SubPart 86-2 - Residential Health Care Facilities

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Public Health Law, Sections 2803(2), 2807(3) 2808

Section 86-2.1 - Definitions

Section 86-2.1 Definitions. As used in this Subpart, the following definitions shall apply:

(a) Residential health care facility, medical facility or facility shall mean all facilities or organizations covered by the term nursing home as defined in article 28 of the Public Health Law, including hospital-based residential health care facilities, and nursing facilities as defined in section 1919 of the Federal Social Security Act, provided that such facility possesses a valid operating certificate issued by the State Commissioner of Health and, where required, has been established by the Public Health Council.

(b) Patient classification groups shall mean patient categories contained in the classification system, Resource Utilization Groups-II (RUG-II), which identifies the relative resource consumption required by different types of long-term care patients as specified in Appendix 13-A, infra.

(c) Case mix shall mean the patient population of a facility as classified and aggregated into patient classification groups.

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Thursday, December 27, 1990
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Section 86-2.2 - Financial and statistical data required

86-2.2 Financial and statistical data required.

(a) Each residential health care facility shall complete and file, with the New York State Department of Health and/or its agent, annual financial and statistical report forms supplied by the department and/or its agent. Residential health care facilities certified for title XVIII of the Federal Social Security Act (Medicare) shall use the same fiscal year for title XIX of the Federal Social

Security Act (Medicaid) as is used for title XVIII. All residential health care facilities must report their operations from January 1, 1977, forward on a calendar-year basis.

(1) Hospital based residential health care facilities whose affiliation changes to free-standing pursuant to of section 86-2.34(a) of this Subpart shall complete and file the free-standing annual cost report (RHCF-4) supplied by the department and/or its agent for the first full calendar year following actual complete closure of the acute care beds of its affiliated hospital.

(b) Federal regulations require the submission of cost reports to the State agency no later than three months after the close of the cost reporting year. State agencies requiring certified reports may grant an extension of 30 days. Since the reports from all residential health care facilities are required to be certified, an extension of 30 days is automatically provided in this subdivision so that all required financial and statistical reports shall be submitted to the department no later than 120 days following the close of the fiscal period. Further extensions of time for filing reports may be granted upon application received prior to the due date of the report and only in those circumstances where the residential health care facility established, by documentary evidence, that the report cannot be filed by the due date for reasons beyond the control of the facility.

(c) In the event a residential health care facility fails to file the required financial and statistical reports on or before the due dates, or as the same may be extended pursuant to subdivision (b) of this section, the State Commissioner of Health shall reduce the current rate paid by state governmental agencies by two percent for a period beginning on the first day of the calendar month following the original due date of the required reports and continuing until the last day of the calendar month in which the required reports are filed.

(d) In the event that any information or data which a residential health care facility has submitted to the State Department of Health, on required reports, budgets or appeals for rate revisions intended for use in establishing rates, is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the department a correction of such information or data which meets the same certification requirements as the document being corrected.

(e) Except as identified in sections 86-2.10(k)(6) and 86-2.15(e), a cost report shall be filed in accordance with this section by each new facility for the first twelve-month period during which the facility has had an overall average utilization of at least 90 percent of bed capacity. This report shall be filed and properly certified within 60 days following the end of the twelve-month period covered by the report. Failure to comply with this subdivision shall result in application of subdivision (c) of this section.

(f) If the financial and statistical reports required by this Subpart are determined by the department to be incomplete, inaccurate or incorrect, the residential health care facility will have 30 days from date of receipt of notification to provide the corrected or additional data. Failure to file the corrected or additional data within 30 days, or within such period as extended by the Commissioner, will result in application of subdivision (c) of this section. Lack of the respective certifications by both the operator and accountant, as required pursuant to sections 86-2.5 and 86-2.6 of this Subpart, shall render a financial and statistical report incomplete.

(g) Specific additional data related to the rate setting process may be requested by the State Commissioner of Health. These data, which include and are limited to those for use in a wage geographic differential survey, a peer grouping data survey, a medical supplies survey and a malpractice insurance survey, must be provided by the residential health care facility within 30

days from the date of receipt of notification to supply such information. The commissioner must supply to each facility prior to the start of each rate period, a preliminary listing of the data that will be required. Failure to submit the additional data shall result in application of subdivision (c) of this section, unless the residential health care facility can prove by documentary evidence that the data being requested is not available.

Effective Date:
Tuesday, January 14, 1997
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Section 86-2.3 - Uniform system of accounting and reporting

86-2.3 Uniform system of accounting and reporting.

(a) Residential health care facilities shall maintain their records in accordance with:

(1) section 414.13 of Article 3 of Subchapter A of Chapter V of this Title; and

(2) for the 1980 calendar year in substantial compliance, and thereafter in full compliance, with Article 9 of Subchapter A of Chapter V of this Title. Substantial compliance shall be defined as the result that would be expected from a good-faith effort taken by an informed, responsible person.

(b) For purposes of rate setting, the report required for the fiscal year beginning on or after January 1, 1980 by residential health care facilities shall be made in accordance with the policies and instructions as set forth in Article 9 of Subchapter A of Chapter V of this Title for financial presentation purposes.

(c) Failure of residential health care facility to file the reports required in accordance with this section will subject the residential health care facility to a rate reduction as set forth in the provisions of section 86-2.2(c) of this Subpart. However, there may be instances where a facility is not in compliance with Article 9 of Subchapter A of Chapter V of this Title, resulting in reports which are inaccurate, incomplete or incorrect, and the area of noncompliance cannot, for the reporting period, be corrected. In such instances a rate reduction shall begin on the first day of the calendar month following the original due date of the required report and continue until the last day of the calendar month in which the required reports are filed.

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Thursday, February 25, 1993
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Section 86-2.4 - Generally accepted accounting principles

86-2.4 Generally accepted accounting principles.

The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the residential health care facility unless the reporting instructions authorized specific variation in such principles.

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Section 86-2.5 - Accountant's certification

86-2.5 Accountant's certification.

(a) The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant. The minimum standard for the term "independent" shall be the standard used by the State Board of Public Accountancy.

(b) Effective with report periods beginning on or after January 1, 1977, the requirements of subdivision (a) of this section shall apply to residential health care facilities operated by units of government of the State of New York heretofore exempt from the requirements of this section except that those medical facilities for which an annual reimbursement audit by a State agency is required by law shall be required to comply herewith effective with report periods beginning on or after January 1, 1978.

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Section 86-2.6 - Certification by operator or officer

86-2.6 Certification by operator or officer.

(a) The financial and statistical reports shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility or the public official responsible for the operation of a public medical facility.

(b) The form of the certification required in subdivision (a) of this section shall be as prescribed in the annual fiscal and statistical report forms provided by the State Commissioner of Health.

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Section 86-2.7 - Audits

86-2.7 Audits.

(a) All fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports, filed by the residential health care facility with the department, shall be kept and maintained by the facility for a period of time not less than six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later date. In this respect, any rate of payment certified by the State Commissioner of Health based on the initial submission of base year data and reports will be construed to represent a provisional rate until such audit is performed and completed, at which time such rate or adjusted rate will be construed to represent the audited rate.

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Section 86-2.8 - Patient days

86-2.8 Patient days.

(a) A patient day is the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hour on two successive days.

(b) In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes residential health care facility days shall be determined by using the higher of the minimum utilization factor of 90 percent of certified beds or the actual patient days of care as furnished by the facility.

(d) Reserved bed patient days shall be computed separately from patient days. A reserved bed patient day is the unit of measure denoting an overnight stay away from the residential health care facility for which the patient, or patient's third-party payor, provides per diem reimbursement when the patient's absence is due to hospitalization or therapeutic leave.

(e) In computing reserved bed patient days, the day of discharge from the residential health care facility shall be counted, but not the day of readmission.

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Section 86-2.9 - Adult day health care in residential health care facilities

86-2.9 Adult day health care in residential health care facilities.

(a) Except as specifically identified in subdivision (g), rates for residential health care facility services for adult day health care registrants shall be computed on the basis of the allowable costs, as reported by the residential health care facility, and the total number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of Chapter V of this Title subject to the maximum daily rate provided for in this section.

(b) For adult day health care programs without adequate cost experience, rates will be computed based upon annual budgeted allowable costs, as submitted by the residential health care facility and the total estimated annual number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of Chapter V of this Title subject to the maximum daily rate provided for in this section.

(c) Allowable costs shall include, but are not limited to, the following:

(1) applicable salary and nonsalary operating costs;

(2) cost of transportation; and

(3) appropriate portion of capital costs, allocated according to instructions accompanying the RHCF-4 report.

(d) The maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24-hour period as described in Part 425 of this Title shall be 75 percent of the sponsoring facility's former skilled nursing facility rate in effect on January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

(e) Notwithstanding subdivision (d) of this section or any other regulations to the contrary, for the period July 1, 1992 to March 31, 1993 and annual periods beginning April 1, thereafter, the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24-hour period as described in Part 425 of this Title shall be 65 percent of the sponsoring facility's former skilled nursing facility rate in effect on January 1, 1990 with the operating component trended forward to the rate year by the sponsoring facility's trend factor. The provisions of this subdivision shall be contingent upon extension of Section 1 of Chapter 41 of the Laws of 1992, or upon the enactment of permanent statutory authority.

(f) For facilities without a skilled nursing facility rate, computed in accordance with section 86-2.10 or section 86-2.15 of this Subpart, in effect on January 1, 1990, a weighted average rate for each region listed in Appendix 13A of this Title shall be used as the proxy for the facility's January 1, 1990 skilled nursing facility rate in determining the maximum daily rate for such facilities as set forth in subdivisions (d) and (e) of this section. The weighted average rate for each region shall be

equal to the statewide weighted average 1990 skilled nursing facility rate with the statewide average direct component and indirect component of the rate adjusted respectively by the regional direct and indirect input price adjustment factors described in section 86-2.10. The statewide weighted average rate shall be computed by multiplying each residential health care facility's 1990 skilled nursing facility rate times its 1990 skilled nursing facility patient days, summing the result statewide, and dividing by the statewide total 1990 skilled nursing facility patient days. The 1990 rate used in computing the statewide weighted average rate shall be the latest 1990 rate in effect on July 1, 1992 for the former skilled nursing level of care which is contained in the rate which has been certified by the commissioner pursuant to section 2807(3) of the Public Health Law.

(g) Effective April 1, 1994 and thereafter, reimbursement for adult day health care services that are provided to registrants with acquired immune deficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses and, effective April 1, 2017, that are provided to registrants who are otherwise considered at the discretion of the commissioner to be part of a high-need population that, regardless of their HIV status, would benefit from receiving these adult day health care services shall be established pursuant to this subdivision. The services to be provided to such registrants shall be the same as those listed in Part 759 of this Title. Reimbursement to a residential health care facility shall be established as follows:

(1) The rate of payment shall consist of a single price per visit to include the operating component, transportation, and the capital cost component of the rate. Payment shall be based upon a per visit rate of $160 with not more than one reimbursable visit per 24-hour period per registrant.

(2) To be eligible to receive reimbursement pursuant to this section, a residential health care facility must be certified by the department pursuant to Part 710 of this Title to provide adult day health care services for AIDS/HIV registrants and, effective April 1, 2017, other high-need registrants.

(3) The price established pursuant to this section shall be full reimbursement for the following:

(i) physician services, nursing services, and other related professional expenses directly incurred by the licensed residential health care facility;

(ii) administrative personnel, business office, data processing, recordkeeping, housekeeping, food services, transportation, plant operation and maintenance and other related facility overhead expenses;

(iii) all other services described in Article 6 of this Title appropriate to the level of general medical care required by the patient; and

(iv) all medical supplies, immunizations and drugs directly related to the provisions of services except for those drugs used to treat AIDS patients for which fee-for-service reimbursement is available as determined by the Department of Social Services.

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Wednesday, June 14, 2017
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Section 86-2.10 - Computation of basic rate

86-2.10 Computation of basic rate. (a) Definitions. For purposes of this section, the following definitions shall apply:

(1) Direct price shall mean the monetary amount established for the direct component of the rate, based on the direct costs of all facilities after application of the regional direct input price adjustment factor, divided by patient days and the average statewide case mix index.

(2) Indirect price shall mean the monetary amount established for the indirect component of the rate, based on the indirect costs for each facility in a peer group, after application of a regional indirect price adjustment factor, divided by total peer group patient days.

(3) Peer group shall mean a set of facilities distinguished by like characteristics which are grouped for purposes of comparing costs and establishing payment rates using such criteria as affiliation (i.e., hospital-based or freestanding), case mix index (i.e., high intensity, case mix index greater than .83, or low intensity, case mix index less than or equal to .83), and size (i.e., less than 300 beds or 300 or more beds).

(4) Cost center shall mean categories into which related costs are grouped in accordance with and defined in Part 455 of this Title.

(5) Case mix index shall mean the numeric weighting of each patient classification group in terms of relative resource utilization as specified in Appendix 13-A, infra.

(6) Rate shall mean the aggregate governmental payment to facilities per patient day as defined in section 86-2.8 of this Subpart, for the care of Medicaid payments which include a direct, indirect, noncomparable and capital component.

(7) Operating portion of the rate shall mean the portion of the rate consisting of the direct, indirect and noncomparable components after application of the roll factor promulgated by the department.

(8) Roll factor shall mean the cumulative result of multiplying one year's trend (inflation) factor times one or more other years' trend factor(s) which is used to inflate costs from a base period to a rate period.

(9) Capital costs shall mean costs reported in the depreciation, leases and rentals, interest on capital debt and/or major movable equipment depreciation cost centers, as well as costs reported in any other cost center under the major natural classification of depreciation, leases and rentals on the facilities annual cost report (RHCF-4).

(10) Base shall mean, as applicable to cost or price, a minimum cost or price.

(11) Ceiling shall mean, as applicable to cost or price, a maximum cost or price.

(12) Corridor shall mean the difference between a base and a ceiling.

(13) Hospital-based shall mean as follows:

(i) For facilities receiving initial operating certificates prior to January 1, 1983, hospital-based shall mean those facilities that are considered by the Federal Health Care Financing Administration (HCFA) to be hospital-based or hospital-related (as pertaining to cost allocation) and which derive and report costs on the basis of a Medicare cost allocation methodology from an affiliated hospital.

(ii) For facilities receiving operating certificates after January 1, 1983, the commissioner shall review and determine whether or not such facilities are hospital-based utilizing the following criteria:

(a) the nature of any construction approval received pursuant to section 2802 of the Public Health Law;

(b) the nature of any establishment approval received pursuant to section 2801-a of the Public Health Law;

(c) the architectural configuration of the residential health care facility unit as related to the hospital physical plant;

(d) the method and amount of cost allocation;

(e) whether a determination that such a facility is hospital-based would result in the efficient and economic operation of such facility.

(b) (1) The rate for 1986 and subsequent rate years shall:

(i) be computed on the basis of allowable fiscal and statistical data submitted by the facility for the fiscal year ending December 31, 1983 as contained in parts I, II, III and IV of the facility's annual cost report (RHCF-4) and for hospital-based facilities, the annual cost report (RHCF-2) and the institutional cost report of its related hospital;

(ii) consist of the following four separate and distinct components, as defined in this section:

(a) direct;

(b) indirect;

(c) noncomparable; and

(d) capital.

(2) The operation portion of the rate for 1986 and subsequent rate years shall consist of the sum of the direct, indirect and noncomparable components of the rate determined in accordance with this section trended to the rate year by the applicable roll factor promulgated by the department.

(3) Allocation and adjustments of reported costs. (i) The computation of the rate for 1986 and for subsequent rate years shall incorporate the use of the single step-down method of cost allocation as defined in section 451.249 of this Title.

(ii) Individual discrete ceilings shall be applied to remuneration for the facility's administrator, assistant administrator and operator as specified in Appendix 13-A, infra.

(iii) Reported costs for 1983 shall be adjusted through the apportionment of retroactive adjustments due to operating appeals which were as a result of significant increases in staff specifically mandated by the commissioner. Such adjustments shall be limited to those related to staff hired subsequent to December 31, 1982 and those appeal requests received by the department prior to July 1, 1985.

(iv) In the determination of rates, reported costs shall be subject to the limitations and adjustments contained in sections 86-2.12, 86-2.17, 86-2.18, 86-2.25 and 86-2.26 of this Subpart.

(v) Salaries paid to related parties shall be subject to an initial maximum not to exceed $17,000. This limitation may be waived by the department pursuant to the provisions of section 86-2.14(a)(7) of this Subpart.

(c) Direct component of the rate. (1) Allowable costs for the direct component of the rate 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 cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending.

(i) nursing administration;

(ii) activities;

(iii) social services;

(iv) transportation;

(v) physical therapy;

(vi) occupational therapy;

(vii) speech and hearing therapy-(speech therapy portion only)

(viii) pharmacy;

(ix) central service supply; and

(x) residential health care facility.

(2) For purposes of calculating the direct component of the rate, the department shall utilize the allowable direct costs reported by all facilities with the exception of specialty facilities as defined in subdivision (i) of this section.

(3) The statewide mean, base and ceiling direct price for patients in each patient classification group shall be determined as follows:

(i) Allowable costs for the direct cost centers for each facility after first deducting capital costs and items not subject to trending, shall be multiplied by the appropriate Regional Direct Input Price Adjustment Factor ("RDIPAF"), as determined pursuant to paragraph (5) of this subdivision. The RDIPAF neutralizes the difference in wage and fringe benefit costs between and among the regions caused by differences in the wage scale of each level of employee.

(ii) The statewide distribution of patients in each patient classification group shall be determined for 1986 payments utilizing the patient data obtained in the patient assessment period, March 1, 1985 through September 30, 1985, conducted pursuant to section 86-2.30 of this Subpart.

(iii) A statewide mean direct case mix neutral cost, a statewide base direct case mix neutral cost and a statewide ceiling direct case mix neutral cost shall be determined as follows:

(a) Allowable direct costs for each facility, after first deducting capital costs and items not subject to trending and adjusted by applying the RDIPAF shall be summed to determine total statewide direct costs.

(b) The aggregate statewide case mix index shall be determined by multiplying number of patients on a statewide basis in each patient classification group by the case mix index for each patient classification group and the results summed.

(c) A statewide mean direct cost per day shall be determined by dividing total statewide direct costs by the aggregate number of statewide 1983 patient days.

(d) A statewide mean direct case mix neutral cost per day shall be determined by dividing the statewide mean direct cost per day by the ratio of aggregate statewide case mix index to the number of patient review instruments received pursuant to section 86-2.30 of this Subpart.

(e) The statewide mean direct case mix neutral cost per day shall be the basis to establish a corridor between the statewide base direct case mix neutral cost per day and the statewide ceiling direct case mix neutral cost per day.

(f) The corridor shall be established by use of a base factor and a ceiling factor expressed as a percentage of the statewide mean direct case mix neutral cost per day.

(g) A statewide base direct case mix neutral cost per day shall be determined by multiplying the base factor times the statewide mean direct case mix neutral cost per day.

(h) A statewide ceiling direct case mix neutral cost per day shall be determined by multiplying the ceiling factor times the statewide mean direct case mix neutral cost per day.

(i) A statewide mean direct price per day for each patient classification group shall be determined by multiplying the statewide mean direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

(j) A statewide base direct price per day for each patient classification group shall be determined by multiplying the statewide base direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

(k) A statewide ceiling direct price per day for each patient classification group shall be determined by multiplying the statewide ceiling direct case mix neutral cost per day by the case mix index for each patient classification group, provided however that the index for reduced physical functioning A shall be .4414.

(l) The corridor referred to in clause (e) of this subparagraph shall be calculated as follows:

(1) The base factor referred to in clause (f) of this subparagraph shall be approximately 90 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, such factor shall be approximately 90 percent. For the period January 1, 1988 through June 30, 1989, such factor shall be increased to approximately 95 percent. For the period July 1, 1989 through March 31, 1990, such factor shall be reduced to approximately 88.25 percent. For the period April 1, 1990, and thereafter, such factor shall be increased to approximately 90 percent.

(2) The ceiling factor referred to in clause (f) of this subparagraph shall be approximately 115 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, such factor shall be reduced to approximately 110 percent. For the period January 1, 1988 through December 31, 1988, and thereafter, such factor shall be reduced to approximately 105 percent.

(3) For the period January 1, 1986 through December 31, 1986, the base factor and ceiling factor contained in the clause shall initially be determined to result in a 20-percent corridor. The ceiling factor shall then be increased by five percent. For the period January 1, 1987 through December 31, 1987, the application of the base factor and ceiling factor contained in this clause shall result in a 20-percent corridor. For the period January 1, 1988 through December 21, 1988, and thereafter, the base factor and ceiling factor contained in this clause shall result in a 10-percent corridor.

(4) The facility-specific direct adjusted payment price per day shall be determined as follows:

(i) The facility-specific mean direct price per day shall be determined by multiplying the statewide mean direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(ii) The facility-specific base direct price per day shall be determined by multiplying the statewide base direct per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(iii) The facility-specific ceiling direct price per day shall be determined by multiplying the statewide ceiling direct price per day for each patient classification group times the number of patients properly assessed and reported by the facility in each patient classification group pursuant to section 86-2.30 of this Subpart and dividing the sum of the results by the total number of patients properly assessed and reported by the facility pursuant to section 86-2.30 of this Subpart.

(iv) The facility-specific cost based direct price per day shall be determined by dividing a facility's adjusted allowable reported direct costs after first deducting capital costs and items not subject to trending and, after application of the RDIPAF, by the facility's 1983 total patient days.

(v) Except as contained in subparagraph (vi) of this paragraph, the facility-specific direct adjusted payment price per day shall be determined by comparison of the facility-specific cost based price per day with the facility-specific base direct price per day and the facility-specific ceiling direct per day pursuant to the following table:

Facility-Specific Cost Based Facility-Specific Direct

Direct Price Per Day Adjusted Payment Price Per Day

Below Facility-Specific Base Facility-Specific Base

Direct Price Per Day Direct Price Per Day

Between Facility-Specific Base Facility-Specific Cost

Direct Price Per Day and Facility-Based Direct Price Per Day

Specific Ceiling Direct

Price Per Day

Above Facility-Specific Ceiling Facility-Specific Ceiling

Direct Price Per Day Direct Price Per Day

(vi) The facility-specific direct adjusted payment price per day shall be considered to be the facility-specific cost based direct price per day when such price is below the facility specific base direct price per day subject to the provisions of paragraph (6) of this subdivision for the following operators of residential health care facilities:

(a) an operator who has had an operating certificate revoked pursuant to section 2806(5) of the Public Health Law and is operating a residential health care facility pursuant to an order of the Commissioner of this department; and

(b) operator of a facility in which the Federal Health Care Financing Administration (HCFA) has imposed a ban on payment for all Medicare and Medicaid admissions after a specified date pursuant to section 1866(f) of the Federal Social Security Act until the lifting of the ban in writing by HCFA.

