48	\$108.38
January 1, 2014	\$116.58	\$58.29	\$109.43	\$54.72	\$113.00
January 1, 2015	\$117.94	\$58.97	\$110.70	\$55.35	\$114.32
January 1, 2016	\$118.48	\$59.24	\$111.21	\$55.61	\$114.85
January 1, 2017	\$119.02	\$59.51	\$111.71	\$55.86	\$115.37
Direct Component of the Price Medicare Part B Eligible Price, Medicare Part B and Part D Eligible Price (-300 Bed Peer Group)					
Effective Date of Prices	Direct Price (a)	50% of Direct Price (b)	Direct -300 Bed Price (c)	50% of Direct -300 Bed Price (d)	Total Direct Component of Price for -300 Bed Peer Group (b)+(d)
January 1, 2012	\$104.34	\$52.17	\$97.90	\$48.95	\$101.12
January 1, 2013	\$110.28	\$55.14	\$103.47	\$51.74	\$106.88
January 1, 2014	\$114.98	\$57.49	\$107.88	\$53.94	\$111.43
January 1, 2015	\$116.33	\$58.17	\$109.14	\$54.57	\$112.73
January 1, 2016	\$116.86	\$58.43	\$109.64	\$54.82	\$113.25
January 1, 2017	\$117.39	\$58.70	\$110.14	\$55.07	\$113.76

(2) As used in this subdivision, Medicare Ineligible Price shall mean the price applicable to Medicaid patients that are not Medicare eligible, Medicare Part B Eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part B eligible, Medicare Part D Eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part D eligible and Medicare Part B and Part D Eligible Price shall mean the price applicable to Medicaid patients that are Medicare Part B and Part D Eligible.

(3) Subsequent revisions to the peer group prices set forth in paragraph (1) of this subdivision shall be published on the New York State Department of Health website at:

<http://www.health.ny.gov>

(f) The allowable costs percent reduction for the direct component shall be as follows:

Effective Date	Allowable Cost Percent Reduction
January 1, 2012	19.545660%
January 1, 2013	14.963800%
January 1, 2014	11.339480%
January 1, 2015	10.305120%
January 1, 2016	9.893250%
January 1, 2017	9.485290%

Subsequent revisions to the allowable costs percent reduction shall be published on the New York State Department of Health website at: <http://www.health.ny.gov/>

(g) Allowable costs for the direct component of the rate shall 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).

(h) The direct component of the price shall be adjusted by a wage equalization factor (WEF).

The WEF adjustment shall be calculated using cost and statistical data reported in each facility's 2009 cost report ((RHCF-4), or extracted from a hospital-based facility's 2009 cost report (RHCF-2) and the institutional cost report of its related hospital as applicable), from available certified cost reports as determined by the Commissioner, subject to applicable trace back percentages. The WEF adjustment shall consist of 50% of a Facility Specific Direct WEF and 50% of a Regional Direct WEF.

(i) The Facility Specific Direct WEF shall be calculated as follows:

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

(1) The Facility Specific Wage Ratio shall be 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.

(2) The Wage Index shall be 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).

(3) The Facility Specific Non-Wage Ratio shall be calculated by subtracting from 1 the Facility Specific Wage Ratio.

(j) A Regional Direct WEF shall be calculated for each of the following 16 regions. The county geographic boundaries shall be the sole factor considered in determining which WEF region a facility is located in.

(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.

(k) The Regional Direct WEF shall be calculated for each of the 16 regions as follows:

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

(1) The Regional Wage Ratio shall be calculated by dividing total salaries and fringes related to direct costs in the Region from 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 (42), central service supply (043), and residential health care facility (051) by total direct operating expenses in the Region from such cost centers.

(2) The Regional Wage Index shall be calculated by dividing labor costs per hour in the region 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).

(3) The Regional Non-Wage Ratio shall be calculated by subtracting from 1 the Regional Wage Ratio.

(l) 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 in this section shall be equal to 100% of the applicable Regional WEF.

(m) The direct component of the price shall be subject to a case mix adjustment in accordance with the following:

(1) The application of 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.

(2) New York State wages shall be used to determine the weight of each RUG. The cost for each RUG shall be 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 shall be multiplied by the New York average dollar per hour to determine the fiscal resources need to care for that patient type. This amount shall be multiplied by the number of patients in that RUG. RUG weights shall be assigned based on the distance from the Statewide average. The RUGS III weights shall be 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.

