NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

October 7, 2016

Subject: 2017 Capital Schedule Preview
Medicaid Rates for Nursing Facilities and ADHC

Dear Administrator:

This is to inform you that a preview of the 2017 Medicaid capital rate schedules for free-standing and hospital-based nursing facilities and any associated Adult Day Health Care programs can be obtained via the Health Commerce System (HCS). These Preview rates reflect the 2017 capital component that is based upon the facility's 2015 cost report. Initial rates, which are expected to be released in early November, will include both the capital and operating components.

Facilities that have not properly submitted the corresponding RHCF-II, RHCF-IV, or an appropriate ICR, are not included in this posting. Facilities that have not provided the Department with hard copies of properly certified financials for related companies will be contacted for resolution.

The Attestation process implemented with the 2016 rates will continue for the 2017 rates. This administrative process allows for facilities to review and adjust the capital component before the rates are promulgated.

Facilities can accept the capital component that the Department has provided on the HCS or can attest to a capital component that is revised and properly submitted with supporting documentation for any appropriate changes. The attestation form attached to this letter, provides the Department with the assurance that the capital component is accurate and complies with the Department's statutes, regulations and policies regarding capital reimbursement.

The preview capital calculations are not subject to appeal at this time. Any changes that the facility wishes to make to the Department's capital calculations, as posted on the HCS, are to be sufficiently explained in a narrative. This narrative, along with an adjusted pro-forma capital schedule and a properly signed and dated attestation, are to be sent via email to the Department at NFRATES@health.ny.gov The Department reserves the right not to accept an attestation of an unreasonable or inaccurate adjusted capital schedule. The subject line of the email should state, "**2017 Capital Rate Attestation**".

Initial rates will reflect attested capital changes that have been processed up to the release of those rates. All 2017 capital attestations must be received by December 2, 2016. No attestations will be accepted after the deadline. Please note that failure to submit an attestation will not preclude submission of a formal administrative rate appeal when such rate is published. However, any rate appeal received for a capital issue for which an attestation was submitted, invalidates the attestation and the capital will be reset to the initial capital.

Any questions regarding this process or general capital questions should also be addressed in an email to NFRATES@health.ny.gov No phone calls will be accepted.

Sincerely,

Steven M. Simmons
Director
Bureau of Residential Health Care Reimbursement
Office of Health Insurance Programs

New York State Department of Health
Office of Health Insurance Programs
Capital Reimbursement Certification

Facility_____
Operating Certificate Number_____
Capital Reimbursement Rate Year - 2017
Declaration Control Number (DCN) of corresponding RHCF-2 or 4_____

Certification Statement

Misrepresentation or falsification of any information contained on this form may be punishable by fine and/or imprisonment under New York State Law and Federal Law.

Certification of Operator

I hereby certify that I am the signatory to the RHCF-2 or 4 for the attached capital reimbursement schedule and that I have the authority to bind the above listed facility. I have read the above statement and I have examined the attached capital reimbursement schedule, which serves as the basis for the capital per diem of the corresponding rates, based upon certified information contained in the DCN identified above, and that to the best of my knowledge and belief, it is true and complete.

I certify that this schedule was completed, to the best of my knowledge and ability, in accordance with the New York State statutes, regulations and policies that govern Medicaid capital reimbursement for free standing nursing facilities.

I will provide any supporting documentation as requested by the Department of Health, the Office of the Medicaid Inspector General and any other audit, enforcement or oversight agency and/or body.

I understand that this attestation is in lieu of an administrative appeal of the attested rate. Further, I understand that any challenge to the attested rate, through administrative action or otherwise, will result in forfeiture of the attested rate and adoption of the Department's original reimbursement rate. I understand that this in no way limits the administrative appeal rights of the facility and that an administrative appeal may be pursued in accordance with applicable New York State statutes, regulations and policies, including any rights under 10 NYCRR 86-21.3.

I understand that the Department of Health's acceptance of the attached schedule, in no way precludes the Office of the Medicaid Inspector General from conducting audits and/or exercising its oversight capacity in any manner whatsoever, including, but not limited to, actions taken pursuant to 18 NYCRR Parts 517, 518 and 519.

I hereby certify that I have read the foregoing conditions and that I have the legal authority to bind the above listed facility to the terms herein.

Modifications of the terms contained herein shall render this attestation null and void.

_____
DATE

_____
SIGNATORY'S NAME (PRINTED)

_____
SIGNATURE

_____
SIGNATORY'S TITLE