(vii) The direct component of a facility's rate shall be the facility-specific direct adjusted payment price per day determined in subparagraph (v) or (vi) of this paragraph as applicable after applying the RDIPAF.

(5) The RDIPAF shall be based on the following factors:

(i) Residential health care facilities shall be grouped, by county, into 16 regions within the State as outlined in Appendix 13-A, infra.

(ii) The facility's staffing, based on case mix predicted staffing for registered professional nurses, licensed practical nurses, and aides, orderlies and assistants for each facility. The case mix predicted staffing shall be adjusted annually on January 1st of each rate year based on the PRI's submitted by each facility for the fourth quarter of the preceding calendar year, in accordance with sections 86-2.11(b) and 86-2.30 of this Subpart. Until such PRIs are available, the case mix predicted staffing shall be based on the most current PRIs available prior to calculation of the initial rate effective January 1st of each rate year. The case mix predicted staffing shall subsequently be

revised based on more recent PRI submissions until such time as the PRIs for the fourth quarter of the preceding calendar year are available.

(iii) The proportion of salaries and fringe benefit costs for the direct care cost centers indicated in subdivision (c) of this section to the total costs of such direct care cost centers.

(6) Case mix adjustment. A facility shall receive an increase or decrease in the direct component of its rate if the facility has increased or decreased its case mix from one assessment period to the next and, in accordance with subparagraph (4)(v) of this subdivision, would not have received any change in the direct component of its rate from that determined as of January 1, 1986 to the current calculation date. The increases or decreases in the direct component of the rate shall be determined as follows:

(i) The facility-specific mean price per day effective January 1, 1986 as determined in accordance with subparagraph (4)(i) of this subdivision shall be compared to the facility-specific mean price per day determined as a result of the submissions required in accordance with section 86-2.11(b) of this Subpart. Any increase or decrease determined as a result of such comparison, shall be expressed as a percentage, positive or negative, of the facility-specific mean price per day effective January 1, 1986.

(ii) This percentage shall be applied to the facility-specific cost based direct price per day determined as of January 1, 1986, and an adjustment factor shall be determined.

(iii) This adjustment factor shall be added to or subtracted from the facility-specific cost based direct price per day determined as of January 1, 1986, to arrive at an adjusted facility-specific cost based direct price per day which shall become for a facility their facility-specific adjusted payment price per day for the applicable rate period for which payment rates are adjusted pursuant to section 86-2.11 of this Subpart.

(d) Indirect component of the rate. (1) Allowable costs for the indirect component of the rate 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 cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting for capital costs and allowable items not subject to trending:

(i) fiscal services;

(ii) administrative services;

(iii) plant operations and maintenance (with the exception of utilities and real estate and occupancy taxes);

(iv) grounds;

(v) security;

(vi) laundry and linen

(vii) housekeeping;

(viii) patient food services;

(ix) cafeteria;

(x) non-physician education;

(xi) medical education;

(xii) housing; and

(xiii) medical records.

(2) For the purposes of establishing the allowable indirect component of the rate, facilities shall be combined into peer groups as follows:

(i) Size:

(a) less than 300 beds;

(b) 300 or more beds. (ii) Affiliation:

(a) free-standing;

(b) hospital-based.

(iii) Case mix index:

(a) high intensity, case mix index greater than .83;

(b) low intensity, case mix index less than or equal to .83.

(3) If any peer group contains fewer than five facilities, those facilities shall be included in a peer group of a similar type.

(4) For each of the peer groups, the indirect component of the rate shall be determined as follows:

(i) A mean indirect price per day shall be computed as follows:

(a) Reported allowable costs for the indirect cost centers for each facility in the peer group, after first deducting capital costs and allowable items not subject to trending shall be adjusted by applying the Regional Indirect Input Price Adjustment Factor (RIIPAF), as determined pursuant to paragraph (7) of this subdivision.

(b) The results of the calculation in clause (a) of this subparagraph shall be aggregated and divided by total 1983 patient days of all facilities in the peer group.

(ii) The mean indirect price per day shall be the basis to establish a corridor between the base indirect price per day and the ceiling indirect price per day. The corridor shall be established by use of a base factor and a ceiling factor expressed as a percentage of the mean indirect price per day.

(a) The base factor shall be approximately 90 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, such factor shall be increased to approximately 95 percent. For the period January 1, 1988 through June 30, 1989, such factor shall be increased to approximately 97.5 percent. For the period July 1. 1989 through

March 31, 1990 such factor shall be reduced to approximately 90.75 percent. For the period April 1, 1990, and thereafter, such factor shall be increased to approximately 92.5 percent.

(b) The ceiling factor shall be approximately 110 percent for the period January 1, 1986 through December 31, 1986. For the period January 1, 1987 through December 31, 1987, and thereafter, such factor shall be reduced to approximately 105 percent.

(iii) For the period January 1, 1986 through December 31, 1986, the base factor and ceiling contained in subparagraph (ii) of this paragraph, shall result in a 20-percent corridor. For the period January 1, 1987 through December 31, 1987, the base factor and ceiling factor contained in subparagraph (ii) of this paragraph shall result in a 10-percent corridor. For the period January 1, 1988 through December 31, 1988, and thereafter, the base factor and ceiling factor contained in subparagraph (ii) of this paragraph shall initially be determined to result in a five-percent corridor. The ceiling factor shall then be increased by 2.5 percent.

(iv) The base indirect price per day shall be determined by multiplying the base factor times the mean indirect price per day.

(v) The ceiling indirect price per day shall be determined by multiplying the ceiling factor times the mean indirect price per day.

(vi) The facility specific indirect adjusted payment price per day shall be determined by comparison of a facility's adjusted reported indirect costs after determining capital costs and items not subject to trending and after application of the RIIPAF, divided by the facility's total 1983 patient days, with the base indirect price per day and the ceiling indirect price per day. Except as outlined in subparagraph (vii) of this paragraph, the facility specific indirect adjusted payment price per day shall be established as presented by the following table:

Facility Adjusted Costs Facility Specific Indirect Adjusted Payment

Divided by Patient Days Price Per Day

Below Base Indirect Price Per Day Base Indirect Price Per Day

Between Base Indirect Price Per Day Reported Adjusted and Ceiling Indirect Price Per Day Costs Per Day

Ceiling Indirect Price Per Above Ceiling Indirect Price Per Day Day

(vii) The facility specific indirect adjusted payment price per day shall be considered to be the facility specific cost based indirect price per day when such price is below the facility specific base indirect price per day for the following operators of residential health care facilities:

(a) an operator who has had an operating certificate revoked pursuant to section 2806(5) of the Public Health Law and is operating a residential health care facility pursuant to an order of the commissioner of the department; and

(b) an operator of a facility in which the Federal Health Care Financing Administration (HCFA) has imposed a ban on payment for all Medicare and Medicaid admissions after a specified date pursuant to section 1866(f) of the Federal Social Security Act until the lifting of the ban in writing by HCFA.

(5) For each rate year, a facility's indirect costs shall be compared to the peer groups identified in paragraph (2) of this subdivision as follows:

(i) A facility's peer group established pursuant to paragraphs (2)(i) and (ii) of this subdivision shall be based on that facility's affiliation status prior to the effective rate period, contingent upon the provisions of section 86-2.34 of this Subpart, and total certified bed capacity listed on the operating certificate.

(ii) Those facilities having 80% or more of all patients falling into patient classification groups with weights greater than .83 shall be compared to the peer group established pursuant to clause (a) of subparagraph (iii) of paragraph (2) of this subdivision.

(iii) Those facilities having 80% or more of all patients falling into patient classification groups with weights equal to or less than .83 shall be compared to the peer group established pursuant to clause (b) of subparagraph (iii) of paragraph (2) of this subdivision.

(iv) Those facilities who do not meet either of the above conditions identified in subparagraphs (ii) and (iii) of this paragraph, shall be compared to a blended peer group mean price per day. Such price shall be determined by blending the number of a facility's patients which have patient classification group weights above .83 at the high intensity peer group mean price and the number of a facility's patients at or below .83 at the low intensity peer group mean price as defined pursuant to paragraph (4) of this subdivision.

(v) The peer group mean price effective January 1st of each rate year shall be based on the PRIs submitted by each facility for the fourth quarter of the preceding calendar year in accordance with 86-2.11(b) and 86-2.30 of this Subpart. Until such PRIs are available, the peer group mean price shall be based on the most current PRIs available prior to calculation of the initial rate effective January 1st of each rate year. The peer group mean price shall subsequently be revised based on more recent PRI submissions until such time as the PRIs for the fourth quarter of the preceding calendar year are available.

(6) The indirect component of a facility's rate shall be the facility specific indirect adjusted payment price per day determined in accordance with subparagraphs (vi) and (vii), as applicable of paragraph (4) of this subdivision after application of the RIIPAF.

(7) The RIIPAF shall be based on the following factors:

(i) residential health care facilities shall be grouped by county, into 16 regions within the State as outlined in Appendix 13-A, infra.

(ii) the facility's staffing, based on case mix predicted staffing for registered professional nurses, licensed practical nurses, and aides, orderlies and assistants for each facility. The case mix predicted staffing shall be adjusted annually on January 1st of each rate year based on the PRI's submitted by each facility, for the fourth quarter of the preceding calendar year, in accordance with sections 86.2.11(b) and 86-2.30 of this Subpart. Until such PRIs are available, the case mix predicted staffing shall be based on the most current PRIs available prior to calculation of the initial rate effective January 1st of each rate year. The case mix predicted staffing shall subsequently be revised based on more recent PRI submissions until such time as the PRIs for the fourth quarter of the preceding calendar year are available; and

(iii) the proportion of salaries and fringe benefits costs for the indirect care cost centers indicated in paragraph 1 of this subdivision to the total costs of such indirect care cost centers.

(e) Gain or loss limitation for the direct and indirect component of the rate. Gain or losses resulting from using the regional direct or indirect input price adjustment factors rather than individual facility specific direct or indirect input price adjustment factors shall be determined as follows:

(1) A facility's allowable direct costs divided by the facility's 1983 total patient days shall be compared to the facility's direct component and a direct gain or loss per day calculated.

(2) A facility's allowable indirect costs divided by the facility's 1983 total patient days shall be compared to the facility's indirect component and an indirect gain or loss per day calculated.

(3) The facility's direct gain or loss per day and indirect gain or loss per day shall be summed to arrive at a facility's net composite gain or loss per day.

(4) If a facility's net composite gain or loss per day is greater than $3.50, for the rate year 1986, a limitation shall be applied for rate years 1986 through 1988 as follows:

(i) For 1986 rates, if a facility has a net composite gain, then a facility's direct or indirect cost per day shall be determined by utilizing the regional or the individual facility-specific input price adjustment factor, whichever factor, when applied would reduce the gain.

(ii) For 1986 rates, if a facility has a net composite loss, then a facility's direct or indirect cost per day shall be determined by utilizing the regional or the individual facililty specific input price adjustment factor, whichever factor, when applied, would reduce the loss.

(iii) If a facility's direct or indirect cost per day is determined, pursuant to subparagraph (i) or (ii) of this paragraph, by utilizing the regional input price adjustment factor, such factor shall be utilized in all subsequent rate years.

(iv) If a facility's direct or indirect cost per day is determined, pursuant to subparagraph (i) or (ii) of this paragraph, by utilizing the individual facility-specific input price adjustment factor, the following shall apply to subsequent rate years:

(a) For 1987 rates, a facility's direct or indirect costs per day shall be determined by using a composite of 50 percent of the regional and 50 percent of the facility specific input price adjustment factor.

(b) For 1988 rates, a facility's direct or indirect costs per day shall be determined by using a composite of 75 percent of the regional and 25 percent of the facility specific input price adjustment factor.

(c) For 1989 and subsequent rate years, a facility's direct costs per day shall be determined by using the regional input price adjustment factors.

(5) The limitations of this subdivision shall not be applicable to specialty facilities as defined in subdivision (i) of this section.

(f) Noncomparable component of the rate. (1) The noncomparable component of the rate shall consist of costs which represent allowable costs reported by a facility which because of their nature are not subject to peer group comparisons.

(2) Allowable costs for the noncomparable component of the rate shall include the costs associated with supervision of facility volunteers and costs reported in the following functional cost centers as reported on the facility's annual cost report (RHCF-4) or extracted from a hospital-based facility's annual cost report (RHCF-2) and the institutional cost report of its related hospital, after first deducting capital costs and allowable items not subject to trending:

(i) laboratory services;

(ii) ECG;

(iii) EEG;

(iv) radiology;

(v) inhalation therapy;

(vi) podiatry;

(vii) dental;

(viii) psychiatric;

(ix) speech and hearing therapy-(hearing therapy only);

(x) medical director office;

(xi) medical staff services;

(xii) utilization review;

(xiii) other ancillary; and

(xiv) plant operations and maintenance-(cost for utilities and real estate and occupancy taxes only).

(3) The allowable facility-specific noncomparable component of the rate shall be reimbursed at a payment rate equal to adjusted reported noncomparable costs, after first deducting capital costs and allowable items not subject to trending, divided by the facility's total 1983 patient days.

(g) Capital component of the rate. The allowable facility-specific capital component of the rate shall include allowable capital costs determined in accordance with sections 86-2.19, 86-2.20, 86-2.21 and 86-2.22 of this Subpart and costs of other allowable items determined by the department to be nontrendable divided by the facility's patient days in the base year determined applicable by the department.

(h) A facility's payment rate for 1986 and subsequent rate years shall be equal to the sum of the operating portion of the rate as defined in paragraph (b)(2) of this section and the capital component as defined in subdivision (g) of this section.

(i) Specialty facilities. Facilities which provide extensive nursing, medical, psychological and counseling support services to children with diverse and complex medical, emotional and social problems shall be considered specialty facilities and shall not be subject to the provisions of paragraphs (c)(3), (c)(4), (d)(4), (d)(5), and (d)(6) of this section. The direct component of such facilities' rates shall be calculated based on allowable 1983 direct costs as defined in paragraph (c)(1) of this section, divided by the facilities' total 1983 patient days. The indirect component of such facilities' rates shall be calculated based on allowable 1983 indirect costs as defined in paragraph (d)(1) of this section, divided by the facilities' total 1983 patient days.

(j) Rates for residential health care facility services for nonoccupants for 1986 and subsequent rate years shall be calculated in accordance with section 86-2.9 of this Subpart, with any operating component of the rate trended from the 1983 base year, the rate year by the applicable roll factor promulgated by the department.

(k) Receiverships and new operators. (1) The appointment of a receiver or the establishment of a new operator to an ongoing facility shall require such receiver or operator to file a cost report for the first twelve-month period of operation in accordance with section 86-2.2(e) of this Subpart. This report shall be filed and properly certified within 60 days following the end of the twelve-month period covered by the report. Failure to comply with this subdivision shall result in application of the provisions of section 86-2.2(c) of this Subpart.

(2) The initial rate for facilities covered under this subdivision shall be the higher of:

(i) the rate in effect on the date of the appointment of a receiver or the date of transfer of ownership as applicable; or

(ii) the rate in effect on the date of appointment of a receiver or the date of transfer of ownership as applicable with the direct and indirect component of such rate calculated as follows:

(a) The direct component of the rate shall be equivalent to the facility-specific mean direct price per day after application of the RDIPAF as determined in section 86-2.10(c) of this Subpart. The PRIs used in the computation of the facility-specific mean direct price per day shall be the PRIs used to calculate the rate in effect on the date of appointment of a receiver or the date of transfer of ownership.

(b) The indirect component of the rate shall be equivalent to the mean indirect price per day, determined using the PRIs used to calculate the rate in effect on the date of appointment of a receiver or date of transfer of ownership, and adjusted by the RIIPAF as determined in section 86-2.10(d) of this Subpart.

(3) The facility shall perform an assessment of all patients, pursuant to section 88-2.30 of this Subpart, at the beginning of the fourth month of operation. The direct component of the rate shall be adjusted pursuant to this Subpart effective the first day of the assessment period based on the facility's case mix.

(4) The twelve-month cost report referred to in paragraph (1) of this subdivision shall be used to adjust the direct, indirect, noncomparable and capital components of the rate effective on the first day of the twelve-month cost report period.

(5)(i) For purposes of this subdivision, and except as identified in paragraph (7) herein, the terms "new operator" and "receiver" shall not include any operator or receiver approved to operate a facility when:

(a) a stockholder, officer, director, sole proprietor or partner of such operator or receiver was also a stockholder, officer, director, sole proprietor or partner of the prior operator or receiver of such facility;

(b) the approved operator was the prior receiver of the facility;

(c) any prior corporate operator or receiver is a corporate member of the approved operator or receiver, is otherwise affiliated with the approved operator or receiver through direct or indirect sponsorship or control or when the approved operator or receiver and prior operator or receiver are subsidiaries of a common corporate parent; or

(d) a principal stockholder (owning 10 percent or more of the stock), officer, director, sole proprietor or partner of an approved proprietary operator or receiver is the spouse or child of a principal stockholder, officer, director, sole proprietor or partner of the prior operator or receiver of such facility, regardless of whether such relationship arises by reason of birth, marriage or adoption.

(ii) Rates of reimbursement for operators or receivers which are not considered new operators or receivers under this subdivision shall not be subject to adjustment under this subdivision.

(6) Notwithstanding the provisions of this subdivision, a receiver or new operator of a facility which has had an overall average utilization of at least 90 percent of bed capacity for a six-month period which began prior to April 1, 1993 but after the date on which the receiver was appointed or new operator became the operator shall submit a six-month cost report for that period. Such six-month cost report shall be utilized for the purpose of this subdivision in lieu of the twelve-month cost report identified in paragraph (1) of this subdivision.

(7)(i) Notwithstanding the provisions of this subdivision, when a receiver of a proprietary nursing facility is appointed or a new operator of a previously established proprietary nursing facility is established and a stockholder, sole proprietor, partner or limited liability company member of such receiver or new operator is the child of a stockholder, sole proprietor, partner or member of the limited liability company of the prior operator or receiver of the facility, such receiver or new operator shall receive rates of reimbursement adjusted pursuant to paragraphs (1)-(4) and (6) of this subdivision. For purposes of this paragraph, child shall mean a child or stepchild by birth, adoption, or marriage. Rates of reimbursement for any subsequent operator of such facility who is established within 10 years of the date of appointment or establishment of such child or stepchild shall not be subject to adjustment under this subdivision.

(ii) For purposes of this paragraph, the terms "new operator" and "receiver" shall not include any operator or receiver with a stockholder, sole proprietor, partner, or limited liability company member who was a stockholder, sole proprietor, partner or limited liability company member of the prior operator or receiver of such facility.

(iii) For purposes of this paragraph, "new operator" shall also mean an established operator which has undergone a total change in owners, stockholders, partners or limited liability company members.

(iv) This paragraph shall apply to appointments of receivers and/or the establishment of a new operator on or after the effective date of this paragraph.

(l) Adjustments to the operating component of the rate. (1) Notwithstanding any other provision of this section, the department shall make available the sum of $10 million for rate year 1986 and $5 million for rate year 1987, based on total system costs and total patient days, herein referred to as the transfer amount, to facilities in those rate years, whose reimbursement for the indirect component of their rates is less than their 1983 allowable costs for the indirect component of the rate, herein referred to as indirect losses.

(2) To determine eligibility for such adjustments, facilities shall also have suffered an aggregate loss. For purposes of this subdivision, an aggregate loss shall exist when a facility's composite reimbursement for the direct and indirect components of the rate is less than such a facility's composite 1983 allowable costs for the direct and indirect components.

(3) The transfer amount referred to in paragraph (1) of this subdivision shall be made available by reductions in the operating components of facilities' rates whose composite reimbursement for the direct and indirect components of their rates is more than their composite 1983 allowable costs for the direct and indirect components herein referred to as aggregate gains.

(4) The transfer amounts referred to in paragraph (1) of this subdivision shall be distributed, for the applicable rate years, to eligible facilities by a per diem adjustment in the operating component of their rates in accordance with the following procedure:

(i) The indirect losses of all eligible facilities shall be summed to arrive at total indirect losses.

(ii) The proportion of a facility's indirect loss to total indirect losses shall be expressed as a percentage, herein referred to as a sharing percentage.

(iii) The sharing percentage for an eligible facility shall be multiplied by the transfer amount to arrive at a facility's share of the transfer amount.

(iv) A facility's share of the transfer amount shall be divided by 1983 patient days to arrive at a per diem adjustment to the operating component of a facility's rate.

(5) The transfer amounts referred to in paragraph (1) of this subdivision shall be accumulated from facilities referred to in paragraph (3) of this subdivision by a per diem adjustment to the operating component of their rates in accordance with the following procedure:

(i) The aggregate gains of a facility shall be expressed as a percentage of their composite 1983 allowable costs for the direct and indirect components. Such percentage shall be herein referred to as percentage gain.

(ii) The percentage gain for all facilities shall be ranked from highest to lowest.

(iii) A methodology shall be employed where, beginning with a set percentage, percentage gains in excess of such set percentage shall be noted, arrayed by facility and herein referred to as excess percentage gain.

(iv) The excess percentage gain shall be multiplied by each facility's allowable composite 1983 costs for the direct and indirect components and such total for all faculties accumulated as a funded

amount. The excess percentage gain shall also then be subtracted from a facility's percentage gain and the net percentage gain utilized as a facility's percentage gain for subsequent calculations.

(v) Such process shall continue, decreasing the set percentage used as a standard against which percentage gains of facilities is compared and the funded amounts accumulated until the transfer amounts referred to in paragraph (1) of this subdivision are realized.

(vi) If in this process, moving to the next set percentage used as a standard against which percentage gains of facilities is compared shall result in a total transfer amount in excess of the transfer amounts referred to in paragraph (1) of this subdivision, the following procedure shall be utilized to determine the amounts necessary to be funded by each facility in the final step of this process to attain the transfer amounts referred to in paragraph (1) of this subdivision:

(a) A facility's percentage gain shall be compared to the next lower set percentage that would be utilized as a standard and an excess percentage gain determined.

(b) The excess percentage gain for a facility, at that time, shall be multiplied by the facility's allowable composite 1983 costs for the direct and indirect components and the result herein referred to as an interim funded amount.