(3) The case mix adjustment for the direct component of the price effective January 1, 2012 shall be calculated by dividing the Medicaid only case mix calculated using data for January 2011 by the all-payer case mix for the base year 2007.

(4) The all payer case mix for base year 2007 shall be a blend of:

(i) 50% of the case mix for all facilities, and

(ii) 50% of the case mix for either:

(a) free-standing facilities with certified bed capacities of 300 beds or more and all hospital-based facilities or

(b) all free-standing facilities with certified bed capacities of less than 300 beds.

(5) the Medicaid only case mix shall mean the case mix for patients where Medicaid is the primary payer.

(6) 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.

(7) 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.

(8) The adjustments and related patient classifications for each facility shall be subject to audit review by the Office of the Medicaid Inspector General.

(9) The operator of a proprietary facility, an officer of a voluntary facility, or the public official responsible for the operation of a public facility shall submit to the Department a written certification, in a form as determined by the Department, attesting that all of the “minimum data set” (“MDS”) data reported by the facility for each census roster submitted to the Department is complete and accurate.

(10) In the event the MDS data reported by a facility results in a percentage change in the facility’s case mix index of more than five percent, then the impact of the payment of the Medicaid rate adjustment attributable to such a change in the reported case mix may be limited to reflect no more than a five percent change in such reported data, pending a prepayment audit of

such reported MDS data, provided, however, that nothing in this paragraph shall prevent or restrict post-payment audits of such data as otherwise provided for in this subdivision.

(n) The indirect component of the price shall consist of a blended rate to be determined as follows:

(1) 50% indirect price which shall be based upon allowable operating costs and statistical data for the indirect component of the price as reported in each facility's cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and

(2) 50% of either:

(i) The indirect HBF +300 bed facility price which shall be based upon allowable operating costs and statistical data for the indirect component of the price as reported by each hospital-based facility and each free-standing facility with certified bed capacity of 300 beds or more in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; or

(ii) The indirect -300 bed facility price which shall be based upon allowable operating costs and statistical data for the indirect component of the price as reported by each freestanding facility with certified bed capacity of less than 300

beds in its cost report for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days

(o)(1) The indirect component of the price for each peer group shall be as follows:

Indirect Component of the Price (HBF +300 Bed Peer Group)					
Effective Date of Prices	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)
January 1, 2012	\$53.15	\$26.58	\$61.54	\$30.77	\$57.35
January 1, 2013	\$56.18	\$28.09	\$65.04	\$32.52	\$60.61
January 1, 2014	\$58.57	\$29.29	\$67.82	\$33.91	\$63.19
January 1, 2015	\$59.26	\$29.63	\$68.61	\$34.31	\$63.93
January 1, 2016	\$59.53	\$29.77	\$68.92	\$34.46	\$64.23
January 1, 2017	\$59.80	\$29.90	\$69.23	\$34.62	\$64.52
Indirect Component of the Price (-300 Bed Peer Group)					
Effective Date of Prices	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 for -300 Bed Peer Group (b)+(d)
January 1, 2012	\$53.15	\$26.58	\$48.49	\$24.25	\$50.82
January 1, 2013	\$56.18	\$28.09	\$51.25	\$25.63	\$53.71
January 1, 2014	\$58.57	\$29.29	\$53.44	\$26.72	\$56.00
January 1, 2015	\$59.26	\$29.63	\$54.06	\$27.03	\$56.66
January 1, 2016	\$59.53	\$29.77	\$54.31	\$27.16	\$56.92
January 1, 2017	\$59.80	\$29.90	\$54.55	\$27.28	\$57.18

(2) Subsequent revisions to the prices set forth in paragraph (1) of this subdivision shall be published on the New York State Department of Health website at: <http://www.health.ny.gov>

(p) The allowable costs percent reduction for the indirect component shall be as follows:

Effective Date	Allowable Cost Percent Reduction
January 1, 2012	19.545660%
January 1, 2013	14.963800%
January 1, 2014	11.339480%
January 1, 2015	10.305120%
January 1, 2016	9.893250%
January 1, 2017	9.485290%

Subsequent revisions to the allowable costs percent reduction shall be published on the New York State Department of Health website at: <http://www.health.ny.gov/>

(q) Allowable costs for the indirect component of the rate shall 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).