(c) The interim funded amount for each facility, expressed as a percentage of the aggregate of the interim funded amounts for all facilities shall be multiplied by the remaining amount to be funded for a given rate year to arrive at a facility's portion of the final amount to be funded.

(vii) The funded amounts for a facility arrived at as a result of this paragraph shall be summed, divided by total 1983 patient days and deducted as a per diem adjustment from a facility's operating per diem in the appropriate rate year.

(m) Computation of regional input price adjustment factors applied for purposes other than determining, pursuant to this section, the statewide direct and peer group indirect prices.

(1) The regional direct input price adjustment factor (RDIPAF) as contained in subparagraphs (c)(4)(iv) and (vii) of this section, the regional indirect input price adjustment factor (RIIPAF), as contained in subparagraph (d)(4)(vi) and paragraph (d)(5) of this section and the regional input price adjustment factor as contained in subparagraph (iv) of paragraph (4) of subdivision (e) of this section, hereinafter referred to as factors shall, for rate years beginning on or after January 1, 1987, be based on the regional dollar per hour (RAP) calculated using the financial and statistical data required by section 86-2.2 of this Subpart, reported solely for 1983 calendar year operations, adjusted as follows:

(i) RAPs shall be adjusted for the variation in wage and fringe benefit costs for each region relative to such variation for all other regions through the use of a variable corridor.

(ii) The measurement of the region's variation shall be accomplished by means of the statistical measure of variation, the coefficient of variation, in wage and fringe benefit costs.

(iii) The region with the smallest variation shall receive no corridor. The region with the highest variation shall receive a corridor no greater than a maximum percentage such that the average corridor for all regions in the State shall be approximately plus or minus 10 percent.

(iv) For rate years beginning on or after January 1, 1991, for those regions of the state described in Appendix 13-A, infra, whose Regional Average Dollar Per Hour (RAP), calculated using the financial and statistical data required by section 86-2.2 of this Subpart reported solely for 1987 calendar year operations (1987 RAP) expressed as a percentage of the Statewide RAP for such year is greater than the percentage calculated using the same data reported for 1983 calendar year operations, (1983 RAP), the factors shall be determined utilizing 1987 RAPs and adjusted pursuant to subparagraphs (i), (ii) and (iii) of this paragraph.

(a) Notwithstanding this subparagraph if the utilization of 1987 RAPs to determine the factors would, for any facility within a region described in this sub paragraph, result in less reimbursement than the continued utilization of the 1983 RAPs to determine the factors, the factors utilized for such facility shall continue to be based on 1983 calendar year data.

(n) Long-term inpatient rehabilitation program for traumatic brain-injured residents (TBI). Facilities which have been approved to operate discrete units for the care of residents under the long-term inpatient rehabilitation program for head-injured patients (TBI) patients established pursuant to section 415.36 of this Title shall have separate and distinct payment rates for such units calculated pursuant to this section except as follows:

(1) In determining the facility-specific direct adjusted payment price per day pursuant to paragraph (c)(4) of this section for patients meeting the criteria for and residing in a TBI unit, the case mix index used to establish the statewide ceiling direct price per day for each patient classification group pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of this section for such residents shall be increased by an increment of 1.49. In determining the case mix adjustment pursuant to paragraph (6) of subdivision (c) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.49.

(i) The increment established in paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required by section 415.36 of this Title.

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (4), (5) and (6) of subdivision (d) of this section for residents meeting the criteria for and residing in a TBI unit, a facility's indirect costs shall be compared to the peer group established pursuant to clause (a) of subparagraph (iii) of paragraph (2) of subdivision (d) of this section.

(3) The noncomparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual costs in such cost report for personnel required by section 415.36 of this Title that would be reported in the functional cost centers identified in subdivision (f) of this section.

(o)(1) A per diem amount of $4.00 (subject to adjustment pursuant to the provisions of paragraph (2) of this subdivision) increased to the rate year by the projection factors determined pursuant to section 86-2.12 of this Subpart, adjusted by the RDIPAF determined pursuant to paragraph (5) of subdivision (c) of this section, shall be added to each facility's payment rate for each patient whose primary medical problem, as reported in section V.29 of the patient review form (PRI) as contained in subdivision (i) of section 86-2.30 of this Subpart, is dementia, as defined in paragraph (4) of this

subdivision, and who is properly assessed and reported by the facility in one of the following patient categories as listed in Appendix 13-A of this Title:

Clinically Complex A

Behavioral A

Reduced Physical Functioning A

Reduced Physical Functioning B

(2) Based on the most current 1986 PRI's filed with the Department, the number of eligible dementia patient days for Medicaid patients admitted prior to December 31, 1987, is estimated to be 1,750,000. Aggregate changes in such number in excess of 5% shall be deemed to be attributable to factors other than changes in patient condition and shall result in the recalculation and proportionate, prospective reduction of the per diem amount referred to in paragraph (1) of this subdivision.

(3) Facilities to whom the additional amount is paid shall demonstrate and document positive outcomes from implementation or continuation of programs and/or operations and promulgation of policies designed to improve the care of eligible dementia patients. The additional amount shall be recouped from facilities in which such positive outcomes are not demonstrated.

(4) The per diem amount referred to in paragraph (1) of this subdivision shall be paid for any patients with the following dementia diagnoses. The dementia diagnoses and related codes and descriptions are taken from the International Classification of Diseases, 9th Revision, Clinical Modification, volume 3 (ICD-9-CM).

ICD-9-CM Code ICD-9-CM Diagnosis

290.0 Senile dementia

Uncomplicated senile dementia

NOS, simple type excludes memory disturbance

290.1 Presenile dementia

Brain syndrome with presenile brain disease

Dementia in:

Alzheimer's disease

Creutzfeldt-Jakob disease

Pick's disease of the brain

290.10 Presenile dementia

Uncomplicated presenile dementia

NOS, simple type

290.11 Presenile dementia with delirium

Presenile dementia with acute confusional state

290.12 Presenile dementia with delusional feature

290.13 Presenile dementia with depressive features

290.2 Senile dementia with delusional or depressive features

290.21 Senile dementia with depressive features

290.4 Multi-infarct dementia

290.40 Arteriosclerotic dementia

290.41 Arteriosclerotic dementia

290.42 Arteriosclerotic dementia

290.43 Arteriosclerotic dementia

294.0 Wernicke-Korsakoff syndrome (nonalcoholic)

293.81 Organic brain syndrome

294.8 Other specified organic brain syndrome

294.9 Unspecified organic brain syndrome

310.1 Organic personality syndrome

310.8 Other specified nonpsychotic mental disorders, following organic brain damage

310.9 Unspecified nonpsychotic mental disorders following organic brain damage

331.0 Alzheimer's disease

331.1 Pick's disease

331.2 Senile degeneration of the brain

331.3 Communicating hydrocephalus

331.7 Cerebral degeneration in diseases classified elsewhere

331.8 Other cerebral degeneration

331.9 Cerebral degeneration, unspecified

331.89 Cerebral degeneration, NEC

333.4 Huntington's Chorea

437.0 Cerebral atherosclerosis

(p) Acquired Immune Deficiency Syndrome (AIDS). (1) For rate year 1988 and thereafter, payment rates shall be adjusted, pursuant to this subdivision to provide additional payments to facilities for patients residing in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit approved by the commissioner pursuant to Part 710 of this Title, or a facility which has received approval by the commissioner pursuant to Part 710 of this Title to provide services to a patient whose medical condition is HIV Infection Symptomatic. Such patients shall hereinafter be referred to as AIDS patients.

(2) Separate and distinct payment rates shall be calculated pursuant to this paragraph for AIDS facilities or discrete AIDS units approved by the commissioner pursuant to Part 710 of this Title.

(i) The facility specific direct adjustd price per day shall be determined pursuant to paragraphs (3) and (4) of subdivision (c) of this section and further adjusted as follows:

(a) In determining the direct component of a facility's rate pursuant to paragraphs (3) and (4) of subdivision (c) of this section for providing care for an AIDS patient in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit, the case mix index for the AIDS patient shall be increased by an increment which shall be determined on the basis of the difference between allowable actual direct staffing levels and cost expenditures for the care of AIDS patients in specific patient classification groups and those of non-AIDS patients which are classified in the same patient classification groups based on data submitted by the facility. The increment to be included in a facility's rate shall be approved by the commissioner, but in no event shall the increment exceed 1.0. The facility's direct ceiling price shall be further increased by an occupancy factor of 1.089. (b) For purposes of this paragraph, the allowable costs for the central service supply functional cost center as listed in paragraph (1) of subdivision (c) of this section shall be considered a non-comparable cost.

(ii) Except as identified in subparagraph (iii) of this paragraph, in determining the indirect component of a facility's rate pursuant to paragraphs (4), (5) and (6) of subdivision (d) of this section for providing care for an AIDS patient in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit, the peer group ceiling indirect price shall be increased by a factor of 1.20.

(iii) In determining the indirect component of a facility's rate pursuant to paragraphs (4) and (5) of subdivision (d) of this section for a facility with a total bed complement of less than 40 beds all of which are approved by the commissioner pursuant to Part 710 of this Title solely for the care and management of AIDS patients, the peer group ceiling indirect price shall be increased by a factor of 2.00 for those facilities that are less than or equal to 16 beds and such factor shall be decreased by 0.033 for every additional bed thereafter.

(3) For facilities which have received approval by the commissioner pursuant to Part 710 of this Title to provide services to a patient whose medical condition is HIV Infection Symptomatic, and the facility is not eligible for separate and distinct payment rates pursuant to paragraph (2) of this

subdivision, the patient classification group case mix index for AIDS patients which is used to establish direct cost reimbursement shall be increased by an increment of 1.0.

(q) Long-term ventilator dependent residents. Facilities which have been approved to operate discrete units for the care of long term ventilator dependent patients as established pursuant to section 415.38 of this Title shall have separate and distinct payment rates for such units calculated pursuant to this section except as follows:

(1) The facility specific direct adjusted price per day shall be determined as follows:

(i) In determining the facility specific direct adjusted payment price per day pursuant to paragraph (4) of subdivision (c) of this section for patients meeting the criteria established in section 415.38 of this Title and residing in a discrete unit for the care of long-term ventilator dependent patients, the case mix index used to establish the statewide ceiling direct price per day for each patient classification group pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of this section for such residents shall be increased by an increment of 1.15. In determining the case mix adjustment pursuant to paragraph (6) of subdivision (c) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.15.

(ii) The increment established in subparagraph (a) of paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required by section 415.38 of this Title.

(iii) The allowable costs for the central service supply functional cost center as listed in paragraph (1) of subdivision (c) of this section shall be considered a noncomparable cost reimbursed pursuant to subdivision (f) of this section.

(iv) The allowable costs for prescription drugs, specifically required by generally accepted standards of professional practice for long-term ventilator dependent residents, that are administered at a frequency and volume exceeding those of prescription drugs included in the direct component of the rate pursuant to subdivision (c) of this section shall be considered a noncomparable cost pursuant to subdivision (f) of this section.

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (4), (5) and (6) of subdivision (d) of this section for residents meeting the criteria established in section 415.38 of this Title and residing in a discrete unit for the care of long-term ventilator dependent residents, a facility's indirect costs shall be compared to the peer group established pursuant to clause (a) of subparagraph (iii) of paragraph (2) of subdivision (d) of this section.

(3) The non-comparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual costs in such cost report for personnel required by section 415.38 of this Title that would be reported in the functional cost centers identified in subdivision (f) of this section.

(r) Nursing salary adjustment. (1) The adjustment to the operating portion of the rate to reflect the costs of retaining and recruiting nursing services shall be made as follows:

(i) A percentage figure shall be determined as follows:

(a) An average annual statewide increase in registered nurses and licensed practical nurses salaries between the calendar year ending 1987 and calendar year ending 1988 shall be determined based on certain representative ratified nursing contracts for general hospital services and an average annual regional increase in registered nurses and licensed practical nurses salaries between the calendar year ending 1987 and calendar year ending 1988 shall be determined based upon certain representative wage and salary information for residential health care facilities.

(b) The average annual regional and statewide increase in salaries shall be multiplied by the total number of nursing staff in the region and the total number of nursing staff statewide respectively to arrive at the total regional and statewide adjustment to be made to facilities. The total regional adjustments shall be determined using the regions contained in Appendix 13-A herein.

(c) An adjusted base shall be determined by multiplying the facility specific mean price per day determined pursuant to subparagraph (i) of paragraph (4) of subdivision (c) of this section by total patient days for each facility and the result shall be summed on a regional and statewide basis.

(d) The total adjustment to be made for all facilities determined pursuant to clause (b) of this subparagraph shall be divided by the adjusted base determined pursuant to clause (c) of this subparagraph on a regional and statewide basis to determine the regional percentage increase and the statewide percentage increase.

(e) The facility specific percentage shall be determined by summing 40 percent of the statewide percentage and 60 percent of the corresponding regional percentage determined pursuant to clause (d) of this subparagraph.

(ii) The adjustment to the rate for a facility shall be determined by applying the facility specific percentage figure calculated in subparagraph (i) of this paragraph to a facility's adjusted base. This amount shall be added to the operating portion of the rate.

(s) Adjustment of rates pursuant to methodology changes effective October 1, 1990 and April 1, 1991.

(1) Rate changes resulting from the amendments to sections 86-2.1(a), 86-2.9(c), 86-2.10(a)(3), (c)(1)-(5), (d)(1) and (2) and (p)(2) and (3) and 86-2.30(c)(3) of this Title effective October 1, 1990., and amendments to sections 86-2.10(a)(3), (c)(1), (3) and (5), (d)(1), (2) and (4)-(7), (p)(1)-(3), and (t)(1) and (2) of this Title effective April 1, 1991 shall be transitioned into the rates as follows:

(i) For rates with effective dates commencing between October 1, 1990 and June 30, 1992, the rate shall be computed using the rate methodology in effect on September 30, 1990, adjusted by the most recent PRI submissions applicable to the effective period of the rate, and the adjustment to the regional direct and indirect input price adjustment factors pursuant to subparagraph (iv) of paragraph (1) of subdivision (m) of this section.

(ii) For rates with effective dates commencing on or after July 1, 1992, the full impact of the rate changes cited in paragraph (1) of this subdivision shall be reflected in rates.

(iii) Those facilities with an initial budgeted rate or revised cost-based rate which reflects a change in base year and which is effective after April 1, 1991, shall receive the full impact of the methodology changes cited in paragraph (1) of this subdivision on the effective date of such rate.

(2) For facilities having multiple rates based on levels of care prior to October 1, 1990, such rates shall be combined for the establishment of rates effective October 1, 1990 to June 30, 1992 based on a weighted average of reported Medicaid days for each previous level of care for the latest available cost reporting period. Where the Department is authorized expressly by statute to adjust rates retrospectively, for both positive and negative rate adjustments, such combined rate shall be adjusted by a reconciliation of reported Medicaid days to actual billed Medicaid days for the effective period, provided that such adjustment results in a combined direct and indirect component rate change of more than 5%. Such combined rate shall reflect the amendments referenced in paragraph (1) of this subdivision pursuant to the schedule set forth therein.

(t) Base Year Adjustment for Facilities Who Have Bed Conversions. A facility shall be eligible for an adjustment to its base year costs if its proportion of beds identified as skilled nursing facility beds and health related facility beds as of the first day of its base period differs from the proportion of beds identified as skilled nursing facility beds and health related facility beds as of September 30, 1990. The adjustment shall be separately determined for the direct, indirect, and non-comparable components of a facility's allowable base period costs, and each adjustment shall be added to a facility's allowable direct, indirect and non-comparable costs, respectively, prior to group comparisons. The amount of the adjustment shall be determined as follows:

(1) Base period direct, indirect, and non-comparable costs per bed adjusted for occupancy level shall be separately calculated for both skilled nursing and health related facility beds. The changes in skilled nursing and health related facility beds for the period defined in the above paragraph shall be multiplied by the applicable cost per bed and added together to arrive at each adjustment amount.

(2) An adjustment to allowable days shall also be made for a facility whose total number of beds has changed for the period described in this subdivision to reflect the skilled nursing facility and health related facility occupancy levels used in the calculation of rates effective September 30, 1990. Base period days shall be adjusted by the proportion of total new beds as of September 30, 1990 to total base year beds prior to the determination of the facility-specific price per day for the facility's direct, indirect, and non-comparable cost components.

(u) Adjustment for Additional Federal Requirements. A facility whose rate is based on allowable or budgeted costs for a period prior to April 1, 1991 shall be considered eligible to receive a per diem adjustment to its rate as follows:

(1) A per diem adjustment shall be incorporated into each facility's rate to take into account the additional reasonable costs incurred by facilities in complying with the requirements of subsection (b), (other than paragraph 3(F) thereof), (c), and (d) of section 1919 of the federal Social Security Act effective October 1, 1990 as added by the federal Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). Additional reasonable costs resulting from such federal requirements shall include additional reasonable costs in the following areas: the completion of resident assessments, the development and review of comprehensive care plans for residents, staff training for the new resident assessment tool, quality assurance committee costs, nurse aid registry costs, psychotropic drug reviews, and surety bond requirements.

(i) The per diem adjustment shall be forty-five cents computed on a statewide basis and shall be regionally adjusted to reflect differences in registered nurse salary levels for calendar year 1987. Any costs over the per diem adjustment shall be deemed attributable to factors other than compliance with the federal requirements referenced in this subdivision.

(ii) For purposes of inclusion in facility rates for 1991, the annual incremental per diem add-on shall be effective for the nine month period beginning April 1, 1991 and further adjusted so that the nine months of incremental cost are reflected in a per diem adjustment for July 1, 1991 through December 31, 1991 rates.

(2) For rates years beginning on or after January 1, 1992, the annual incremental per diem add-on calculated pursuant to subparagraph (i) of paragraph (1) shall be trended forward by the applicable facility trend factor.

(v) Extended care of residents with traumatic brain injury. (1)(i) Except as provided in subparagraph (ii) of this paragraph, effective April 1, 1993, a per diem amount of $25, adjusted by the RDIPAF determined pursuant to paragraph (5) of subdivision (c) of this section, and increased in rate years thereafter, by the projection factors determined pursuant to section 86-2.12 shall be added to a facility's payment rate determined pursuant to this Subpart for each resident with traumatic brain injury identified as requiring extended care and receiving services pursuant to section 415.40 of this Title.

(ii) Effective with rates revised based upon patient review instrument (PRI) assessment data for an assessment period set forth in section 86-2.11(b) of this Subpart beginning on or after November 1, 1994, a TBI patient per diem amount shall be added to a facility's average Medicaid payment rate determined pursuant to this Subpart only for Medicaid residents with traumatic brain injury identified as requiring extended care and receiving services pursuant to section 415.40 of this Title. The TBI patient per diem amount shall be determined as follows: The total number of Medicaid traumatic brain injury (TBI) extended care residents shall be multiplied by $25 per patient day times 365 days to determine the annual TBI amount. The annual TBI amount shall then be adjusted by the facility RDIPAF, determined pursuant to subdivision (c)(5) of this section, to establish the allowable TBI dollars. The allowable TBI dollars shall be divided by the facility total annual Medicaid days to determine the facility TBI patient per diem amount. The TBI patient per diem amount shall be increased annually by the projection factor determined pursuant to section 86-2.12 of this Subpart. For purposes of this subdivision, a Medicaid resident is defined as a resident whose primary payor description is coded as Medicaid on the PRI assessment data.

(2) Residents reimbursed pursuant to this subdivision shall not be reimbursed pursuant to subdivision (n) and (o) of this section.

(w) Specialized programs for residents requiring behavioral interventions. Facilities which have been approved to operate discrete units specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions as established pursuant to section 415.39 of this Title shall have separate and distinct payment rates calculated pursuant to this section except as follows:

(1) In determining the facility specific direct adjusted payment price per day pursuant to paragraph (4) of subdivision (c) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, the case mix index used to establish the statewide ceiling price per day for each patient classification group pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of this section for such residents shall be increased by an increment of 1.40. In determining the case mix adjustment pursuant to paragraph (6) of subdivision (c) of this section, the case mix index used to calculate the facility specific mean price for each patient classification group shall be increased by an increment of 1.40.

(i) The increment established in paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facility's cost report submitted pursuant to this Subpart is less than the staffing pattern required by section 415.39 of this Title.

(2) In determining the indirect component of a facility's rate pursuant to paragraphs (4), (5) and (6) of subdivision (d) of this section for residents meeting the criteria established in section 415.39 of this Title and residing in a discrete unit specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, a facility's indirect costs shall be compared to the peer group established pursuant to clause (a) of subparagraph (iii) of paragraph (2) of subdivision (d) of this section.

(3) The noncomparable component of such facilities' rates shall be determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart including approved actual costs in such cost report for personnel required by section 415.39 of this Title that would be reported in the functional cost centers identified in subdivision (f) of this section.

(x) Specialized programs for residents with neurodegenerative disease providing care to patients diagnosed with Huntington’s disease and amyotrophic lateral sclerosis. Facilities which have been approved to operate discrete units specifically designated for the purpose of providing care to residents with Huntington’s disease and amyotrophic lateral sclerosis, as established pursuant to section 415.41 of this Title, shall have separate and distinct payment rates calculated pursuant to this section. The noncomparable component of such facilities’ rates shall be determined pursuant to this section utilizing the cost report filed pursuant to section 86-2.2(e) of this Subpart.

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Statutory Authority:
PHL Secs 2803(2), 2807(3) and 2808

Section 86-2.11 - Adjustments to direct component of the rate

86-2.11 Adjustments to direct component of the rate.

(a) Payments for 1986 and subsequent rate years for the direct component of the rate as defined in section 86-2.10(c) of this Subpart shall be adjusted periodically as described in this section to reflect changes in the case mix of facilities.

(b) Facilities shall report to the department changes in patient case mix as follows:

(1) Full reassessments. Facilities shall, on a schedule to be established by the department, assess all their patients semiannually and submit patient review instruments pursuant to section 86-2.30 of this Subpart. The department shall consider, in developing such schedule, that for each of the six

months in a semiannual period, there would be submitted approximately 1/6 of the assessments for all patients in the State.

(2) Assessment of patients admitted since the last assessment period. Three months from the date facilities are scheduled to perform full reassessments, facilities shall assess patients admitted and still residing in the facility since the last full assessment period. Patient review instruments for such patients shall be submitted pursuant to section 86-2.30 of this Subpart on a schedule to be established by the department. The department shall consider, in developing such schedule that for each of the six months in a semiannual period, there would be submitted approximately 1/6 of the assessments of such new admissions.

(3) Notification to department of patients discharged since last assessment period. Facilities shall notify the department of any patients assessed during the previous full reassessment period as described in paragraph (1) of this subdivision and since discharged concurrent with the submission required by paragraph (2) of this subdivision for patients admitted since the last assessment period.

(c) Payment rates for the direct component of the rate as defined in section 86-2.10(c) of this Subpart shall be adjusted, on a facility specific basis for changes in patient case mix retroactive to the beginning date of the month in which the assessment of patients was scheduled by the department and performed by the facility.

(d) Adjusted payment rates shall be determined by recalculating a facility's number of patients in each patient classification group as a result of the submissions in accordance with this section and such results shall be used in the calculation of the facility specific direct adjusted payment price per day pursuant to section 86-2.10(c)(4) of this Subpart.

(e) Trending. Payment rates for the operating component of the rate as defined in section 86-2.l0(b)(2) of this Subpart may be adjusted for changes in the trend factors originally promulgated by the department in accordance with section 86-2.12 of this Subpart.

Doc Status:
Complete

Section 86-2.12 - Adjustments to basic rate

86-2.12 Adjustments to basic rate.

(a) To the allowable basic rate prior to the addition of capital costs and depreciation and interest related to movable equipment, there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. Such factor shall be determined as follows:

(1) The elements of a residential health care facility's cost shall be weighted based upon data for the following categories:

(i) salaries;

(ii) employee health and welfare expense;

(iii) nonpayroll administrative and general expense;

(iv) nonpayroll household and maintenance expense;

(vi) nonpayroll dietary expense; and

(vii) nonpayroll professional care expense.

(2) Each weight shall be adjusted by the appropriate price index for each category noted in paragraph (1) of this subdivision, as well as for subcategories. Included among these cost indicators are elements of the United States Department of Labor consumer and wholesale price indices and special indices developed by the State Commissioner of Health for this purpose.

(3) Geographic differentials may be established where appropriate.

(b) The cost indicators used in determining the projection factors shall be compared, on a semiannual basis with available data on such indicators, and any other economic indicators as deemed appropriate by the Commissioner of Health. Based upon such review the commissioner may, in his discretion, either certify new rates or adjust subsequent rates for any period or portion thereof when he determines that such new rates or adjusted rates are necessary to avoid substantial inequities arising from the use of previously certified rates.

(c) Beginning April 1, 1991, the commissioner, in accordance with the methodology developed pursuant to subdivisions (d), (e) and (f) of this section, shall establish trend factors for residential health care facilities to project allowable cost increases for the effects of inflation during the effective period of the reimbursement rate. The allowable basic rate prior to the addition of capital costs and depreciation and interest related to movable equipment shall be trended, beginning on April 1, 1991, to the applicable rate year by the trend factors developed in accordance with subdivisions (d) through (f) of this section.

(d) The methodology for developing the trend factors shall be established by a panel of four independent consultants with expertise in health economics appointed by the commissioner.

(e) Reserved.

(f)(1) On or about September first of each year, the consultants shall provide to the commissioner and the state hospital review and planning council, the methodology to be used to determine the trend factors for the rate period, commencing on the next January first. The commissioner shall monitor the actual price movements during these periods of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants and shall implement the recommendations of the consultants for one prospective interim annual adjustment to the initial trend factors to reflect such price movements and to be effective on January first, one year after the initial trend factors were established and one prospective final annual adjustment to the revised trend factors to reflect such price movements and to be effective on January first, two years after the initial trend factors were established.

(2) Notwithstanding the dates specified in paragraph (1), the consultants shall provide as soon as possible to the commissioner and the state hospital review and planning council, the methodology to be used to determine the trend factors for the rate period April 1, 1991 to December 31, 1991. One prospective interim annual adjustment for this rate period shall be made on January 1, 1992 and one prospective final annual adjustment for this rate period shall be made January 1, 1993.

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Section 86-2.13 - Adjustments to provisional rates based on errors

86-2.13 Adjustments to provisional rates based on errors.

(a) Errors resulting from submission of fiscal and statistical information by a residential health care facility may be corrected if brought to the attention of the State Commissioner of Health within 120 days of receipt of the commissioner's initial rate computation sheet. Errors on the part of the State Department of Health resulting from the rate computation process may be corrected if brought to the attention of the commissioner within 120 days of receipt of the commissioner's initial rate computation sheet. Subsequent errors on the part of the State Department of Health resulting from the revision of a rate may be corrected if brought to the attention of the commissioner within 30 days of receipt of the commissioner's revised rate computation sheet. In no event, however, shall a facility have less than 120 days from receipt of the initial rate computation sheets to bring errors to the attention of the commissioner.

(b) Rate appeals pursuant to this section, if not commenced within 120 days of receipt of the commissioner's initial rate computation sheet, may be initiated at time of audit of the base year cost figures at or prior to the audit exit conference. Such rate appeals shall be recognized only to the extent that they are based upon errors in the cost and/or statistical data submitted by the residential health care facility, or by revisions initiated by a third-party fiscal intermediary, or in the case of a governmental facility, by the sponsor government or errors made by the Department of Health.

Doc Status:
Complete

Section 86-2.14 - Revisions in certified rates

86-2.14 Revisions in certified rates.

(a) The State Commissioner of Health may consider only those applications for revisions of certified rates which are based on:

(1) cost reports filed pursuant to subdivision (e) of section 86-2.2 of this Subpart. Such rate shall become effective on the first day of the twelve-month period referred to in section 86-2.2(e) of this Subpart;

(2) six-month cost reports filed pursuant to sections 86-2.10(k)(6) and/or 86-2.15(e). Such rate shall become effective on the first day of the six-month period referred to in sections 86-2.10(k)(6) and 86-2.15(e) of this Subpart;

(3) errors made by the department in the rate calculation process and errors in data submitted by a medical facility which have been brought to the attention of the commissioner within the time limits prescribed in section 86-2.13 of this Subpart. This paragraph shall not apply to the patient assessment process as contained in section 86-2.30 of this Subpart;

(4) significant increases in the overall operating costs of a residential health care facility resulting from the implementation of additional programs or services specifically mandated for the facility by the commissioner;

(5) significant increases in the overall operating costs of a residential health care facility resulting from capital renovation, expansion, replacement or the inclusion of new programs or services approved for the facility by the commissioner;

(6) requests for waivers of any provisions of this Subpart for which waivers may be granted by the commissioner as prescribed in specific sections;

(7) alternative means of allocating costs in the cost-finding process which have been submitted with the annual cost report (RHCF-4) and approved in accordance with section 456.2(b) and (c) of this Title; and

(8) requests for relief from the provision of section 86-2.25 of this Subpart relating to compensation of other than the administrative type of services rendered by an operator or relative of an operator. Such request must contain sufficient documentation to demonstrate that the services rendered are necessary and are reasonably related to the efficient production of such services.

(b) An application by a residential health care facility for review of a certified rate is to be submitted on forms provided by the department and shall set forth the basis for the appeal and the issues of fact. Documentation shall accompany the application, where appropriate, and the department may request such additional documentation as determined necessary. An application based upon error shall be submitted within the time limit set forth in section 86-2.13 of this Subpart. Beginning with appeals for rate year 1983 and, on an annual basis thereafter for all subsequent rate year appeals, the commissioner shall act upon all properly documented applications for a rate year based upon errors within one year of the end of the 120-day period referred to in section 86-2.13(a) of this Subpart. The commissioner shall act upon all other properly documented applications for a rate year appeal submitted pursuant to paragraphs (1) and (3)-(7) of subdivision (a) of this section within one year of the end of the aforementioned 120-day period or the receipt of such applications, whichever date is later. In the event the department requests additional documentation, the one-year time limit shall be extended for a mutually agreed upon time period for receipt of the documentation established by the commissioner in conjunction with the residential health care facility. The deadline will be set according to the nature and quantity of documentation necessary. The one-year time limit shall not apply to rate appeals submitted pursuant to section 86-2.13(b) of this Subpart.

(1) The affirmation or revision of the rate upon such staff review shall be final, unless within 30 days of its receipt a hearing is requested, by registered or certified mail, before a rate review officer on forms supplied by the department. The request shall contain a statement of the factual issues to be resolved. The facility may submit memoranda on legal issues which it deems relevant to the appeal.

(2) Where the rate review officer determines that there is no factual issue, the request for a hearing shall be denied and the facility notified of such determination. No administrative appeals shall be available from this determination. The rate review officer, where he determines that there is factual issue, shall issue a notice of hearing establishing the date, time and place of the hearing and setting forth the factual issues as determined by such officer. The hearing shall be held in conformity with the provisions of Public Health Law, section 12-a and the State Administrative Procedure Act.

(3) The recommendation of the rate review officer shall be submitted to the Commissioner of Health for final approval or disapproval and recertification of the rate where appropriate. (4) The procedure set forth in this subdivision shall apply to all applications for rate reviews which are pending as of April 1, 1978. Rate appeals filed prior to April 1, 1978 will not be required to be resubmitted subsequent to April 1, 1978.

(c) Any modified rate certified under paragraphs (3) and (4) of subdivision (a) of this section shall be effective on the first day of the month in which the respective change is operational.

(d) In reviewing appeals for revisions to certified rates the commissioner may refuse to accept or consider an appeal from a residential health care facility:

(1) providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council;

(2) operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council in one of its facilities;

(3) where it has been determined by the commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law;

(4) where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid. In such instances the provisions of subdivision (c) of this section shall not be effective until the date the appeal is accepted by the commissioner.

(e) Any residential health care facility determined after review by the State Hospital Review and Planning Council to be providing an unacceptable level of care shall have its current reimbursement rate reduced by 10 percent as of the first day of the month following 30 days after the date of the determination. This rate reduction shall remain in effect for a one-month period or until the first day of the month following 30 days after a determination that the level of care has been improved to an acceptable level, whichever is longer. Such reductions shall be in addition to any revision of rates based on audit exceptions.

(g) In order to promote labor stability in the residential health care facility industry, and to minimize the disruption of care to patients in residential health care facilities in the event of labor disputes, multi-year agreements are to be encouraged.

(1) In the case of a written multi-year commitment by a residential health care facility, a substantial number of whose employees are not represented by a labor organization, to increase compensation to all or a class of its employees on or after April 1, 1978, but before December 31, 1978, such facility may petition for a determination as to the adequacy of future revenues to meet the increased labor costs resulting from such multi-year commitment as provided in this paragraph.

(i) The petition brought by the facility shall be heard by a labor cost review panel to be comprised of one representative designated by the commissioner, one representative designated by the petitioner and a third party mutually agreed upon by the petitioner and the department (to be selected from a list of independent hearing officers designated as a commissioner's representative).

(ii) Such facility may file a petition each time an annual incremental labor cost occurs as a result of a multi-year commitment; however, no petition by or on behalf of any facility may be filed less than 12 months after the preceding petition. Any subsequent petition shall relate only to those incremental labor costs since those covered by the last petition.

(iii) The labor cost review panel shall determine the total amount by which such residential health care facility making a multi-year commitment has had increased labor costs as a result of the commitment, and shall determine the extent, if any, to which the current and projected revenues factored for labor costs are inadequate to cover such increased labor costs, provided that the panel may make no award to compensate for any disallowances. In reaching such determination, the labor cost review panel shall apply criteria agreed to by the petitioner and the department. Any areas of disagreement in the criteria shall be resolved by the panel. All such criteria and resulting recommendations are to be consistent with applicable Federal and State laws, rules and regulations.

(iv) Where the labor cost review panel determines that the multi-year commitment has increased labor costs beyond a facility's current and projected revenues factored for labor costs, the department shall certify a revised per diem Medicaid rate for such facility. No facility shall be entitled to an increase in rate with respect to the labor costs attributable to the commitment apart from the adjustment provided by this subdivision. (v) Any facility availing itself of these procedures does so with the understanding that it is choosing said procedure as an alternative to any other administrative or judicial review, and agrees that no other administrative or judicial review will be sought from a determination of the labor cost review panel.

(vi) The procedures of the labor cost review panel shall be governed by section 12-a of the Public Health Law, except that the parties to the proceeding may agree, with the consent of the panel, to modify the procedures.

(vii) In order to activate these procedures, the facility must file a petition within 60 days of the date of promulgation of the multi-year commitment or any increase in labor costs resulting therefrom. Upon the filing of the petition, an independent hearing officer, who has been designated as the commissioner's representative, will recommend whether the commitment is reasonable. The hearing before the labor cost review panel will be convened within 30 days from the date on which the petition is received at the Office of the Deputy Director for Health Care Financing, Office of Health Systems Management, Empire State Plaza, Albany, NY.

(viii) The decision of the labor cost review panel shall require the concurrence of two of the three members hearing the matter. A decision shall be issued within 30 days from the conclusion of the hearing or final submission of any additional documents, whichever is later.

(ix) Any revision in the per diem rate of payment for government programs resulting from application of this subdivision shall be effective on the effective date of the increased labor cost as provided in the multi-year commitment.

(x) The decision of the panel will not cause the imposition of labor cost ceiling disallowances, except that ceilings for overstaffing shall be applied.

(2) In the case of a multi-year collective bargaining agreement entered into by a residential health care facility, or an association of facilities, with a representative of their employees on or after April 1, 1978, but before December 31, 1978, the association of residential health care facilities, a member facility or any facility found by the commissioner to be affected by the agreement may petition for a determination as to the adequacy of future revenues to meet the increased labor costs resulting from such collective bargaining agreement as provided in this paragraph.

(i) The petition brought by the association or facility shall be heard by a labor cost review panel to be comprised of one representative designated by the commissioner, one representative designated by the petitioner and a third party mutually agreed upon by the petitioner and the department.

(ii) Within 21 days after receipt of the first petition concerning any collective bargaining agreement, the commissioner shall promulgate a list of facilities found to be affected by the collective bargaining agreement. Any facility found so affected shall be provided with notice of, and an opportunity to present evidence before in labor cost review panel. Such facility must request such opportunity within 21 day after receipt of the notice. Any facility not on the list shall have a period of 21 days from promulgation of the list to petition the commissioner to be included as a facility affected.

(iii) The facilities, or the association on behalf of individual facilities, may file petition each time an annual incremental labor cost occurs as a result of a collective bargaining agreement; however, no petition by or on behalf of any facility may be filed less than 12 months after the preceding petition. Any subsequent petition shall relate only to those incremental labor costs since those covered by the last petition.

(iv) The labor cost review panel shall determine the total amount by which each residential health care facility affected by the agreement has had increased labor costs as a result of the agreement, and shall determine the extent, if any, to which the current and projected revenues factored for labor costs are inadequate to cover such increased labor costs, provided that the panel may make no award to compensate for any disallowances. In reaching such determination, the labor cost review panel shall apply criteria agreed to by the petitioner and the department. Any areas of disagreement in the criteria shall be resolved by the panel. All such criteria and resulting recommendations are to be consistent with applicable Federal and State laws, rules and regulations.

(v) Where the labor cost review panel determines that the collective bargaining agreement has increased the labor costs beyond a facility's current and projected revenues factored for labor costs, the department shall certify a revised per diem Medicaid rate for each of the affected facilities. No facility shall be entitled to an increase in rate with respect to the labor costs attributable to the agreement apart from the adjustment provided by this subdivision. (v i) Any facility or association availing itself of these procedures does so with the understanding that it, or in the case of an association, its members, are choosing said procedure as an alternative to any other administrative or judicial review, and agrees that no other administrative or judicial review will be sought from a determination of the labor cost review panel.

(vii) The procedures of the labor cost review panel shall be governed by section 12-a of the Public Health Law, except that the parties to the proceeding may agree, with the consent of the panel, to modify the procedures.

(viii) In order to activate these procedures, the association or facility must file a petition within 60 days of the date of ratification of the collective bargaining agreement or any increase in labor costs

resulting therefrom. Upon the filing of the petition an independent hearing officer, who has been designated as the commissioner's representative, will recommend whether the commitment is reasonable. The hearing before the labor cost review panel will be convened within 30 days from the date on which the petition is received at the Office of the Deputy Director for Health Care Financing, Office of Health Systems Management, Empire State Plaza, Albany, NY.

(ix) The decision of the labor cost review panel shall require the concurrence of two of the three members hearing the matter. A decision shall be issued within 30 days from the conclusion of the hearing or final submission of any additional documents, whichever is later.

(x) Any revision in the per diem rate of payment for government programs resulting from application of this subdivision shall be effective on the effective date of the increased labor cost as provided in the collective bargaining agreement.

(xi) The decision of the panel will not cause the imposition of labor cost ceiling disallowances, except that ceilings for overstaffing shall be applied.

(3) Any reimbursement to a facility pursuant to this subdivision shall be dependent upon approval of Federal financial participation by the United States Department of Health, Education and Welfare.

(4) This subdivision shall expire on December 31, 1981.

Effective Date:
Thursday, April 1, 1993
Doc Status:
Complete

Section 86-2.15 - Rates for residential health care facilities without adequate cost experience

86-2.15 Rates for residential health care facilities without adequate cost experience.

(a) (1) This subdivision shall apply where the fiscal and statistical data of the facility are unavailable through no fault of the provider or its agents, and due to circumstances beyond its control, or when there is a new facility without adequate cost experience as set forth in subdivision (e) of section 86-2.2 of this Subpart.

(2) The appointment of a receiver or the establishment of a new operator for an ongoing facility shall not be considered a new facility for the purposes of this section. Reimbursement for such receiver or new operator shall be in accordance with sections 86-2.10 and 86-2.11 of this Subpart.

(b)(1) Except as identified in paragraphs (5), (6) and (7) of this subdivision, for the first three months of operation, the direct component of the rate shall be equivalent to the statewide mean direct case mix neutral cost per day after application of the RDIPAF as determined pursuant to

section 86-2.10 of this Subpart. The facility shall perform an assessment of all patients, pursuant to section 86-2.30 of this Subpart, at the beginning of the fourth month of operation and at the beginning of each third month thereafter until the end of the twelve-month cost report period referred to in section 86-2.2(e) of this Subpart or if applicable, the six-month cost report period identified in subdivision (e) of this section. The direct component of the rate shall be adjusted pursuant to section 86-2.10 of this Subpart, effective the first day of the month of each assessment period, based on the facility's case mix.

(2) Except as identified in paragraphs (5), (6) and (7) of this subdivision, for the first three months of operation, the indirect component of the rate shall be equivalent to a blended mean price for the applicable affiliation group as identified in subdivision (d) of section 86-2.10 of this Subpart. The blended mean price shall be established using a proportion of 60 residents in the high case mix index peer group and 40 residents in the low case mix index peer group both as identified in subdivision (d) of 86-2.10 of this Subpart, adjusted by the RIIPAF. Effective on the first day of the fourth month the indirect component shall be the mean price determined using the facility's PRI's and adjusted by the RIIPAF.

(3) The noncomparable component of the rate shall be determined on the basis of the generally applicable factors, including but not limited to the following:

(i) satisfactory cost projections:

(ii) allowable actual expenditures; and

(iii) an anticipated average utilization of no less than 90 percent.

(4) Rates established pursuant to this subdivision shall also include an adjustment pursuant to subdivision (u) of section 86-2.10 of this Subpart.

(5) Acquired Immune Deficiency Syndrome (AIDS). Except as identified in subparagraph (v) of this paragraph, a facility which is approved as a distinct AIDS facility or has a discrete AIDS unit pursuant to Part 710 of this Title, shall have rates established pursuant to this subdivision as follows:

(i) The direct component of the rate shall be determined in accordance with paragraph (1) of this subdivision provided however that the direct mean rate for the first three months of operation shall be determined pursuant to an approved facility's projection of case mix. The direct component of the rate shall be enhanced by an increment which shall be determined on the basis of the difference between budgeted costs of care and staffing levels for AIDS patients in specific patient classification groups and the costs of care and staffing levels for non-AIDS patients which are classified in the same patient classification groups based on data submitted by a facility. The increment to be included in the facility's rate pursuant to this subparagraph shall be approved by the commissioner, but in no event shall the increment be greater than 1.0. The direct component of the rate shall also be increased by an occupancy factor of 1.225.

(ii) The indirect component shall be determined in accordance with paragraph (2) of this subdivision provided however, that the indirect mean price for the first three months of operation shall be detemined pursuant to an approved facility's projection of case mix. The indirect component of the rate shall be increased by the AIDS factor as determined pursuant to section 86-2.10(p) of this Subpart.

(iii) The allowable costs for the central service supply functional cost center as listed in paragraph (1) of section 86-2.10(c) shall be considered a non-comparable cost.

(iv) Rates developed pursuant to this paragraph shall remain in effect until a facility submits twelve-month financial and statistical data pursuant to subdivision (e) of section 86-2.2 of this Subpart. (v) Notwithstanding the provisions of subparagraph (i), (ii), and (iii) of this paragraph, any facility which prior to April 1, 1991 has a rate approved and certified by the commissioner pursuant to section 2807 of the Public Health Law, which includes AIDS specific adjustments pursuant to this Subpart, or has been approved as an AIDS specific facility by the Public Health Council, and/or has had a certificate of need application approved or conditionally approved pursuant to Part 710 of this Title for the operation of a discrete AIDS unit shall have its rate determined in accordance with the following:

(a) The direct component of the rate shall be based on the statewide ceiling direct case mix neutral cost per day after application of the RDIPAF as determined pursuant to section 86-2.10 of this Subpart and a case mix proxy for AIDS patients established by this subparagraph, and increased by an occupancy factor of 1.225. The case mix proxy for AIDS patients shall be determined as follows:

(1) A facility which was approved based on a written application for establishment and/or construction which indicated that a majority of its AIDS patients would fall into patient classification groups with a case mix index exceeding 0.83 prior to application of any AIDS factors or increments identified in this subdivision shall be assigned a case mix proxy as determined by the following:

(i) For its first three months of operation, the facility shall be assigned a case mix proxy of 2.32.

(ii) Beginning with the start of the fourth month of operation, and pursuant to the facility's performance of patient assessments referred to in paragraph (1) of subdivision (b) of this section, an AIDS patient shall be assigned a case mix proxy based on the sum of responses to section III - Activities of Daily Living (ADLs), questions 19, 21, and 22 of the patient review instrument (PRI) as contained in section 86-2.30(i) of this Subpart as follows:

CASE MIXADL TOTAL PROXY
3-6 2.187-8 2.329 2.64

(2) A facility which was approved based on a written application for establishment and/or construction which indicated a majority of its AIDS patients would fall into patient classification groups with a case mix index equal to or less than 0.83 prior to application of any AIDS factors or increments identified in this subdivision shall have a case mix proxy equal to 1.55. This case mix proxy shall remain in effect until a facility submits financial and statistical data pursuant to subdivision (e) of section 86-2.2 of this Subpart.