(r) The indirect component of the price shall be adjusted by a Wage Equalization Factor (WEF). The WEF adjustment shall be calculated using cost and statistical data reported in each facility's 2009 cost report ((RHCF-4), or extracted from a hospital-based facility's 2009 costs report (RHCF-2) and the institutional cost report of its related hospital as applicable from available certified cost reports as determined by the Commissioner, subject to applicable trace back percentages. The WEF adjustment shall consist of 50% of a Facility Specific Indirect WEF and 50% of a Regional Indirect WEF.

(s) The Facility Specific Indirect WEF shall be calculated as follows:

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

(1) The Facility Specific Wage Ratio shall be 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.

(2) The Wage Index shall be 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).

(3) The Facility Specific Non-Wage Ratio shall be calculated by subtracting from 1 the Facility Specific Wage Ratio.

(t) A Regional Indirect WEF shall be calculated for each of the following 16 regions. The county geographic boundaries shall be the sole factor considered in determining which WEF region a facility is located in.

(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.

(u) The Regional Indirect WEF shall be calculated for each of the 16 regions, calculated as follows:

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

(1) The Regional Indirect Wage Ratio shall be calculated by dividing total salaries and fringes related to indirect cost centers in each Region from 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) for such indirect cost centers, by total indirect operating expenses in the Region for such cost centers.

(2) The Regional Wage Index shall be calculated by dividing labor costs per hour in the Region 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).

(3) The Regional Non-Wage Ratio shall be calculated by subtracting from 1 the Regional Wage Ratio.

(v) 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.

(w) The non-comparable component of the price shall be calculated using allowable operating costs and statistical data as reported in each facility's cost report for the 2007 calendar year, or from otherwise available certified cost reports as determined by the Commissioner, divided by total 2007 patient days, or divided by patient days derived from otherwise available certified cost reports as determined by the Commissioner.

(x) Allowable costs for the non-comparable component of the price shall include costs reported in the following functional cost centers on the facility's annual cost report (RHCF-4), or

extracted from a hospital-based facility's annual costs 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.

(y) The non-comparable component of the price for facilities for which 2007 cost report data is unavailable or insufficient to calculate the non-comparable component as described in this

section shall initially receive a noncomparable rate which is calculated using the most recently available certified cost report, as determined by the Commissioner, and if no such report is available, the regional average shall be utilized until such time as a certified cost report is available.

(z) Per diem adjustments for certain patients. If applicable, and as updated pursuant to case mix adjustments made pursuant to paragraph (m) of this section, the operating component of the facility's price shall be adjusted to reflect the following:

(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.

(4) Effective for services provided on and after June 1, 2012, rates of payment for residential health care facilities which have received approval by the Commissioner of Health to provide services to more than 25 patients whose medical condition is HIV Infection Symptomatic, and

the facility is not eligible for separate and distinct payment rates for AIDS facilities or discrete AIDS units, shall be adjusted by a per diem adjustment that shall not be in excess of the difference between such facility's 2010 allowable operating cost per day, as determined by the Commissioner, and the weighted average non-capital component of the rate in effect on and after January 1, 2012, and as subsequently updated by case mix adjustments made in July and January of each calendar year as described in paragraph (m) of this section.

(aa) For the calendar year 2012, the operating component of the price of each facility that fails to submit to the Department data or reports on quality measures, as required and defined by regulation, shall be subject to a per diem reduction calculated by multiplying 50 million dollars by each facility's share of Medicaid days. Facilities determined by the Department to be subject to this adjustment may request an expedited administrative hearing with regard to such adjustment, provided, however, that such adjustment shall not be held in abeyance pending the completion of such a hearing.

(ab) Per diem transition adjustments. Over the five year period beginning January 1, 2012 and ending December 31, 2016, facilities shall be eligible for per diem transition rate adjustment, to be calculated as follows:

(1)(i) In each year for each eligible facility computations shall be made by the Department pursuant to subparagraphs (ii) and (iii) of this paragraph and per diem rate adjustments shall be made for each year such that the difference between such computations for each year is no greater than the percentage, as identified in subparagraph (iv) of this paragraph, of the total

Medicaid revenue received from the facility's July 7, 2011 non-capital rate as communicated to facilities by the Department in the letter dated November 9, 2011, and deemed not subject to subsequent reconciliation or adjustment, provided, however, that those facilities which are, subsequent to November 9, 2011, issued a revised non-capital rate for rate periods including July 7, 2011, reflecting a new base year that is subsequent to 2002, shall have such revised non-capital rate as in effect on July 7, 2011 utilized for the purpose of computing transition adjustments pursuant to this subdivision.