(3)(i) The indirect component of the rate for facilities identified in subclause (1) of this clause shall be equivalent to the indirect ceiling price per day of the high intensity peer group established pursuant to paragraph (2) of subdivision (d) of section 86-2.10 of this Subpart after application of the RIIPAF as determined pursuant to section 86-2.10 of this Subpart and increased by the indirect AIDS factor as determined pursuant to subdivision (p) of section 86-2.10 of this Subpart.

(ii) The indirect component of the rate for facilities identified in subclause (2) of this clause shall be equivalent to the ceiling indirect price per day of the low intensity peer group established pursuant to paragraph (2) of subdivision (d) of section 86-2.10 of this Subpart after application of the RIIPAF as determined pursuant to section 86-2.10 of this Subpart and increased by the indirect AIDS factor as determined pursuant to subdivision (p) of section 86-2.10 of this Subpart.

(4) For purposes of this subparagraph, the allowable costs for the central service supply functional cost center as listed in paragraph (1) of section 86-2.10(c) shall be considered a non-comparable cost.

(5) Rates developed pursuant to this subparagraph shall remain in effect until a facility submits financial and statistical data pursuant to section 86-2.2(e) of this Subpart.

(6) Long-term inpatient rehabilitation program for traumatic brain-injured residents (TBI). A facility which is approved to operate discrete units for the care of residents under the long-term inpatient rehabilitation program for TBI patients established pursuant to section 415.36 of this Title shall have separate and distinct payment rates established pursuant to this subdivision as follows:
(i) For the first three months of operation, the direct component shall be equivalent to the statewide mean direct case mix neutral cost per day established pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of section 86-2.10 increased by a factor of 3.28 and adjusted by the RIIPAF pursuant to section 86-2.10. The direct component shall be further increased by an occupancy factor of 1.225 for the first six months of operation. The facility shall perform an assessment of all residents, pursuant to section 86-2.30, at the beginning of the fourth month of operation and at the beginning of each third month for the period set forth in paragraph 1 of this subdivision. Effective on the first day of the month of each assessment period, the direct component of the rate shall be adjusted pursuant to subdivision (c) of section 86-2.10 of this Subpart based on the facility's case mix. The case mix index which is used to establish the facility specific mean direct price per day for each patient classification group pursuant to paragraph (4) of subdivision (c) of section 86-2.10 for TBI residents shall be increased by an increment of 1.49.

(ii) The indirect component of the rate shall be equivalent to the mean indirect price developed pursuant to section 86-2.10(d) of this Subpart for the applicable peer group established for high intensity case mix identified in paragraph (2) of subdivision (d) of section 86-2.10, adjusted by the RIIPAF pursuant to 86-2.10(d). The indirect component shall be further adjusted by an occupancy factor of 1.225 for the first six months of operation.

(iii) The noncomparable component of the rate shall be determined as follows:

(a) For an existing facility that opens a discrete unit for the care of patients under the long-term inpatient rehabilitation program for TBI patients, the noncomparable component of the rate shall be equal to the noncomparable component of the existing residential health care facility's rate computed pursuant to subdivision (f) of section 86-2.10 plus approved budgeted costs for personnel required by section 415.36 of this Title that would be reported in the functional cost centers identified in subdivision (f) of section 86-2.10.

(b) For a new facility without a residential health care facility rate computed pursuant to section 86-2.10 of this Subpart, the noncomparable component of the rate shall be determined in accordance with paragraph (3) of this subdivision.

(iv) Rates established pursuant to this paragraph shall also include an adjustment pursuant to section 86-2.10(u) of this Subpart.

(7) Long-term ventilator dependent residents. A facility which is approved to operate discrete units for the care of long-term ventilator dependent patients as established pursuant to section 415.38 of this Title shall have separate and distinct payment rates established pursuant to this subdivision as follows:

(i) For the first three months of operation, the direct component shall be equivalent to the statewide mean direct case mix neutral cost per day established pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of section 86-2.10 increased by a factor of 2.89 and adjusted by the RDIPAF pursuant to section 86-2.10. The direct component shall be further increased by an occupancy factor of 1.225 for the first six months of operation. The facility shall perform an assessment of all residents, pursuant to section 86-2.30, at the beginning of the fourth month of operation and at the beginning of each third month for the period set forth in paragraph 1 of this subdivision. Effective on the first day of the month of each assessment period, the direct component of the rate shall be adjusted pursuant to subdivision (c) of section 86-2.10 based on the facility's case mix. The case mix index which is used to establish the facility specific mean direct price per day for each patient classification group pursuant to paragraph (4) of subdivision (c) of section 86-2.10 for long-term ventilator dependent residents shall be increased by an increment of 1.15.

(ii) The indirect component of the rate shall be equivalent to the mean indirect price developed pursuant to section 86-2.10(d) for the applicable peer group established for high intensity case mix identified in paragraph (2) of subdivision (d) of section 86-2.10, adjusted by the RIIPAF pursuant to section 86-2.10(d). The indirect component shall be further adjusted by an occupancy factor of 1.225 for the first six months of operation.

(iii) The noncomparable component of the rate shall be determined as follows:

(a) For an existing facility that is approved to operate discrete units for the care of long-term ventilator residents, the noncomparable component of the rate shall be equal to the noncomparable component of the existing residential health care facility's rate computed pursuant to subdivision (f) of section 86-2.10 plus approved budgeted costs as identified in clauses (c) and (d) of this subparagraph plus approved budgeted costs for personnel required by section 415.38 of this Title that would be reported in the functional cost centers identified in subdivision (f) of section 86-2.10.
(b) For a new facility without a residential health care rate computed pursuant to section 86-2.10, the noncomparable component of the rate shall be determined in accordance with paragraph (3) of this subdivision and include approved budgeted costs identified in clauses (c) and (d) of this subparagraph.

(c) The approved budgeted costs for the central service supply functional cost center as listed in paragraph (1) of subdivision (c) of this section shall be considered a noncomparable cost reimbursed pursuant to subdivision (f) of this section.

(d) The approved budgeted costs for prescription drugs, specifically required by generally accepted standards of professional practice for long-term ventilator dependent residents, that are administered at a frequency and volume exceeding those of prescription drugs included in the direct component of the rate pursuant to subdivision (c) of this section shall be considered a noncomparable cost pursuant to section 86-2.10(f) of this Subpart.

(iv) Rates established pursuant to this paragraph shall also include an adjustment pursuant to section 86-2.10(u).

(8) Specialized programs for residents requiring behavioral interventions. A facility which is approved to operate discrete units specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions as established pursuant to section 415.39 of this Title shall have separate and distinct payment rates established pursuant to this subdivision as follows:

(i) For the first three months of operation, the direct component shall be equivalent to the statewide mean direct case mix neutral cost per day established pursuant to subparagraph (iii) of paragraph (3) of subdivision (c) of section 86-2.10 increased by a factor of 2.65 and adjusted by the RDIPAF pursuant to section 86-2.10 of this Subpart. The direct component shall be further increased by an occupancy factor of 1.225 for the first six months of operation. The facility shall perform an assessment of all residents, pursuant to section 86-2.30 of this Subpart, at the beginning of the fourth month of operation and at the beginning of each third month for the period set forth in paragraph 1 of this subdivision. Effective on the first day of the month of each assessment period, the direct component of the rate shall be adjusted pursuant to subdivision (c) of section 86-2.10 based on the facility's case mix. The case mix index which is used to establish the facility specific mean direct price per day for each patient classification group pursuant to paragraph (4) of subdivision (c) of section 86-2.10 for residents requiring behavioral interventions shall be increased by an increment of 1.40.

(ii) The indirect component of the rate shall be equivalent to the mean indirect price developed pursuant to section 86-2.10(d) of this Subpart for the applicable peer group established for high intensity case mix identified in paragraph (2) of subdivision (d) of section 86-2.10 of this Subpart, adjusted by the RIIPAF pursuant to section 86-2.10(d) of this Subpart. The indirect component shall be further adjusted by an occupancy factor of 1.225 for the first six months of operation.

(iii) The noncomparable component of the rate shall be determined as follows:

(a) For an existing facility that is approved to operate discrete units specifically designated for the purpose of providing specialized programs for residents requiring behavioral interventions, the noncomparable component of the rate shall be equal to the noncomparable component of the existing residential health care facility's rate computed pursuant to subdivision (f) of section 86-2.10 plus approved budgeted costs for personnel required by section 415.39 of this Title that would be reported in the functional cost centers identified in subdivision (f) of section 86-2.10 of this Subpart.

(b) For a new facility without a residential health care rate computed pursuant to section 86-2.10, the noncomparable component of the rate shall be determined in accordance with paragraph (3) of this subdivision.

(iv) Rates established pursuant to this paragraph shall also include an adjustment pursuant to section 86-2.10(u).

(c) The rates developed pursuant to this section shall remain in effect until a facility submits a twelve-month cost report in accordance with section 86-2.2(e) of this Subpart for a twelve-month period during which the facility had an overall average utilization of at least 90 percent of bed capacity. This cost report shall be used to adjust the direct, indirect, noncomparable and capital

components of the rate effective on the first day of the cost report period. (d) All rates of reimbursement certified pursuant to this section shall be subject to audit pursuant to section 86-2.7 of this Subpart. After audit, the facility shall receive a rate based upon actual allowable costs incurred during the rate period, and computed in accordance with section 86-2.10 of this Subpart. Except as described in section 86-2.19(d)(2) of this Subpart, an occupancy rate of not less than 90 percent shall be used when calculating the capital and noncomparable components in the rate calculation.

(e) Notwithstanding the provisions of this section, an operator of a facility which has had an overall average utilization of at least 90 percent of bed capacity for a six-month period which began prior to April 1, 1993 but after the date on which the operator began operations shall submit a six-month cost report for that period. Such six-month cost report shall be utilized for purposes of this section in lieu of the twelve-month cost report identified in subdivision (e) of section 86-2.2 of this Subpart.

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Complete

Section 86-2.16 - Less expensive alternatives

86-2.16 Less expensive alternatives. Reimbursement for the cost of providing services may be the lesser of the actual costs incurred or those costs which could reasonably be anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served effective alternatives or substitutes for the whole or any part of such service.

Doc Status:
Complete

Section 86-2.17 - Allowable costs

86-2.17 Allowable costs.

(a) To be considered as allowable in determining reimbursement rates, costs shall be properly chargeable to necessary patient care. Except as otherwise provided in this Subpart, or in accordance with specific determination by the commissioner, allowable costs shall be determined by the application of the principles of reimbursement developed for determining payments under title XVIII of the Federal Social Security Act (Medicare) program.

(b) Allowable cost shall include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a residential health care facility.

(c) Allowable costs may not include amounts in excess of reasonable or maximum Title XVIII of the Federal Social Security Act (Medicare) or in excess of customary charges to the general public. For purposes of this determination, customary charges to the general public shall equal an average

of the applicable charges weighted by patient days. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(d) Allowable costs shall not include expenses or portions of expenses reported by individual residential health care facilities which are determined by the commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item.

(e) Any general ceilings applied by the commissioner, as to allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.

(f) Allowable costs shall not include costs not properly related to patient care or treatment which principally afford diversion, entertainment or amusement to owners, operators or employees of residential health care facilities.

(g) Allowable costs shall not include any interest charged related to rate determination or penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty.

(h) Allowable costs shall not include the direct or indirect costs of advertising, public relations or promotion except in those instances where the advertising is specifically related to the operation of the residential health care facility and not for the purpose of attracting patients.

(i) Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(j) Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated, to the satisfaction of the commissioner, to be allocable to expenditures other than for public relations, advertising or political contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the commissioner.

(k) Allowable costs shall not include any element of cost as determined by the commissioner to have been created by the sale of a residential health care facility.

(l) Allowable costs shall not include the interest paid to a lender related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained.

(m) Allowable costs shall be reduced by income earned for Medicare part B eligible services to the extent that Medicaid has paid for these services.

(n) Allowable costs shall include any fee assessed by the commissioner on a residential health care facility, for the purpose of providing revenue for the account established pursuant to chapter 1021 of the Laws of 1981. The reimbursement rate for a facility shall reflect the cost of the annual fee prior to collection of the fee through the rate of reimbursement.

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Thursday, December 27, 1990
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Section 86-2.18 - Recoveries of expense

86-2.18 Recoveries of expense.

(a) Operating costs shall be reduced by the costs of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs of these services and activities. Examples of activities and services covered by this provision include:

(1) drugs and supplies sold to other than employees for use outside the residential health care facility;

(2) telephone and telegraph services for which a charge is made;

(3) discount on purchases;

(4) living quarters rented to persons other than employees;

(5) meals provided to special nurses or patients' guests;

(6) operation of parking facilities for community convenience;

(7) lease of office and other space of concessionaires providing services not related to residential health care facility service; and

(8) tuitions and other payments for educational service, room and board and other services not directly related to residential health care facility service.

(b) Operating costs shall be reduced by the actual revenue received from services and activities which are provided to employees at less than cost, as a form of fringe benefit. Examples of activities and services covered by this provision include:

(1) drugs and supplies sold or provided to employees;

(2) living quarters rented or provided to employees; and

(3) meals sold or provided to employees.

Doc Status:
Complete

Section 86-2.19 - Depreciation for voluntary and public residential health care facilities

86-2.19 Depreciation for voluntary and public residential health care facilities.

(a) Reported depreciation based on approved historical cost of buildings, fixed equipment and capital improvements thereto is recognized as a proper element of cost for voluntary and public residential health care facilities. Useful lives shall be the higher of the reported useful life or those useful lives from the most recent edition of Estimated Useful Lives of Depreciable Hospital Assets, American Hospital Association.

(b) In the computation of rates effective for voluntary residential health care facilities, depreciation shall be included on a straight line method on plant and nonmovable equipment. Depreciation shall be funded unless the Commissioner of Health shall have determined, upon application by the residential health care facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required or for the amortization of capital indebtedness. Funding for plant and fixed equipment shall mean that the transfer of monies to the funded accounts shall occur by the end of the fiscal period in which the depreciation is recorded. Board-designated funds and the accrual of liabilities to the funded depreciation accounts (due to/from accounts) shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts to be considered as valid funding transactions unless expended for the purpose for which it was funded.

(c) In the computation of rates for public residential health care facilities, depreciation is to be included on a straight line method on plant and nonmovable equipment.

(d) Residential health care facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law (defined as "facilities" for purposes of this subdivision only) shall conform to the requirements of this Subpart.

(1) In lieu of depreciation and interest, on the loan-financed portion of the facilities the State Commissioner of Health shall allow debt service on the mortgage loan as set forth in the mortgage repayment schedule computed by the Medical Care Facilities Finance Agency, together with such required fixed charges, sinking funds and reserves as may be determined by the commissioner as necessary to assure repayment of the mortgage indebtedness. Such mortgage repayment schedule may allow for the accelerated repayment of the soft costs, including, but not limited to, mortgage and bond insurance costs, start-up operating costs, underwriter discounts, government agency fees and investment contract fees, included in the approved total project cost.

(2) Effective January 1, 1995 for facilities in an initial period of operation, facilities which have approved discrete units serving specialty populations as defined in paragraphs (5), (6), (7) and (8) of section 86-2.15(b) of this Subpart, which serve AIDS residents, long term ventilator dependent residents, residents requiring behavioral interventions in specialized programs or traumatic brain injured residents who receive long term inpatient rehabilitation, respectively, shall be reimbursed for certain capital expenditures requiring a cash outlay as follows:

(i) Debt service amortization and interest, property insurance and SONYMA annual fees shall be divided by an estimate of patient days in the calculation of the capital component of the specialty population unit rate that is promulgated for the initial period of operation.

(a) An estimate of patient days shall be determined by the department based on a reasonable projection of utilization during the initial period of operation. The reasonable projection of

utilization shall be based on factors that shall include, but not be limited to, prior initial utilization of similarly situated facilities.

(b) Initial period of operation is defined as the period commencing on the initial effective date on which the facility is certified by the department to begin operation of the discrete unit(s) identified in paragraph (2) of this subdivision, and ending on the last day of the twelfth month of continuous operation or the beginning date of the initial cost report filed in accordance with subdivision (e) of section 86-2.2 of this Subpart, whichever is shorter.

(ii) The capital component of the facility's rate for the initial period of operation shall be subject to audit for utilization based on actual patient days in the initial period of operation. Such capital component of the rate shall be retrospectively or prospectively adjusted based on such audit. (e) In the computation of rates for voluntary residential health care facilities which are rented from proprietary interests, the provisions of section 86-2.21 of this Subpart shall apply, except where the realty was previously owned by the voluntary residential health care facility or where the proprietary interest has representation on the board of directors of the voluntary residential health care facility.

(f)(1) In the event that a residential health care facility is sold or leased or is the subject of any other realty transaction, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction has not occurred.

(2) A lease with a related organization described in subdivisions (a) or (d) of section 86-2.26 of this Subpart shall be deemed to be a non-arms length lease.

(3) Any capital expenditures associated with non-arms length leases shall be approved and certified to, if required, pursuant to Article 28 of the Public Health Law. In the computation of reimbursement for non-arms length leases, the capital cost shall be included in allowable costs only to the extent that it does not exceed the amount which the facility would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance and interest. Accelerated depreciation on these assets may not be included in allowable costs under any circumstances.

(g) (1) The provisions of subdivision (a) of this section may be waived for certain qualifying facilities. In order to be considered a qualifying facility, all of the following conditions must be met:

(i) A sale or transfer between nonrelated parties must take place.

(ii) The purchaser must assume the seller's remaining mortgage repayment schedule at the associated fixed rate of interest.

(iii) The difference between the unpaid principal balance of the seller's mortgage (first mortgage) and the Medicaid-allowable transfer price must be generated either from second mortgage proceeds or contributed equity capital or both.

(iv) The annual amount of allowable interest expense incurred as described in section 86-2.20 of this Subpart under terms of the first and second mortgage, plus the annual principal debt amortization, exclusive of that portion attributable to the acquisition of land must be less than that which would otherwise be reimbursed pursuant to subdivision (a) of this section and section

86-2.20 of this Subpart if no assumption of the existing first mortgage were made. (This comparison is hereinafter referred to as the comparative analysis test.)

(v) For purposes of this subdivision, the loan-financed portion of the Medicaid-allowable transfer price shall be held constant and the comparative analysis test shall be applied to each year of the effective term of the first and second mortgages. Equity capital will be considered as first applying to the acquisition of the land, then to the acquisition of the building. In instances where more than one facility is involved in the transaction, the facilities may be combined for purposes of the comparative analysis test.

(2) Qualifying facilities shall be reimbursed principal debt amortization, interest and return of equity in the following manner:

(i) Principal debt amortization. In each year, during the effective term of the mortgage, the capital cost component of the rate shall include a payment factor sufficient to reimburse the principal debt amortization component of the allowable portion of the mortgage, with the exception of that portion of the indebtedness which is attributable to the acquisition of the land.

(ii) Interest. The capital cost component shall include a payment factor sufficient to reimburse interest associated with the allowable portion of the mortgage at a rate which the commissioner finds to be reasonable and is in accordance with the provisions of section 86-2.20 of this Subpart.

(iii) Return of equity. The equity portion of the Medicaid-allowable transfer price, except for that portion which is attributable to the acquisition of the land, shall be reimbursed in equal annual amounts beginning in the first year following the expiration of the term of the mortgages over the remaining useful facility life.

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Section 86-2.20 - Interest for all residential health care facilities

86-2.20 Interest for all residential health care facilities.

(a) Necessary interest on both current and capital indebtedness is an allowable cost for all residential health care facilities.

(b) To be considered as an allowable cost, debt generating interest shall be incurred to satisfy a financial need, and interest expense shall be at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained. Financial need for capital indebtedness relating to a specific project shall exist when all

available restricted funds designated for capital acquisition of that type have been considered for equity purposes.

(c)(1) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trusteed malpractice insurance funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor-restricted fund or funded depreciation is an allowable expense. Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss is not allowable.

(2) For rate years beginning prior to January 1, 1994, investment income reported for the fiscal year ending December 31, 1983, (or for a subsequent fiscal year if that subsequent year's report is being used by the department to establish the basic rate pursuant to section 86-2.10 of this Subpart) shall reduce the interest expense allowed for reimbursement as follows:

(i) For all residential health care facilities, investment income shall first reduce the interest expense allowed each year for operational cost reimbursement; and

(ii) the amount of any remaining investment income, after application of subparagraph (i), shall reduce the interest expense reimbursed each year as capital cost for residential health care facilities; and

(iii) the amount of any remaining investment income after application of subparagraph (ii), shall not be considered in the computation of the rate.

(3) For rate years beginning on or after January 1, 1994, for all residential health care facilities, investment income reported for the same year used to compute capital cost reimbursement for a facility's rate shall reduce the interest expense allowed for reimbursement.

(d)(1) Interest on current indebtedness shall be treated and reported as an operating, administrative expense for rate years beginning prior to January 1, 1994. For rate years beginning on or after January 1, 1994, interest on current indebtedness, reported for the same cost report period used to compute capital cost reimbursement for a facility's rate, shall be reported as an administrative expense and reimbursed as a nontrendable expense.

(2)(i) Approval by the commissioner shall be required for reimbursement of interest expense on current indebtedness incurred on or after January 1, 1994 when such interest expense exceeds the threshold established for that calendar year. The threshold for each calendar year shall be equal to the interest charges that would be generated by current indebtedness with an interest rate equal to the prime lending rate as published in the first issue of the Wall Street Journal for the calendar year plus 200 basis points on a loan principal of $270,000 for facilities with 120 or less beds or $270,000 plus an additional $2,250 for each bed over 120 for facilities with more than 120 beds. Approval shall be granted in accordance with the standards set forth in subdivision (b) of this section. Prior approval shall not be required.

(ii) New facilities without adequate cost experience whose rates are calculated pursuant to section 86-2.15 of this Subpart shall be exempt from the requirements in subparagraph (a) until January 1st of the first calendar year used as the basis for computing capital cost reimbursement and for which a cost report is filed subsequent to the cost report described in section 86-2.2(e) of this Subpart.

This exemption shall not apply to operating facilities that open new discrete units providing services reimbursed in accordance with the provisions of paragraphs (5), (6) and/or (7) of section 86-2.15(b) of this Subpart or other similar discrete units providing care to residents with special needs that receive a separate and distinct payment rate under section 86-2.15 of this Subpart.

(iii) The interest expense threshold for facilities operated by receivers or new operators who are required to file a cost report for the first twelve-month period of operation pursuant to section 86-2.10(k) of this Subpart shall be established for that cost report period in accordance with subparagraph (a) of this paragraph, using the prime lending rate in effect on January 1st of the year in which the cost report period begins. (e) Interest on capital indebtedness, as defined in paragraph 86-2.21(a)(1) of this Subpart, except as provided for in section 86-2.20(c) of this Subpart for rate years beginning January 1, 1986 and thereafter, is an allowable cost if the debt generating the interest is approved by the commissioner, incurred for authorized purposes, and the principal of the debt does not exceed either the approval of the commissioner or the cost of the authorized purposes. Interest related to refinancing indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness than being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable on acceptable demonstration of the Commissioner of Health that such refinancing will result in a debt service savings over the life of the indebtedness.

(f) Where a public finance authority has established a mortgage rate of interest such that sufficient cash flows exist to retire the mortgage prior to the stated maturity, the amount of the mortgage to be forgiven, at the time of such forgiveness, shall be capitalized as a deferred asset and amortized over the remaining mortgage life, as a reduction to the facility's capital expense.

(g) Voluntary facilities shall report mortgage obligations financed by public finance authorities for their benefit and which they are responsible to repay, as liabilities in the general fund when such mortgage obligations are incurred.

Effective Date:
Tuesday, December 28, 1993
Doc Status:
Complete

Section 86-2.21 - Capital cost reimbursement for proprietary residential health care facilities

86-2.21 Capital cost reimbursement for proprietary residential health care facilities.

(a) Definitions. As used in this section, the following terms shall be defined as follows:

(1) Capital indebtedness. The term capital indebtedness shall mean all debt obligations of a facility that are:

(i) evidenced by a mortgage note or bond and secured by a mortgage on the land, building or nonmovable equipment of a facility or evidenced by a note incurred in accordance with subparagraph (ii) of this paragraph;

(ii) incurred for the purpose of financing the acquisition, construction or renovation of land, building or nonmovable equipment (hereinafter called the "authorized purpose"); and

(iii) found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility in accordance with standards set forth in section 86-2.21(e)(3)(ii) of this Subpart. Refinancing of capital indebtedness shall be recognized only to the extent of the then unpaid balance of the debt being refinanced.

(2) Commissioner. The term commissioner shall mean the Commissioner of Health of the State of New York.

(3) Department. The term Department shall mean the Department of Health of the State of New York.

(4) Equity. The term equity shall mean all cash or other assets, net of liabilities, invested by a facility or its operator in land, building and nonmovable equipment, and found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility. Equity shall not include any change in the book value of a facility resulting from revaluation of assets or from the amortization of capital indebtedness resulting from payments made pursuant to subdivision (e), paragraph (3) of this section.

(5) Facility. The term facility shall mean a proprietary residential health care facility, as the term residential health care facility is defined in article 28 of the Public Health Law and in regulations of the department.

(6) Initial allowed facility cost. The term initial allowed facility cost shall mean the portion of certified costs approved by the commissioner or, in the case of facilities granted operating certificates prior to April 15, 1973, the costs of the facility as verified by audit to the satisfaction of the commissioner or, in the case of facilities not able to comply with either of the foregoing standards, costs imputed pursuant to subdivision (g) of this section, in or prior to the first year of useful facility life attributable to the acquisition of land and the construction, acquisition or renovation of building and nonmovable equipment. The commissioner shall disregard any costs relating to prior transactions involving the facility which he finds were not bona fide or the terms of which are found to be other than fair and reasonable.

(7) Useful facility life. The term useful facility life shall mean a period of 40 years measured from the calendar year in which a facility commences operations as determined by the commissioner.

(8) Rate of return. The term rate of return shall mean the annual rate of return on equity invested, and said rate for a rate year shall be equal to the yield on thirty year United States Treasury bonds in effect on the second Wednesday of September of the year prior to the rate year.

(9) Capital improvement. The term capital improvement shall mean any addition to, replacement of, or improvement of a capital item of plant or nonmovable equipment approved by the commissioner as reasonable, necessary and in the public interest.

(10) Capital improvement cost. The term capital improvement cost shall mean the actual expenditure or portion thereof attributable to a capital improvement approved by the commissioner as reasonable, necessary and in the public interest.

(11) Hospital-based residential health care facility. The term hospital-based residential health care facility shall mean a facility holding a certificate of operation as a residential health care facility which is wholly owned by a hospital as that term is defined in Subpart 86-1 of this Title, and is physically located in a building or buildings, part of which building or buildings are also used for provision of acute care hospital services.

(12) Effective term. The term effective term shall mean the number of years and months required, pursuant to the term of the note or mortgage, to fully amortize the principal of the debt, predicated upon the regular principal payments required by the mortgage or note, but determined without regard to any provision for making the balance all due and payable at a given date or upon a stated event, and without regard to any provision for acceleration of the debt or any original or subsequent agreement for the suspension or moratorium of principal payments. (b) Subject to subdivision (f) of this section, the reimbursement rate of every facility certified by the commissioner and approved by the State Director of the Budget pursuant to article 28 of the Public Health Law shall, in each year of useful facility life, include a capital cost component determined in accordance with the provisions of subdivision (c), (d) or (e) of this section applicable to the facility in such year.

(c) (1) The provisions of subdivision (e) of this section shall not apply for the term prescribed by paragraph (3) of this subdivision to any facility which, as of the effective date of this section, is located in and operated from leased space pursuant to a lease:

(i) which was entered into and approved for reimbursement prior to March 10, 1975; and

(ii) which the commissioner finds to be bona fide, valid and noncancelable; and

(iii) the payments, or a portion thereof, made pursuant to such lease are found by the commissioner to have been the proper basis for reimbursement of capital paid to such facility pursuant to article 28 of the Public Health Law prior to March 10, 1975.

(2) The capital cost component of a facility within the provisions of paragraph (1) of this subdivision shall, for the term prescribed by paragraph (3) of this subdivision, consist of a payment factor sufficient to reimburse the facility for the total payments required under its lease to the extent approved by the commissioner pursuant to paragraph (1) of this subdivision, and subject to the historical limitations set forth by the commissioner.

(3) Capital cost reimbursement for leased facilities shall be made pursuant to this subdivision for the balance of the lease term (computed without regard to any future extension or option to renew authorized by the lease) remaining as of the effective date of this subdivision. Upon the expiration of such balance of the lease term provided in an approved lease (as said lease so provides as of August 1, 1977) or such earlier expiration date as may be agreed to by the parties to an approved lease, capital cost reimbursement shall be made pursuant to subdivision (e) of this section notwithstanding any extension or renewal of such lease or the execution of a new lease by or on behalf of the facility; provided, however, that the commissioner may, in his discretion, continue capital cost reimbursement for such leased facilities pursuant to this subdivision, at a rental amount approved by the commissioner prior to such extension or renewal, and not pursuant to subdivision (e), upon his finding that there is a public need for such facility at the time and place and under the

circumstances proposed and that the continued operation of such facility would be jeopardized by a limitation of reimbursement pursuant to subdivision (e).

(4) A lease with a related organization described in subdivisions (a) or (d) of section 86-2.26 of this Subpart shall be deemed to be a non-arms length lease.

(5) Any capital expenditures associated with non-arms length leases shall be approved and certified to, if required, pursuant to Article 28 of the Public Health Law. In the computation of reimbursement for non-arms length leases, the capital cost shall be included in allowable costs only to the extent that it does not exceed the amount which the facility would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance and interest. Accelerated depreciation on these assets may not be included in allowable costs under any circumstances. (d) The provisions of subdivision (e) of this section shall not apply to hospital-based residential health care facilities. Such facilities will be reimbursed pursuant to capital cost regulations in Subpart 86-1 of this Part.

(e) (1) Subject to the provisions of subdivisions (c), (d) and (f) of this section, the capital cost component for every facility shall consist of the payment factors provided in this subdivision that, in any year of useful facility life, are applicable to the facility.

(2) Interest. The capital cost component shall, in each year of useful facility life, include a payment factor sufficient to reimburse, at a rate which the commissioner finds to be reasonable under the circumstances prevailing at the time of the placing of the capital indebtedness, interest on capital indebtedness.

(3) Amortization. (i) Subject to the limitations of paragraph (5) of this subdivision, the capital cost component shall, in each year of useful facility life, include a payment factor sufficient to reimburse the amortization component of capital indebtedness pursuant to the terms of the mortgage note or bond.

(ii) The capital indebtedness of a facility, to the extent that the original principal of such debt does not exceed the initial allowed facility cost of the facility, shall be recognized as follows: (a)For capital indebtedness with an effective term of 10 years or less, amortization expense will be recognized for the purpose of reimbursement only, if the schedule of debt amortization is within the limitation set forth in section 86-2.21(e)(5) of this Subpart for each of the years of debt amortization.

(b)For capital indebtedness with an effective term in excess of 10 years, amortization expense will be recognized for the purpose of reimbursement upon a determination by the commissioner that the following standards are met:

(1) the debt is incurred for authorized purposes;

(2) the interest rate is reasonable for the time and place in which the capital indebtedness is committed, and for the type of indebtedness associated with the interest rate;

(3) the amortization schedule is reasonable (amortization must be required in each year of the mortgage in accordance with the established financial practices);

(4) the effective term is consistent with customary commercial practices in the geographic area of the facility; and

(5) the effective term is in accordance with efficient production of services.

(c)For capital indebtedness other than first mortgages, the amortization expense will be recognized for the purpose of reimbursement upon a determination by the commissioner that the debt, complies with the standards set forth in section 86-2.21(e)(3)(ii)(b) of this Subpart, and the following additional standards:

(1) they must be incurred for the purpose of financing either an approved purchase or construction of a facility; and

(2) the effective term of financing for a capital improvement is reasonable when compared to the estimated useful life of the improvement.

(d)Capital indebtedness for any unauthorized purpose will not be recognized for any reimbursement purpose.

(4) Return of equity. Subject to the limitations of paragraph (5) of this subdivision, the capital cost component shall include a payment factor sufficient to return equity. A facility shall be eligible for the return of equity commencing in the first year following the department's determination, among other factors, that the facility has the ability to meet current capital indebtedness (including principal and interest) over the balance of useful facility life. This shall mean that within the confines of the regulations expressed in this Subpart, capital reimbursement will be sufficient to provide for the remaining amortization of capital indebtedness. The commissioner's determination shall also take into account such factors as the age, size, location and condition of the facility, and the financial condition of the facility.

(5) Limitation. (i) Annual reimbursement payments for capital cost under paragraphs (3) and (4) of this subdivision shall not at any time result in accumulative average payment in excess of three and three one-hundredths percent of initial allowed facility cost. For years prior to 1981, actual amortization or depreciation paid by Medicaid will be used in the computation of the limitation. For years prior to Medicaid or in years when Medicaid payments did not include an expense equivalent of depreciation or amortization, a three and three one-hundredths percent payment will be imputed.

(ii) This limitation may be waived by the commissioner where a facility applies to the commissioner for approval to refinance an existing mortgage because its recognized amortization expense exceeds the amount of allowable reimbursement for amortization of principal and interest expense (including credit from prior amortization reimbursement). In those instances where the commissioner determines that it would be more expensive to reimburse the debt service that would be incurred if the facility refinanced the remaining principal, than it would be to continue to reimburse the debt service on the existing mortgage, the commissioner may reimburse up to the actual debt service incurred by the facility under the existing mortgage, plus return on equity in accordance with the provisions of paragraph (6) of this subdivision.

(6) Return on equity. The capital cost component for every facility shall include a payment factor sufficient to pay an annual rate of return on average equity, as such average annual equity shall be determined by the commissioner in each year of useful facility life.

(7) Residual reimbursement. After the expiration of useful facility life, the commissioner may approve a payment factor for any facility for which he determines that continued capital cost reimbursement is appropriate; provided, however, that such payment factor shall not exceed one

half of the capital cost reimbursement received by such facility in the final year of useful facility life. (8) Capital improvement cost reimbursement. (i) The capital improvement cost shall be reimbursed by adjusting the initial allowed facility cost, capital indebtedness, equity determinations and limitations as stated in paragraph (5) of this subdivision, to include the capital improvement cost.

(ii) Adjustments in accordance with subparagraph (i) of this paragraph shall be made in the following manner:

(a)if the cost of an improvement is $100,000 or more, and certificate of need approval has been granted by the commissioner, then component useful life for the improvement will be permitted. Such component useful life will be equivalent to the estimated asset life in accordance with the Medicare Provider Reimbursement Manual or the remaining useful life of the facility, whichever is less. Where a capital improvement adjusts the expected useful life of the facility beyond the remaining portion of the original useful facility life, the limitation set forth in section 86-2.21(e)(5) of this Subpart, will be increased to allow for the reimbursement of the amortization component of the debt obtained to finance the improvement.

(b)If the cost of an improvement is less than $100,000, then the cost will be reimbursed over the remaining portion of the expected useful life. In such instances the reimbursement will commence with either the reporting of such costs on an annual certified cost report or, upon submission of a cost report, certified by an independent public accountant, whichever is submitted first. In either event, the reporting of such costs must be accompanied by a sworn statement by the administrator or the chief fiscal officer of the facility to the effect that the improvements made are not part of a number of planned related projects which, in the aggregate, total $100,000 or more.

(c)If the cost of an improvement is less than $100,000 and:

(1)is undertaken as the result of an emergency situation;

(2)affects the health and safety of the patients; and

(3)the facility can demonstrate dire financial condition; then the limitation set forth in section 86-2.21(e)(6) of this Subpart will be modified to allow for the reimbursement of the debt service associated with the financing of the approved capital improvement over the effective term of the obligation or five years, whichever is greater. Any contribution to the improvement by the facility and not financed by the debt obligation will be considered an equity contribution and an adjustment to the facility's total capital equity will be made.

(d)If a facility undertakes an authorized improvement without incurring additional debt, then the facility will receive a return on equity and, when a determination has been made in accordance with section 86-2.21(e)(4) of this Subpart, a return of equity, for the funds invested in the improvement.

(f) (1) With respect to facilities granted operating certificates prior to March 10, 1975, the commissioner may modify or provide exceptions to subdivision (c) or (e) of this section in circumstances where he finds that application of the provisions of either subdivision would result in (i) excessive reimbursement to the facility, or (ii) severe economic hardship to the facility not caused by circumstances reasonably under the control of the facility. In determining severe economic hardship, the commissioner shall consider such factors as debt service required on capital indebtedness, prior withdrawal of assets from the facility, and the financial condition of the facility

in general. In such cases where the commissioner makes a finding of severe economic hardship, the capital cost component of the rate shall not exceed the debt service on capital indebtedness.

(2) The commissioner may revise the capital cost component of the reimbursement rate applicable to any facility which he determines is based upon previous error, deceit or any other misrepresentation or misstatement by the facility.

(3) The capital cost component shall not be affected by any sale, lease or transfer occurring after March 10, 1975.

(g) In lieu of determining initial allowed facility cost pursuant to subdivision (a) of this section, the commissioner may estimate the original fair and reasonable cost of the facility with due regard for the fair and reasonable cost of facilities of comparable age, size, location and condition, and impute an initial allowed facility cost to:

(1) every facility for which records on the historical cost or book value of land, building or nonmovable equipment are not available or not verifiable to the satisfaction of the commissioner;
(2) every leased facility which, as of the effective date of this section, is not eligible for reimbursement pursuant to subdivision (c) of this section;

(3) every facility which, after the effective date of this section, ceases to be eligible for reimbursement pursuant to subdivision (c) of this section and becomes eligible for reimbursement pursuant to subdivision (e) of this section; or

(4) every facility whose construction was completed prior to the calendar year in which this section becomes effective and whose initial facility year occurs in or after the calendar year in which this section becomes effective.

(h) In the event that a facility fails to submit information necessary for the implementation of this section, after notification pursuant to subdivision (f) of section 86-2.2 of this Subpart, the capital cost component of the rate shall consist of interest, if reported, and amortization not in excess of the lesser of the amortization payment required under capital indebtedness, or 2-1/2 percent of initial allowed facility cost.

(i) (1) The limitation provision of paragraph (e)(5) of this section may be waived for certain qualifying facilities. In order to be considered a qualifying transaction, ail of the following conditions must be met:

(i) A sale or transfer between nonrelated parties must take place.

(ii) The purchaser must assume the seller's remaining mortgage repayment schedule at the associated fixed rate of interest.

(iii) The difference between the unpaid principal balance of the seller's mortgage (first mortgage) and the Medicaid-allowable transfer price must be generated either from second mortgage proceeds or contributed equity capital or both.

(iv) The annual amount of allowable interest expense incurred as described in this section, under the terms of the first and second mortgage, plus the annual principal debt amortization must be less than that which would otherwise be reimbursed pursuant to this section, if no assumption of the existing first mortgage were made. (This comparison is hereinafter referred to as the comparative

analysis test.) For purposes of this subdivision, the loan-financed portion of the Medicaid-allowable transfer price shall be held constant and the comparative analysis test shall be applied to each year of the effective term of the first and second mortgages. In instances where more than one facility is involved in the transaction, the facilities may be combined for purposes of the comparative analysis test.

(2) Qualifying facilities shall be reimbursed principal debt amortization, interest and return of equity in the following manner:

(i) Principal debt amortization. In each year, during the effective term of the mortgage, the capital cost component of the rate shall include a payment factor sufficient to reimburse the principal debt amortization component of the allowable portion of the mortgage.

(ii) Interest. The capital cost component shall include a payment factor sufficient to reimburse interest associated with the allowable portion of the mortgage as defined by paragraph (e)(2) of this section.

(iii) Return of equity. The equity portion of the Medicaid-allowable transfer price shall be reimbursed in equal annual amounts beginning in the first year following the expiration of the term of the mortgages over the remaining useful facility life.

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Tuesday, December 28, 1993
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Section 86-2.22 - Movable equipment

86-2.22 Moveable Equipment.

(a) Necessary and reasonable expenses related to movable equipment (depreciation computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years-digits method, interest on indebtedness, lease, etc.) are considered allowable costs for residential health care facilities subject to such ceilings as may be established and promulgated by the Commissioner of Health.

(b) An arms length lease purchase agreement with a nonrelated lessor involving equipment entered into on or after October 23, 1992 which meets any one of the four following conditions, establishes the lease as a virtual purchase.

(1) The lease transfers title of the equipment to the lessee during the lease term.

(2) The lease contains a bargain purchase option.

(3) The lease term is at least 75 percent of the useful life of the equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the equipment.

(4) The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the equipment. Present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.

(c) If a lease is established as a virtual purchase under subdivision (b) of this section, the rental charge is includable in capital-related costs as the lesser of the annual rent or the annual costs of ownership which shall be limited to depreciation and interest. When the cost of ownership becomes less than the annual rent, the rental charge shall be includable in capital-related costs. The aggregate rental or lease costs included in capital-related costs may not exceed the costs of ownership that would have been included in capital-related costs over the useful life of the asset had the provider received legal title to the asset.

(d) If a facility enters into a sale and leaseback agreement involving equipment on or after October 23, 1992, the amounts to be included in capital-related costs are the lesser of the annual rent or the annual costs of ownership. When the cost of ownership becomes less than the annual rent, the rental charge shall be includable in capital-related costs. The aggregate rental or lease costs included in capital-related costs may not exceed the costs of ownership which shall be limited to depreciation and interest that would have been included in capital-related costs over the useful life of the asset had the provider retained legal title to the asset.

Effective Date:
Monday, October 25, 1993
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Complete

Section 86-2.23 - Research

86-2.23 Research.

(a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understanding, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

Doc Status:
Complete

Section 86-2.24 - Educational activities

86-2.24 Educational activities.

The costs of educational activities, less tuition and supporting grants, shall be included in the calculation of the basic rate, provided such activities are directly related to patient care services.

Doc Status:
Complete

Section 86-2.25 - Compensation of operators or relatives of operators

86-2.25 Compensation of operators and relatives of operators.

(a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a nonrelated employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law or regulation.

(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full-time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators the commissioner may consider the quality of care provided to patients by the facility during the year in question.

Doc Status:
Complete

Section 86-2.26 - Related organizations

86-2.26 Related organizations.

(a) A related organization shall be defined as any entity which the residential health care facility is in control of or is controlled by, either directly or indirectly, or an organization or institution whose actions or policies the facility has the power, directly or indirectly, to significantly influence or direct, or a special purpose organization, or where an association of material interest exists in an entity which supplies goods and/or services to the residential health care faculty, or any entity which is controlled directly or indirectly by the immediate family of the operator. Immediate family shall include each parent, child, spouse, brother, sister, first cousin, aunt and uncle, whether such relationship arises by reason of birth, marriage or adoption.

(b) The costs of goods and/or services furnished to a residential health care facility by a related organization are includable in the computation of the basic rate at the lower of the cost to the

related organization, or the market price of comparable goods and/or services available in the residential health care facility's region within the course of normal business operations.

(c) If the residential health care facility has incurred any costs in connection with a related organization, the final payment rate shall include the costs of such goods and/or services.

(d) A special purpose organization shall be defined as an organization which is established to conduct certain of the provider's patient-care-related or non-patient-care-related activities. The special purpose organization shall be considered to be related if:

(1) the facility controls the special purpose organization through contracts or other legal documents that allow direct authority over the organization's activities, management and policies; or

(2) the facility is, for all practical purposes, the sole beneficiary of the special organization's activities. The facility shall be considered the special purpose organization's sole beneficiary if one or more of the three following circumstances exist:

(i) a special purpose organization has solicited funds in the name of and with the expressed or implied approval of the facility, and substantially all the funds solicited by the organization were intended by the contributor or were otherwise required to be transferred to the facility or used at its discretion or direction;

(ii) the facility has transferred some of its resources to a special purpose organization, substantially all of whose resources are held for the benefit of the facility; or

(iii) the facility has assigned certain of its functions (such as the operation of a dormitory) to a special purpose organization that is operating primarily for the benefit of the facility.

Effective Date:
Wednesday, March 11, 1992
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Complete

Section 86-2.27 - Termination of service

86-2.27 Termination of service.

The Division of Health Care Financing in the Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notifications shall include a statement indicating the date of the deletion or withholding of such service and the cost impact on the residential health care facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 88-2.7 of this Subpart.