(ii) A facility's Medicaid revenue, calculated by summing the direct component, indirect component, 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.

(iii) A facility's Medicaid revenue calculated by multiplying the facility's July 7, 2011 rate (as determined in accordance with the provisions of subparagraph (i) of this paragraph) 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.

(iv) In year one the percentage shall be 1.75%, in year two it shall be 2.5%, in year three it shall be 5.0%, in year four it shall be 7.5% and in year five it shall be 10.0%. In year 6, the prices calculated in this section shall not be subject to per diem transition rate adjustments.

(v) 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.

(ac) Other Provisions:

(1) The appointment of a receiver or the establishment of a new operator or renovation of an existing facility on or after January 1, 2012 shall not result in a revision to the non-capital components of the price.

(2) For rate computation purposes, “patient days” shall include “reserved bed days”, defined as the unit of measure denoting an overnight stay away from the facility for which the patient, or the patient’s third-party payor, provides per diem reimbursement when the patient’s absence is due to hospitalization or therapeutic leave consistent with a plan of care ordered by such patient’s treating health care professional or due to other leaves of absences.

(3) The base year used to calculate the direct and indirect price components, the base year used to calculate the direct and indirect wage equalization factor, and the Resource Utilization Groups System used to calculate case mix and described herein shall be periodically updated as determined by the Commissioner.

(4)(i) Subject to the availability of federal financial participation, for services provided on and after July 1, 2012, to patients 21 years of age and older, Medicaid payments for reserved bed days, as defined in paragraph (2) of this subdivision, which are related to a patient’s

hospitalization shall be reduced from 95% to 50% of the Medicaid rate otherwise payable to the facility with regard to such days of care.

(ii) Subject to the availability of federal financial participation, for services provided on and after July 1, 2012, to patients 21 years old or older, Medicaid payments for reserved bed days, as defined in paragraph (2) of this subdivision, which do not involve the patient's hospitalization and which are (a) related to a patient's therapeutic leave of absence for visits to a health care professional that is expected to improve the patient's physical condition or quality of life and that is consistent with a plan of care ordered by such patient's treating health care professional, or (b) are other leaves of absences, shall be made at 95% of the Medicaid rate otherwise payable to the facility with regard to such days of care.

(iii) Medicaid payments for reserved bed days which are otherwise in accordance with the provisions of this paragraph shall be available with regard to each Medicaid patient for any twelve month period for up to a combined aggregate of fourteen days for hospitalizations and other therapeutic leaves of absences for visits to a health care professional that are expected to improve the patient's physical condition or quality of life and that are consistent with a plan of care ordered by the patient's treating health care professional, and for up to an aggregate of ten days for other leaves of absence, provided, however, that these limitations shall not apply to patients who are less than of 21 years of age.

(iv) Subject to the availability of federal financial participation, in the event the commissioner determines, in consultation with the director of the budget, that the reduction in payments for reserved bed days implemented by the provisions of subparagraph (i) of this paragraph shall

achieve projected aggregate Medicaid savings, as determined by the commissioner, of less than forty million dollars for the state fiscal year beginning April first, two thousand twelve, and each state fiscal year thereafter, the commissioner shall establish a prospective per diem rate adjustment, subject to subsequent reconciliation and adjustment, for all nursing homes, other than nursing homes providing services primarily to children under the age of twenty-one, sufficient to achieve such forty million dollars in savings for each such state fiscal year.

(ad) (1) 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.

(2) The non-capital components of rates for new specialty facilities with initial rates issued for periods beginning after January 1, 2009, shall be in accordance with the following:

(i) For specialty facilities with an initial rate issued for periods beginning after January 1, 2009 but before April 1, 2009, the non-capital components of their rate effective for periods on and after January 1, 2012 shall be the rate in effect on the date the facility commenced operation.

(ii) For specialty facilities with an initial rate issued for periods beginning after March 31, 2009, but before July 8, 2011, the non-capital components of their rate effective for periods on and after January 1, 2012 shall be the rate in effect on July 7, 2011.

(iii) For specialty facilities with an initial rate issued for periods beginning after July 7, 2011, the non-capital components of their rate effective for periods on and after January 1, 2012 shall be based on budgeted costs, as submitted by the facility and approved by the Department and as issued by the Department effective on the facility's first day of operation, provided, however, that such specialty facilities shall file certified cost reports reflecting such specialty facility's first twelve months of operation at an occupancy level of 90% or more. The Department shall thereafter issue such facilities rates with non-capital components reflecting such cost reports and such rates shall be effective retroactive to the first day of such twelve month cost report. Nothing in this subparagraph shall be understood as exempting specialty facilities which have not yet achieved 90% occupancy from the generally applicable requirement to file annual calendar year cost reports.