Doc Status:
Complete

Section 86-2.28 - Return on investment

86-2.28 Return on investment.

(a) For rate year 1993, in computing the allowable cost of a proprietary residential health care facility, there will be included, after subtracting for current and noncurrent time deposits and equivalents, investments and construction in progress, a reasonable return on average equity capital invested for necessary and proper operation for patient care activities of a residential health care facility and related organizations, as defined in section 86-2.26(a) of this Subpart. For purposes of this section, average equity capital shall mean the difference between total assets less total liabilities averaged over the applicable cost report period, including assets and liabilities attributable to land, plant, fixed equipment and capital improvements thereto. It shall also include the average equity capital of related organizations proportionate with the percentage of a related organization's business with the residential health care facility, as calculated in the annual report forms filed in accordance with section 86-2.2 of this Subpart.

(b) The allowable average equity capital shall be further adjusted by subtracting the equity, as that term is defined in section 86-2.21(a)(4) of this Subpart, upon which a return is calculated pursuant to section 86-2.21(e)(6) of this Subpart. The return on investment for rate year January 1, 1993 shall be computed on the basis of allowable fiscal and statistical data submitted by the facility for the fiscal year ended December 31, 1991, or other applicable cost report period used to determine the capital component of the 1993 rate, in accordance with section 86-2.21 of this Subpart. The return on investment for subsequent rate years shall be based upon the annual cost report used by the department to determine the capital component of the rate in accordance with section 86-2.21 of this Subpart. The percentage to be used in computing the return on investment shall be equal to the twenty-six week United States Treasury Bill rate in effect on the second Wednesday of September of the year prior to the rate year.

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Tuesday, December 28, 1993
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Section 86-2.29 - Payments to receivers

86-2.29 Payments to receivers.

(a) The commissioner may make noninterest-bearing payments to receivers, appointed pursuant to Public Health Law, section 2810, according to the terms set forth in this section and subject to the availability of moneys therefor.

(b) No such payments shall be made unless the commissioner reasonably anticipates that repayment shall be made prior to or upon termination of the receivership.

(c) Any such payment to a receiver shall be pursuant to a written agreement between such receiver and the commissioner. The amount of such payment shall not exceed the facility's anticipated

Medicaid revenue for a four-week period. When the commissioner is the receiver, no written agreements shall be required, but the commissioner shall comply with all other provisions of this section.

(d) A receiver may request a payment upon a showing that:

(1) there is a need for such funds based on the financial condition of the facility;

(2) there are debts that were incurred prior to the receivership, which must be paid by the receiver to assure uninterrupted patient care; or

(3) funds are not otherwise available to correct serious or life-threatening structural deficiencies other than alterations prohibited in Public Health Law, section 2810(2)(c).

(e) The criteria to be considered in determining the reasonableness of anticipating repayment by a receiver of any payment made pursuant to this section shall be:

(1) assignment to the commissioner by the receiver of anticipated revenues not less than the amount of the payment, payable upon demand by the commissioner; and

(2) a signed confession of judgment by the receiver to the commissioner for the full amount of said payment.

(f) Repayment by a receiver of any payment made pursuant to this section shall be applied to reimburse any special revenue fund appropriations made for the purposes of this section and chapter 1021 of the Laws of 1981.

Doc Status:
Complete

Section 86-2.30 - Residential health care facilities patient assessment for certified rates

86-2.30 Residential health care facilities patient assessment for certified rates. (a) For the purpose of determining reimbursement rates effective January 1, 1986 and thereafter, for governmental payments, each residential health care facility shall, on an annual basis or more often as determined by the department pursuant to this Subpart, assess all patients to determine case mix intensity using the patient review criteria and standards promulgated and published by the department (Patient Review Instrument (PRI) and instructions: patient review instrument) and specified in subdivision (i) of this section.

(b)(1) The patient review form (PRI) shall be submitted according to a written schedule determined by the department. Such written schedule shall be established by the Commissioner of Health with notice to residential health care facilities. Extension of the time for filing may be granted upon application received prior to the due date of the patient review forms and only in circumstances where the residential health care facility establishes, by documentary evidence, that t he patient review forms cannot be submitted by the due date for reasons beyond the control of the facility.

(2) Rate schedules shall not be certified by the Commissioner of Health unless residential health care facilities are in full compliance with the requirements of this section. Compliance with the assessment requirements of this section shall include, but not be limited to, the timely filing of properly certified patient review forms (PRI) which are complete and accurate. Failure of a residential health care facility to file the patient review form (PRI) pursuant to the written schedule established pursuant to this subdivision, shall subject the residential health care facility to the provisions of section 86-2.2(c) of this Subpart.

(c) The operator of a residential health care facility shall ensure:

(1) that the patient review form (PRI) is completed for all patients of the facility pursuant to subdivision (a) of this section;

(2) that the patient review form (PRI) is completed by a registered professional nurse who is qualified by experience and demonstrated competency in long-term care and who has successfully completed a training program in patient case mix assessment approved by the department to train individuals in the completion of the patient review form (PRI) for the purposes of establishing a facility's case mix financial reimbursement; and

(3) that the patient review form (PRI) is certified by the operator and the nurse assessor responsible for completion of the patient review form (PRI). (The form of the certification required shall be as prescribed in the report form provided by the department.)

(d) In order to maximize reliability and accuracy, a limited number of personnel for each residential health care facility may be responsible for completion of the patient review form (PRI) during each assessment period. The maximum number of personnel which may be responsible in each residential health care facility is as follows:

Bed size of facility Number of responsible assessors
Under 100 Two
101 to 200 Three
201 to 300 Four
301 to 400 Five
401+ Five plus one additionalassessor for eachadditional 100 beds orpart thereof.

(e)(1) The department shall monitor and review each residential health care facility's performance of its patient assessment function as described in this section through the following activities which may include, but shall not be limited to:

(i) analysis of patient case mix profiles and statistical data;

(ii) review of information provided by the residential health care facility; and

(iii) on-site inspections.

(2) The purpose of the department's monitoring and review shall be to determine whether the residential health care facility is complying with the assessment requirements contained in this section.

(3) The patient review form (PRI) and any underlying books, records, and/or documentation which formed the basis for the completion of such form shall be subject to review by the department.

(4) The department shall acknowledge, in writing, receipt of the residential health care facilities patient review forms (PRI). In the event that any information or data that the facility has submitted is inaccurate or incorrect, the facility shall correct such information or data in the following manner: the facility shall submit to the department, within five days of receipt of the department's written acknowledgement provided for in this paragraph, such corrections on a form which meets the same certification requirements as the document being corrected. Once receipt of corrected data is acknowledged in writing by the department, a residential health care facility may not correct or amend the patient review form for (PRI) or submit any additional information for the assessment period. (5) The department, in order to ensure accuracy of the patient review form (PRI), may also conduct timely on-site observations and/or interviews of patients/residents and review of their medical records. When an additional on-site review is performed by the department as a result of controverted items found during the initial on-site review, the facility shall be afforded an on-site conference prior to the conclusion of such additional on-site review. Upon completion of a department on-site review pursuant to this subdivision, the department, in order to ensure accuracy of the patient review form (PRI), shall correct, where necessary, a residential health care facility's assessment of its patient case mix intensity. The department's on-site determination shall be considered final for purposes of assessing the residential health care facility's case mix intensity for that assessment period and notwithstanding section 86-2.14 of this Subpart, the residential health care facility may not correct or amend the patient review form (PRI) or submit any additional information after department reviewers have concluded the on-site review. The residential health care facility shall be notified in writing regarding the department determination of any controverted items.

(f)(1) If the department determines pursuant to this section, that a residential health care facility is not performing its case mix intensity assessment function in a timely and/or accurate manner, as required by subdivision (b) of this section, the department shall, in writing:

(i) notify the residential health care facility;

(ii) require the residential health care facility to perform its patient case mix assessment function through written agreement with a person or entity approved by the department for the completion of the patient review form (PRI) for the purpose of establishing a residential health care facilities case mix reimbursement; and

(iii) any patient case mix assessment performed pursuant to subparagraph (ii) of this paragraph shall also be subject to department monitoring and review pursuant to this section.

(2) The department shall determine that a residential health care facility is not performing its case mix intensity assessment function in an accurate manner where there exists inaccuracies in its case mix assessment which results in a statistically significant modification of the residential health care facility's reimbursement.

(3) The cost of written agreements required by paragraph (1) of this subdivision shall not be considered an allowable cost for determining reimbursement rates pursuant to this Subpart.

(4) Certification. Operators of residential health care facilities completing the department's patient review form (PRI) through written agreement with a department approved nonresidential health care facility person or entity shall have such form certified by such person or entity in lieu of a residential health care facility registered professional nurse as required by paragraph (c)(2) of this section.

(g) Reconsiderations. (1) Any residential health care facility after one year from the date it has been notified in writing by the department that it must enter into a written agreement pursuant to paragraph (f)(1) of this section, may request, in writing, that the department rescind its withdrawal of the residential health care facility's patient case mix assessment function.

(2) The department shall not rescind its withdrawal of a residential health care facility's patient case mix assessment function unless the residential health care facility satisfies the department that the residential health care facility has the capability to comply with the requirements of the department's patient case mix assessment process which shall include the capability to accurately complete the patient review form (PRI).

(3) The department shall give written notice of its decision and shall, if negative, give a statement of the reasons for its refusal to rescind its withdrawal of the residential health care facility's patient case mix assessment function.

(4) Any residential health care facility after six months from the date it recelves a written department decision pursuant to paragraph (3) of this subdivision, may again request in writing that the department rescind its withdrawal of the residential health care facility's patient case mix assessment function.

(h) Reserved

(i) Forms

(

NOTE :

For a copy of the PRI form contact the NYS Department of Health, Division of Health Care Financing, Bureau of Financial Management and Information Support, Empire State Plaza, Room 984, Albany, New York (518) 474-1673)

NEW YORK STATE DEPARTMENT OF HEALTH

DIVISION OF HEALTH CARE FINANCING

INSTRUCTIONS: PATIENT REVIEW INSTRUMENT (PRI)

GENERAL CONCEPTS

I. USING THESE INSTRUCTIONS: These instructions and the training manual should be read before completing the PRI. These instructions should be kept with the PRIs as they are being completed. FREQUENT REFERENCE TO THE INSTRUCTIONS WILL BE NEEDED TO COMPLETE THE PRI ACCURATELY.

2. ANSWER ALL QUESTIONS: Answer all questions using the numeric codes provided. DO NOT LEAVE ANY QUESTIONS TOTALLY BLANK. UNUSED BOXES FOR A QUESTION SHOULD REMAIN BLANK. For example, Medical Record Number should be entered: / /9 /6 /2 /1 /0 /. If there are unused boxes, they should be on the left side of the number as shown in the example.

3. QUALIFIERS: Many of the PRI questions contain multiple criteria which are labeled qualifiers. All qualifiers must be met for a question to be answered yes. These qualifiers take the following forms:

o TIME PERIOD - The time period for the questions is the past four weeks, unless stated otherwise. For patients who have been in the facility less than four weeks (that is, new admissions or readmissions), use the time from admission to PRI completion as the time frame.

o FREQUENCY - The frequency specifies how often something needs to occur to meet the qualifier. For example, respiratory care needs to occur daily for four weeks or the PRI cannot be checked for this patient as receiving this care.

o DOCUMENTATION - Some of the questions require specific medical record documentation to be present. Otherwise, the question cannot be answered Ayes@ for the patient.

o EXCLUSIONS - Some of the questions specifically state to omit certain types of care or behavior when answering the question. For example, inhalators are excluded from respiratory care.

4. ACTIVITIES OF DAILY LIVING: The approach to measuring ADLs is slightly different from the other PRI questions. Measure the ADLs according to how the activity was completed 60% or more of the time during the past four weeks. Read the specific instructions for ADLs to understand the CHANGED CONDITION RULE and other details. PERFORMANCE: Measure what the patient does, rather than what the patient might be capable of doing.

5. CORRECTIONS: Cross out any responses which you wish to change and re-enter clearly to the right of the original response. Example: /3/ 4.

6. Use pen, not pencil.

INSTRUCTIONS: PRI QUESTIONS

I. ADMINISTRATIVE DATA

1. OPERATING CERTIFICATE NUMBER: Enter the 8 character identifier (7 numbers followed by the letter "N') stated on the facility's operating certificate. The last character "N" indicates Nursing Facility.

2. SOCIAL SECURITY NUMBER: Your PRIs can not be processed unless this question is accurately entered. Do not leave this question blank, do not enter zero if there is no social security number. Only use the Social Security number that has been specifically designated for the patient and not the spouse of the patient. Only use the number that has been assigned by the federal Social Security Administration. If there is no such number for a patient, a NEW SYSTEM has been developed to enable all facilities in the State to assign a unique ID number to those patients without a Social Security number. If a patient was assigned a computer generated number by the Department, that number should no longer be used. If the patient has no Social Security number, use this method: Enter the first three (3) letters of the patient's last name (starting to the far left), and then enter the six digits of the patient's date of birth. Omit the century in the birth date, which will be either a "19" or "18" as in 1930 or 1896. As an example, if a patient named Cheryl Brant has no social security number and was born on May 8, 1913, you would enter:/B/R/A/0/5/0/8/1/3 on the PRI.

3. RESIDENT IS LOCATED: Former HRF Area or Former SNF Area. This question has been revised to reflect the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). It is imperative that nursing facilities formerly deemed "dual level" complete this section properly.

4. PATIENT NAME: Enter the patient's name, last name first, in the boxes provided. Enter up to the first 10 letters of the patient's last name.

6. MEDICAL RECORD NUMBER: Enter the unique number assigned by the facility to identify each patient. It is not the Medicaid, Medicare or Social Security number unless that is the number used by the facility to identify each of its patients.

7 ROOM NUMBER: Enter the numbers and/or letters which identify the patient's room in the facility.

8. UNIT NUMBER: Enter the one or the two digit number (01-12) assigned by your facility to each nursing unit for the purpose of this data collection.

11. DATE OF INITIAL ADMISSION: Enter the month, day and year the patient (1) entered the present nursing facility. Use the date of the patient's first admission and not the most recent. If the patient were transferred from another facility, it would be an initial admission to your facility. As another example, consider a patient that was admitted to a hospital from your facility and subsequently loses bed hold. If this patient is eventually readmitted to your facility at the original level of care, use the original admission date to complete this item.

12. MEDICAID NUMBER: Enter these numbers if patient has the coverage available, whether

13. MEDICARE NUMBER: or not the coverage is being used. If not, enter only one zero in the

far right box.

14. PRIMARY PAYOR: Enter the one source of coverage which pays for most of the patient's current nursing home stay. Code "Other" only if the primary payor is not Medicaid or Medicare. (Do not code "Other" for a patient with Medicaid coverage supplemented by Medicare Part B Code Medicaid.) Medicaid pending is to be coded as "Medicaid", if there is no other primary coverage being used for the patient's present stay.

15A. REASON FOR PRI COMPLETION: Select the one reason why the PRI is being completed. Responses 3, 4, and 5 under Utilization Review have been eliminated.

REIMBURSEMENT ASSESSMENT CYCLE:

Indicate whether this assessment is being completed as a part of a full facility assessment or as part of a quality assessment cycle for new admissions only.

1. Biannual Full Facility Cycle - The data collection during which all the patients residing in the facility are assessed. These PRI assessments include patients who were assessed during your previous PRI data collection and any new admissions.

2. Quarterly New Admission Cycle - The "new admission only data collection," involving only patients who were not assessed at their present level of care during your previous full facility data collection are reviewed. This specific PRI data collection occurs three months after your full

facility PRI data collection. A new admission may be a new patient from the hospital, community or another nursing facility; or was hospitalized during your previous full facility assessment (regardless of bedhold).

15B. WAS A PRI SUBMITTED BY YOUR FACILITY FOR THIS PATIENT DURING A PREVIOUS FULL FACILITY AND/OR NEW ADMIT CYCLE: Review your facility's records to determine whether a PRI for reimbursement purposes was ever completed for this patient.

II. MEDICAL EVENTS

16. DECUBITUS LEVEL: Enter the level of skin breakdown (located at pressure points) using the qualifiers stated below:

CLARIFICATION OF ADL RESPONSES

19. EATING:

#3 ARequires continual help...@ means that the patient requires a staff person=s continual presence and help for reasons such as: patient tends to choke, has a swallowing problem, is learning to feed self, or is quite confused and forgets to eat.

#5 "Tube or parenteral feeding..." means that all food and drink is given by nursing staff through the means specified.

20. MOBILITY:

#3 AWalks with constant supervision and/or assistance...@ may be required if the patient cannot maintain balance, has a history of falls, has stress fracture potential, or is relearning to ambulate.

21. TRANSFER: Exclude transfers to bath or toilet.

#4 "Requires two people..." may be required for reasons such as: the patient is obese, has contractures, has fractures (or stress fracture potential), has attached equipment that makes transfer difficult (for example, tubes). There must be a logical medical reason why the patient needs the help of two people to transfer.

#5 "Bedfast..." may refer to a patient with acute dehydration, severe decubitus, or terminal illness.

22. TOILETING:

Definition - INCONTINENT - 60% or more of the time the patient loses control of his/her bladder or bowel functions, with or without equipment.

#1 "Continent... Requires no or intermittent supervision" and #2 "... and/or assistance" can refer to the continent patient or the incontinent patient who needs no/little help with his/her toileting equipment (for example, catheter).

#3 "Continent...Requires constant supervision/total assistance... " refers to a patient who may not be able to balance him/herself and transfer, has contractures, has fracture, is confused or is on a rehabilitation program. In addition this level refers to the patient who needs constant help with elimination/incontinence appliances (for example, colostomy, ileostomy).

#4 "Incontinent... Does not use a bathroom" refers to the patient who does not go to a toilet room, but instead may use a bedpan or continence pads. This patient may be bed bound or mentally confused to the extent that a scheduled toileting program is not beneficial.

#5 "Incontinent... Taken to a Bathroom..." refers to a patient who is on a formal toileting schedule, as documented in the medical record. This patient may be on a formal bowel and bladder rehabilitation program to regain or maintain control, or the toileting pattern is known and it is better psychologically and physically for the patient to be taken to the toilet (for example, to prevent decubiti).

A patient may have different levels of toileting capacity for bowel and bladder function. To determine the level of such a patient, note that level four and five refer to incontinence of either bladder or bowel. Thus if a patient receives the type of care described in one of these levels for either type of incontinence, enter that level.

Example 1:

A Patient needs constant assistance with a catheter (level 3) and is incontinent of bowel and is taken to the bathroom every four hours (level 5). In this instance, enter level 5 on the PRI because he is receiving the type of care described in this question for bowel incontinence.

Example 2: The patient requires intermittent supervision for bowel function (level 2) and is taken to the toilet every two hours as part of a bladder rehabilitation program. Enter level 5, as the patient is receiving this type of care for bladder incontinence.

IV. BEHAVIORS - VERBAL DISRUPTION; PHYSICAL AGGRESSION; DISRUPTIVE, INFANTILE/SOCIALLY INAPPROPRIATE BEHAVIOR; AND HALLUCINATIONS

The following qualifiers must be met:

CLARIFICATION OF RESPONSES TO BEHAVIORAL QUESTIONS

23. VERBAL DISRUPTION: Exclude verbal outbursts/expressions/utterances which do not create disruption as defined by the PRI.

24. PHYSICAL AGGRESSION: Note that the definition states "with intent for injury."

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: Note that the definition states this behavior is physical and creates disruption.

EXCLUDE the following behaviors:

o Verbal outbursts

o Social withdrawal

o Hoarding

o Paranoia

26. HALLUCINATIONS: For a "YES" response, the hallucinations must occur at least once per week during the past four weeks, in addition to meeting the other qualifiers noted above for an active treatment plan and psychiatric assessment.

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES:

o For each therapy these three types of information will be entered on the PRI; "Level", "Days" and "Time" (hour and minutes).

o For a patient not receiving a therapy at all, the "Level" will always be entered in the answer key as #1 ("does not receive"), the "Days" will be entered 0 (zero) and the "Time" will be 0 (zero).

o Use the chart on the following page to understand the qualifiers for each of the three types of information that will be entered. Whether a patient is receiving maintenance or restorative therapy will make a difference in terms of the qualifiers to be used.

SEE CHART THAT FOLLOWS FOR THE SPECIFIC QUALIFIERS.

29. MEDICATIONS

A. Monthly average number of all medications ordered: Enter the monthly average number of different medications for which physician orders were written over the course of the past six months. If the resident has been in the facility less than six months determine the monthly average number of medications ordered based on the number of months since admission. The average should include the total number of ordered medications whether or not they were administered: (PRN medications; injectables, ointments, creams, ophthalmics, short-term antibiotic regimens and over-the-counter medications, etc.)

B. Monthly average number of psychoactive medications ordered: Enter the monthly average number of psychoactive medications for which physician orders were written over the course of the past six months. If the resident has been in the facility less than six months, determine the monthly average of psychoactive medications ordered based on the number of months since admission. The average should include all ordered psychoactive medications whether or not they were actually administered.

A Apsychoactive@ mediation is defined as a medication that is intended to affect mental and/or physical processes, namely to sedate, stimulate, or otherwise change mood, thinking or behavior.

The following are classes of psychoactive medications with several examples listed in each:

VI. DIAGNOSIS

30. PRIMARY MEDICAL PROBLEM: Follow the guideline stated below when answering this question.

o NURSING TIME: The primary medical problem should be selected based on the condition that has created the most need for nursing time during the past four weeks. A review of the medical record for nursing and physician, nurse practitioner, or physician assistant notes during the past four weeks may be necessary.

o JUDGMENT: This decision may require the assessor to use her/his own professional judgment in deciding upon the primary problem.

o ICD-9 Refer to the ICD-9 Codes for Common Diagnoses attached at the end of these instructions for easy access to the most frequently used numbers. An ICD-9 code book containing the complete ICD-9 listing should be available in the nursing and/or medical records office of a facility.

o NO ICD-9 NUMBER: Enter A0" (zero) in the far right box if no ICD-9 number can be found for the patient=s primary problem (or if the patient does not have a primary medical problem). If you cannot locate the ICD-9 code for the primary medical problem, PRINT THE NAME OF THE PRIMARY MEDICAL PROBLEM in the space provided on the PRI.

o NOTE: If the patient has AIDS or HIV related illnesses, indicate this in Section II, Medical Events, Item 17F. Do not use AIDS or HIV specific ICD codes (042044). Instead, use the code of the specific problem requiring the most caregiver time. For example, for all patients for whom viral pneumonia (NOS) is the condition requiring the most caregiver time, enter 480.9. Do not enter 042.1 for patients with HIV infection.