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

(ae) Administrative rate appeals from rates issued pursuant to this section shall be subject to otherwise applicable regulatory provisions of this Subpart and to applicable statutory provisions, including, but not limited to, Public Health Law sections 2808(11) and 2808(17).

REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authority for this regulation is contained in Section 2808(2-c) of the Public Health Law (PHL) as enacted by Section 95 of Part H of Chapter 59 of the Laws of 2011, which authorizes the Commissioner to promulgate regulations, with regard to Medicaid reimbursement rates for residential health care facilities. Such rate regulations are set forth in Subpart 86-2 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulation of the State of New York.

Legislative Objectives:

Subpart 86-2 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulation of the State of New York, will be amended by adding a new section 2.40 to establish a new Medicaid reimbursement methodology for nursing homes. The reimbursement methodology is based on a blend of statewide prices and peer group prices, with adjustments for case mix, regional wage differences, add-ons for certain patients, and quality incentives and payments. To ensure a smooth transition to the new pricing methodology by mitigating significant fluctuations (increases or decreases) in the amount of Medicaid revenues received by nursing homes, per diem transition rate adjustments will be included to phase-in the new pricing methodology over a five-year period, with full implementation in the sixth year. The new and streamlined methodology will significantly reduce administrative burdens on both nursing homes and the Department and, by limiting the potential bases of subsequent administrative rate appeals and audit adjustments, enhance the stability and certainty of initial Medicaid payments and reduce the likelihood of litigation.

Needs and Benefits:

The new pricing reimbursement methodology reforms and replaces an outdated, complex, and administratively burdensome (to both providers and the Department) rate-setting system with a stable, predictable and transparent methodology that rewards efficiencies and incentivizes quality outcomes. The new pricing system will also provide a good foundation for the transition of nursing home residents to managed care that will occur over the next several years. The new methodology will also, by limiting the potential bases of subsequent administrative rate appeals and audit adjustments, enhance the stability and certainty of initial Medicaid payments and reduce the likelihood of litigation. The new methodology also contains mechanisms to safeguard the integrity of case mix data reporting. If reported case mix data indicates a change in the facility's case mix of more than five percent, the payment adjustment associated with the change over five percent may be held, pending an audit to verify the accuracy of the reported data. Also, facilities are required to formally certify to the accuracy of their case mix data reporting on an annual basis.

Costs to Private Regulated Parties:

There will be no additional costs to private regulated parties. The only additional data requested from providers would be reporting quality measures in their annual cost report.

Costs to State Government:

There is no additional aggregate increase in Medicaid expenditures anticipated as a result of these regulations.

Costs to Local Government:

Local districts' share of Medicaid costs is statutorily capped; therefore, there will be no additional costs to local governments as a result of this proposed regulation.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of this proposed regulation.

Local Government Mandates:

The proposed regulation does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

The proposed regulation does not create new or additional paperwork responsibility of any kind.

Duplication:

These regulations do not duplicate existing state or federal regulations.

Alternatives:

The Department is required by the Public Health Law section 2808 2-c to implement the new pricing methodology. The department worked closely with the Nursing Home Industry

Associations to develop the details of the pricing methodology to be implemented by the regulation.

Federal Standards:

The proposed regulation does not exceed any minimum standards of the federal government for the same or similar subject area.

Compliance Schedule:

The new prices will be published by the department and transmitted to the EMedNY system. There are no new compliance efforts required by the nursing homes.

Contact Person: Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
Corning Tower Building, Rm 2438
Empire State Plaza
Albany, NY 12237
(518) 473-7488
(518) 473-2019 (FAX)
REGSQNA@health.state.ny.us

**REGULATORY FLEXIBILITY ANALYSIS
FOR
SMALL BUSINESSES AND LOCAL GOVERNMENTS**

Effect of Rule:

For the purpose of this regulatory flexibility analysis, small businesses were considered to be residential health care facilities with 100 or fewer employees. Based on recent financial and statistical data extracted from Residential Health Care Facility Cost Reports, approximately 60 residential health care facilities were identified as employing fewer than 100 employees.

To ensure a smooth transition and mitigate significant swings in Medicaid revenues, the new Medicaid reimbursement methodology for nursing homes implemented by this regulation will be phased-in over a five year period (full implementation in the sixth year). Of the 60 nursing homes, 36 nursing homes that are subject to this regulation will experience a decrease in Medicaid revenues. The losses in Medicaid revenues will occur gradually – and will increase from .473% of total operating revenue in year one to 5.4% of total operating revenue in year six. Twenty-four nursing homes that are subject to this regulation will experience an increase in Medicaid revenues. The gains in Medicaid revenues will occur gradually – and will increase from 1.2% of total operating revenue in year one to 2% of total operating revenue in year six. In addition, the new methodology will also, by limiting the potential bases of subsequent administrative rate appeals and audit adjustments, enhance the stability and certainty of initial Medicaid payments and reduce the likelihood of litigation.

This rule will have no direct effect on local governments.

Compliance Requirements:

There are no new compliance requirements.

Professional Services:

No new or additional professional services are required in order to comply with the proposed amendments.

Compliance Costs:

No additional compliance costs are anticipated as a result of this rule.

Economic and Technological Feasibility:

The proposed rule doesn't require additional technological or economic requirements.

Minimizing Adverse Impact:

To ensure a smooth transition to the new pricing methodology by mitigating significant fluctuations (increases or decreases) in the amount of Medicaid revenues received by nursing homes, per diem transition rate adjustments will be included to phase-in the new pricing methodology over a five-year period, with full implementation in the sixth year. The new methodology will also, by limiting the potential bases of subsequent administrative rate appeals and audit adjustments, enhance the stability and certainty of initial Medicaid payments and reduce the likelihood of litigation.

Small Business and Local Government Participation:

The State filed a Federal Public Notice, published in the State Register, prior to the

effective date of the change. The Notice provided a summary of the action to be taken and instructions as to where the public, including small businesses and local governments, could locate copies of the corresponding proposed State Plan Amendment. The Notice further invited the public to review and comment on the related proposed State Plan Amendment. The Department worked closely with the major nursing home industry associations to develop the details of the pricing methodology to be implemented by the regulation. In addition, contact information for the Department was provided for anyone interested in further information.

RURAL AREA FLEXIBILITY ANALYSIS

Effect on Rural Areas:

Rural areas are defined as counties with populations less than 200,000 and, for counties with populations greater than 200,000, include towns with population densities of 150 persons or less per square mile. The following 43 counties have populations of less than 200,000:

Allegany	Hamilton	Schenectady
Cattaraugus	Herkimer	Schoharie
Cayuga	Jefferson	Schuyler
Chautauqua	Lewis	Seneca
Chemung	Livingston	Steuben
Chenango	Madison	Sullivan
Clinton	Montgomery	Tioga
Columbia	Ontario	Tompkins
Cortland	Orleans	Ulster
Delaware	Oswego	Warren
Essex	Otsego	Washington
Franklin	Putnam	Wayne
Fulton	Rensselaer	Wyoming
Genesee	St. Lawrence	Yates
Greene		

The following nine counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

There are no new compliance requirements as a result of the proposed rule.

Professional Services:

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendments.

Compliance Costs:

No additional compliance costs are anticipated as a result of this rule.

Minimizing Adverse Impact:

To ensure a smooth transition to the new pricing methodology by mitigating significant fluctuations (increases or decreases) in the amount of Medicaid revenues received by nursing homes, per diem transition rate adjustments will be included to phase-in the new pricing methodology over a five-year period, with full implementation in the sixth year. The new methodology will also, by limiting the potential bases of subsequent administrative rate appeals

and audit adjustments, enhance the stability and certainty of initial Medicaid payments and reduce the likelihood of litigation.

Rural Area Participation:

The Department, in collaboration with the major nursing home industry associations (which include representation of rural nursing homes), worked collaboratively to develop the key components of the statewide pricing methodology. In addition, a Federal Public Notice, published in the New York State Register invited comments and questions from the general public.

JOB IMPACT STATEMENT

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is not expected that the proposed rule to establish a new Medicaid reimbursement methodology for nursing homes will have a material impact on jobs or employment opportunities across the nursing home industry. To ensure a smooth transition to the new pricing methodology by mitigating significant fluctuations (increases or decreases) in the amount of Medicaid revenues received by nursing homes, per diem transition rate adjustments will be included in the proposed regulations to phase-in the new pricing methodology over a five-year period, with full implementation in the sixth year.