31. QUALIFIED ASSESSOR NUMBER: The qualified assessor who is attesting to the accuracy of the assessment must sign the completed form and enter the assessor Identification Number which was assigned at an approved N.Y.S. Department of Health Training Program.

Since the PRI is completed and submitted for the purposes of a reimbursement assessment cycle, the certified assessor must have actually completed the patient assessment, utilizing medical records and/or observations or interviews of the patient. This should be indicated by checking the YES box.

38. RACE/ETHNIC GROUP:

The following definitions are to be utilized in determining race and ethnic groups:

1. WHITE: A person having origins in any of the original peoples of Europe, North Africa or the Middle East.

2. WHITE/HISPANIC: A person who meets the definition of both White and Hispanic (See Hispanic Below)

3. BLACK: A person having origins in any of the Black racial groups of Africa.

4. BLACK/HISPANIC: A person who meets the definition of both Black and Hispanic (see below).

5. ASIAN OR PACIFIC ISLANDER: A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This includes, for example, China, Japan, Korea, the Philippine Islands and Samoa.

6. ASIAN or PACIFIC ISLAND/HISPANIC: A person who meets the definition of both Asian or

Pacific Islander and Hispanic (see below).

7. AMERICAN INDIAN or ALASKAN NATIVE: A person having origins in any of the original peoples of North American and who maintains tribal affiliation or community recognition.

8. AMERICAN INDIAN or ALASKAN NATIVE/HISPANIC: A person who meets the definition of both American Indian or Alaskan Native and Hispanic (see below).

9. OTHER: Other groups not included in previous categories.

HISPANIC: A person of Puerto Rican, Mexican, Cuban, Dominican, Central or South American, or other Spanish Culture or origins.

(j) Residential health care facilities shall submit the data contained in the PRI using an electronic medium including but not limited to magnetic computer tape, floppy disk or an electronic telecommunication system consistent with the technical specifications established by the department. (1) The electronically produced data shall be accompanied by a certification statement executed by the operator or a person authorized to sign on the operator's behalf in a format provided or approved by the department.

(2) Facilities shall have an additional ten days from the time specified pursuant to subdivision (b) of this section to file the required information.

(3) Adjustments to certified rates made pursuant to section 86-2.11 of this Subpart shall be certified by the Commissioner of Health within 90 days from the date upon which a facility's rate was last certified pursuant to this Subpart or within 90 days from the latest scheduled PRI submission date pursuant to section 86-2.11 of this Subpart, whichever is later. Such ninety day time frames shall not apply in any instance where a facility has been notified that its submitted PRI data is inaccurate or incorrect pursuant to paragraph (e)(4) of this section until such data has been corrected to the satisfaction of the commissioner, or if an additional on-site review has been deemed necessary pursuant to paragraph (e)(5) of this section.

Effective Date:
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Complete

Section 86-2.31 - Recalibration

86-2.31 Recalibration.

(a) For rate years 1989, 1990 and 1991, notwithstanding any other provision of this Subpart and subject to the provisions of paragraph (1) of this subdivision, payment rates shall be adjusted in accordance with this subdivision to reflect a percentage recalibration adjustment based on the change in each facility's case mix which has been determined by the department to be due to factors other than changes in patient population or condition. Such payment rate adjustments shall be implemented utilizing the direct component of facility rates for such rate years determined in accordance with sections 86-2.10 and 86-2.11 of this Subpart.

(1) The percentage recalibration adjustment provided for in this subdivision shall neither exceed 3.035% nor be less than 0%.

(2) The percentage recalibration adjustment shall be calculated as follows for each facility:

(i) A statewide distribution of patients in each patient classification group shall be determined by utilizing the patient data for the assessment of all patients obtained in the patient assessment period March 1, 1985 through September 30, 1985 (the 1985 period) conducted pursuant to section 86-2.30 of this Subpart.

(ii) The statewide distribution of patients in each patient classification group shall be further segregated by the following length of stay (LOS) groups:

(a) less than or equal to 90 days;

(b) greater than 90 days but less than or equal to 1 year;

(c) greater than 1 year but less than or equal to 2 years;

(d) greater than 2 years but less than or equal to 3 years;

(e) greater than 3 years but less than or equal to 4 years;

(f) greater than 4 years but less than or equal to 5 years; or

(g) greater than 5 years;

(iii) A statewide average initial case mix index for each LOS group for the 1985 period shall be calculated by multiplying the initial distribution of patients in each patient classification group within each LOS group times the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the total number of patients in all patient classification groups within each LOS group.

(iv) For each facility, a 1985 distribution of patients in each patient classification group and a 1985 distribution of patients by the LOS groups specified in subparagraph (ii) of this paragraph shall be determined by utilizing the patient data for the assessment of all patients obtained in the 1985 period, conducted pursuant to section 86-2.30 of this Subpart. In the event a facility commenced operations after the patient assessment period, March 1, 1985 through September 30, 1985 (the 1985 period) but prior to January 1, 1988, or if the facility has the lesser of ten cases or twenty percent of its patients in the distributions as determined in this subparagraph for the 1985 period, or if the facility had undergone the appointment of a receiver or the establishment of a new operator subsequent to the 1985 period but prior to January 1, 1988 and had filed a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which was used in the calculation of the payment rate, the distribution of patients to be used for the purposes of this subparagraph shall be that distribution pertaining to the earliest full patient assessment period conducted pursuant to section 86-2.30 of this Subpart subsequent to the 1985 period or subsequent to the effective date of the appointment of a receiver or the change in operator (the "substituted 1985 period"), and such distribution shall be deemed the facility's "substituted 1985 distribution" of patients for the calculations in subparagraphs (vi) and (vii) of this paragraph. For purposes of this subparagraph, the only patients to be included in the distributions shall be patients that have been identified by the department as also having been included in the patient assessment period July 1, 1988 through December 31, 1988.

(v) For each facility, a 1988 distribution of patients in each patient classification group and a 1988 distribution of patients by the LOS groups specified in subparagraph (ii) of this paragraph shall be determined by utilizing the patient data obtained in the patient assessment period July 1, 1988

through December 31, 1988. For purposes of this subparagraph, the only patients to be included in the distributions shall be patients that were admitted to the facility in which they are presently residing before October 1, 1985 and have been identified by the department as also having been included in the patient assessments during the 1985 period. In the event a facility commenced operations after the patient assessment period, March 1, 1985 through September 30, 1985 (the 1985 period) but prior to January 1, 1988, or if the facility had the lesser of ten cases or twenty percent of its patients in the distributions for the 1985 period as determined pursuant to subparagraph (iv) of this paragraph, or if the facility had undergone the appointment of a receiver or the establishment of a new operator subsequent to the 1985 period but prior to January 1, 1988 and had filed a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which was used in the calculation of the payment rate, the facility's substituted 1985 period, as defined in subparagraph (iv) of this paragraph, shall be used in lieu of the 1985 period for the purposes of this subparagraph, and the only patients to be included shall be patients that were admitted to the facility in which they are presently residing before the end date of the facility's substituted 1985 period and have been identified by the department as also having been included in the patient assessments during the substituted 1985 period. (vi) A percentage increase in case mix attributable to LOS shall, for each facility, be determined as follows:

(a) A 1985 aggregate case mix index shall be determined by multiplying the facility's 1985 distribution of patients, or a substituted 1985 distribution of patients where applicable, within each LOS group, determined pursuant to subparagraph (iv) of this paragraph by the statewide average initial case mix index for each LOS group for the 1985 period, as determined pursuant to subparagraph (iii) of this paragraph, and dividing the sum of the results by the facility's total number of patients in all LOS groups, as determined pursuant to subparagraph (iv) of this paragraph.

(b) A 1988 LOS adjusted case mix index shall be determined by multiplying the facility's 1988 distribution of patients within each LOS group determined pursuant to subparagraph (v) of this paragraph by the statewide average initial case mix index for each LOS group for the 1985 period, as determined pursuant to subparagraph (iii) of this paragraph, and dividing the sum of the results by the facility's total number of patients in all LOS groups, as determined pursuant to subparagraph (v) of this paragraph.

(c) The 1985 aggregate case mix index shall be subtracted from the 1988 LOS adjusted case mix index and the result divided by the 1985 aggregate case mix index to arrive at the percentage increase in case mix attributable to LOS.

(vii) An actual percentage increase in case mix shall, for each facility, be determined as follows:

(a) A 1985 actual case mix index shall be determined by multiplying the facility's 1985 distribution of patients, or a substituted 1985 distribution of patients where applicable, in each patient classification group, as determined pursuant to subparagraph (iv) of this paragraph, by the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the facility's total number of patients in all patient classification groups, as determined pursuant to subparagraph (iv) of this paragraph.

(b) A 1988 actual case mix index shall be determined by multiplying the facility's 1988 distribution of patients in each patient classification group, as determined pursuant to subparagraph (v) of this paragraph, by the case mix index for each patient classification group as contained in Appendix

13-A herein and dividing the sum of the results by the facility's total number of patients in all patient classification groups, as determined pursuant to subparagraph (v) of this paragraph.

(c) The 1985 actual case mix index shall be subtracted from the 1988 actual case mix index and the result divided by the 1985 actual case mix index to arrive at an actual percentage increase in case mix.

(viii) Except as provided in subparagraph (ix) of this paragraph, a percentage recalibration adjustment shall be determined by annualizing the result obtained by subtracting the percentage increase in case mix attributable to LOS determined pursuant to subparagraph (vi) of this paragraph from the actual percentage increase in case mix determined pursuant to subparagraph (vii) of this paragraph.

(ix) If a facility had undergone the appointment of a receiver or the establishment of a new operator on or after January 1, 1988 but prior to January 1, 1992, and filed a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which was used in the calculation of a revised payment rate, or for new facilities who received an initial operating certificate on or after January 1, 1988 but prior to January 1, 1992, the percentage recalibration adjustment provided for in this subdivision shall be 0% for such revised rate or such new facilities.

(3) The operating portion of each residential health care facility's rate of payment, as defined pursuant to paragraph (7) of subdivision (a) of Section 86-2.10 of this Subpart, shall be reduced by a per diem recalibration adjustment which shall be determined as follows:

(i) The percentage recalibration adjustment identified in subparagraph (viii) of paragraph (2) of this subdivision shall be applied to the direct component of the rate determined in accordance with Sections 86-2.10 and 86-2.11 of this Subpart, to arrive at each facility's per diem recalibration adjustment in 1983 base year dollars.

(ii) Each facility's per diem recalibration adjustment in 1983 base year dollars shall then be trended to the rate year by the applicable roll factor as defined in paragraph (8) of subdivision (a) of Section 86-2.10 of this Subpart. (b) For rate years 1992 and thereafter, notwithstanding any other provision of this Subpart and subject to the provisions of paragraph (1) of this subdivision and subdivision (c) of this section, payment rates shall be adjusted in accordance with this subdivision to reflect a percentage recalibration adjustment based on the change in each facility's case mix which has been determined by the department to be due to factors other than changes in patient population or condition. Such payment rate adjustments shall be implemented utilizing the direct component of facility rates for such rate years determined in accordance with sections 86-2.10 and 86-2.11 of this Subpart.

(1) The percentage recalibration adjustment provided for in this subdivision shall not be less than 0% nor greater than one hundred fifty percent of the statewide weighted average percentage recalibration adjustment obtained by utilizing the facility-specific percentage recalibration adjustments as determined pursuant to this subdivision.

(2) The percentage recalibration adjustment shall be calculated as follows for each facility:

(i) A statewide distribution of patients in each patient classification group shall be determined by utilizing the patient data for the assessment of all patients obtained in the patient assessment period

March 1, 1985 through September 30, 1985 (the 1985 period) conducted pursuant to section 86-2.30 of this Subpart.

(ii) The statewide distribution of patients in each patient classification group shall be further segregated by the following length of stay (LOS) groups:

(a) less than or equal to 90 days;

(b) greater than 90 days but less than or equal to 1 year;

(c) greater than 1 year but less than or equal to 2 years;

(d) greater than 2 years but less than or equal to 3 years;

(e) greater than 3 years but less than or equal to 4 years;

(f) greater than 4 years but less than or equal to 5 years; or

(g) greater than 5 years;

(iii) A statewide average initial case mix index for each LOS group for the 1985 period shall be calculated by multiplying the initial distribution of patients in each patient classification group within each LOS group times the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the total number of patients in all patient classification groups within each LOS group.

(iv) For each facility, a 1985 distribution of patients in each patient classification group and a 1985 distribution of patients by the LOS groups specified in subparagraph (ii) of this paragraph shall be determined by utilizing the patient data for the assessment of all patients obtained in the 1985 period, conducted pursuant to section 86-2.30 of this Subpart. In the event a facility commenced operations after the patient assessment period, March 1, 1985 through September 30, 1985 (the 1985 period) but prior to January 1, 1988, or if the facility has the lesser of ten cases or twenty percent of its patients in the distributions as determined in this subparagraph for the 1985 period, or if the facility had undergone the appointment of a receiver or the establishment of a new operator subsequent to the 1985 period but prior to January 1, 1988 and had filed a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which was used in the calculation of the payment rate, the distribution of patients to be used for the purposes of this subparagraph shall be that distribution pertaining to the earliest full patient assessment period conducted pursuant to section 86-2.30 of this Subpart subsequent to the 1985 period or subsequent to the effective date of the appointment of a receiver or the change in operator (the "substituted 1985 period"), and such distribution shall be deemed the facility's "substituted 1985 distribution" of patients for the calculations in subparagraphs (vi) and (vii) of this paragraph. For purposes of this subparagraph, the only patients to be included in the dist ributions shall be patients that have been identified by the department as also having been included in the patient assessment period July 1, 1988 through December 31, 1988.

(v) For each facility, a 1988 distribution of patients in each patient classification group and a 1988 distribution of patients by the LOS groups specified in subparagraph (ii) of this paragraph shall be determined by utilizing the patient data obtained in the patient assessment period July 1, 1988 through December 31, 1988. For purposes of this subparagraph, the only patients to be included in the distributions shall be patients that were admitted to the facility in which they are presently

residing before October 1, 1985 and have been identified by the department as also having been included in the patient assessments during the 1985 period. In the event a facility commenced operations after the patient assessment period, March 1, 1985 through September 30, 1985 (the 1985 period) but prior to January 1, 1988, or if the facility had the lesser of ten cases or twenty percent of its patients in the distributions for the 1985 period as determined pursuant to subparagraph (iv) of this paragraph, or if the facility had undergone the appointment of a receiver or the establishment of a new operator subsequent to the 1985 period but prior to January 1, 1988 and had filed a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which was used in the calculation of the payment rate, the facility's substituted 1985 period, as defined in subparagraph (iv) of this paragraph, shall be used in lieu of the 1985 period for the purposes of this subparagraph, and the only patients to be included shall be patients that were admitted to the facility in which they are presently residing before the end date of the facility's substituted 1985 period and have been identified by the department as also having been included in the patient assessments during the substituted 1985 period. (vi) A percentage increase in case mix attributable to LOS shall, for each facility, be determined as follows:

(a) A 1985 aggregate case mix index shall be determined by multiplying the facility's 1985 distribution of patients, or a substituted 1985 distribution of patients where applicable, within each LOS group, determined pursuant to subparagraph (iv) of this paragraph by the statewide average initial case mix index for each LOS group for the 1985 period, as determined pursuant to subparagraph (iii) of this paragraph, and dividing the sum of the results by the facility's total number of patients in all LOS groups, as determined pursuant to subparagraph (iv) of this paragraph.

(b) A 1988 LOS adjusted case mix index shall be determined by multiplying the facility's 1988 distribution of patient within each LOS group determined pursuant to subparagraph (v) of this paragraph by the statewide average initial case mix index for each LOS group for the 1985 period, as determined pursuant to subparagraph (iii) of this paragraph, and dividing the sum of the results by the facility's total number of patients in all LOS groups, as determined pursuant to subparagraph (v) of this paragraph.

(c) The 1985 aggregate case mix index shall be subtracted from the 1988 LOS adjusted case mix index and the result divided by the 1985 aggregate case mix index to arrive at the percentage increase in case mix attributable to LOS.

(vii) An actual percentage increase in case mix shall, for each facility, be determined as follows:

(a) A 1985 actual case mix index shall be determined by multiplying the facility's 1985 distribution of patients, or a substituted 1985 distribution of patients where applicable, in each patient classification group as determined pursuant to subparagraph (iv) of this paragraph, by the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the facility's total number of patients in all patient classification groups, as determined pursuant to subparagraph (iv) of this paragraph.

(b) A 1988 actual case mix index shall be determined by multiplying the facility's 1988 distribution of patients in each patient classification group, as determined pursuant to subparagraph (v) of this paragraph, by the case mix index for each patient classification group as contained in Appendix 13-A herein and dividing the sum of the results by the facility's total number of patients in all patient classification groups, as determined pursuant to subparagraph (v) of this paragraph.

(c) The 1985 actual case mix index shall be subtracted from the 1988 actual case mix index and the result divided by the 1985 actual case mix index to arrive at an actual percentage increase in case mix.

(viii) Except as provided in subparagraph (ix) of this paragraph, a percentage recalibration adjustment shall be determined by annualizing the result obtained by subtracting the percentage increase in case mix attributable to LOS determined pursuant to subparagraph (vi) of this paragraph from the actual percentage increase in case mix determined pursuant to subparagraph (vii) of this paragraph.

(ix) If a facility undergoes the appointment of a receiver or the establishment of a new operator on or after January 1, 1992 and files a new cost report in accordance with the provisions of section 86-2.10(k) of this Subpart which is used in the calculation of a revised payment rate, or for new facilities who receive an initial operating certificate on or after January 1, 1992, the percentage recalibration adjustment provided for in this subdivision shall be 0% for such revised payment rate or for such new facilities.

(3) The operating portion of each residential health care facility's rate of payment, as defined pursuant to paragraph (7) of subdivision (a) of Section 86-2.10 of this Subpart, shall be reduced by a per diem recalibration adjustment which shall be determined as follows:

(i) The percentage recalibration adjustment identified in subparagraph (viii) of paragraph (2) of this subdivision shall be applied to the direct component of the rate determined in accordance with Sections 86-2.10 and 86-2.11 of this Subpart, to arrive at each facility's per diem recalibration adjustment in 1983 base year dollars.

(ii) Each facility's per diem recalibration adjustment in 1983 base year dollars shall then be trended to the rate year by the applicable roll factor as defined in paragraph (8) of subdivision (a) of Section 86-2.10 of this Subpart.

(c) For a residential health care facility receiving a percentage recalibration adjustment greater than zero percent, as determined in subdivision (b) of this section, the percentage recalibration adjustment may be modified as provided in this subdivision. (1) In order to be eligible for a modification, a facility shall meet all of the following conditions.

(i) A modification request shall be submitted by a facility as an appeal application and shall be submitted within the time limit set forth in section 86-2.13(a) of this Subpart.

(ii) A facility shall document that the percentage change in the facility's reported case mix index (CMI) from the annual rate period 1985 through 1988, such percentage reduced by the percentage recalibration adjustment as determined by subdivision (b) of this section, is at least ten percent. The percentage change in the facility's reported CMI, for purposes of this subparagraph, shall utilize the CMI calculated from the facility's patient data obtained during the patient assessment period, March 1, 1985 through September 30, 1985, to the patient assessment period July 1, 1988 through December 31, 1988, conducted pursuant to section 86-2.30 of this Subpart, and shall be calculated by subtracting from the reported 1988 CMI, the reported 1985 CMI and the result divided by the reported 1985 CMI.

(iii)(a) Except as provided in clause (b) of this subparagraph, a facility shall document that the percentage change in direct care cost over trend from the annual rate period 1985 through 1988, as

defined by those cost centers listed in subdivision (c) of section 86-2.10 of this Subpart, is at least ten percent. The percentage change in direct care cost over trend for purposes of this subparagraph shall be calculated by subtracting from the 1988 annual reported direct care cost, the 1985 annual reported direct care cost trended to 1988 by the applicable trend factors promulgated by the department for 1986, 1987 and 1988, and the result divided by the trended 1985 direct care cost. The annual reported direct care costs for 1985 and 1988, for purposes of this subparagraph, shall be those which the facility has submitted using the result of the single step-down method of cost allocation as defined in section 451.29 of this Title.

(b) In the event a facility's facility-specific cost based direct price per day exceeds the facility-specific ceiling direct price per day, as determined pursuant to section 86-2.10(c)(4) of this Subpart, for the annual rate period 1988, such excess percentage shall be used to determine a credit to be added to the facility's percentage change in direct care cost over trend as determined in clause (a) of this subparagraph for the purposes of meeting the required percentage change in direct care cost over trend identified in clause (a) of this subparagraph. The amount of the credit shall be equal to such excess percentage if the facility documents that its percentage change in indirect care cost over trend from the annual rate period 1985 through 1988, as defined by those cost centers listed in subdivision (d) of section 86-2.10 of this Subpart, does not exceed its percentage change in direct care cost over trend for this period, as determined in clause (a) of this subparagraph, and if the facility cannot so document, the credit identified in this clause shall be reduced (but not be less than 0%) by the extent to which the percentage change in indirect care cost over trend exceeds the percentage change in direct care cost over trend. The percentage change in indirect care cost over trend for purposes of this subparagraph shall be calculated by subtracting from the 1988 annual reported indirect care cost, the 1985 annual reported indirect care cost trended to 1988 by the applicable trend factors promulgated by the department for 1986, 1987 and 1988, and the result divided by the trended 1985 indirect care cost. The annual reported indirect care costs for 1985 and 1988, for purposes of this subparagraph, shall be those which the facility has submitted using the result of the single step-down method of cost allocation as defined in section 451.29 of this Title.

(iv) Documentation shall be included in an appeal filed by the facility to the department that supports the reasons for the direct care cost increase which shall be based on increases in staffing levels and/or range and/or types of patient services. Increased direct care cost resulting solely from an increase in the bed complement of a facility shall not constitute sufficient justification for granting a modification pursuant to this subdivision.

(2) For a facility meeting all conditions specified in paragraph (1) of this subdivision, the modified percentage recalibration adjustment shall be determined as follows.

(i) The modification to the percentage recalibration adjustment shall be determined by annualizing the result obtained by subtracting the percentage change in the facility's reported CMI reduced by the percentage recalibration adjustment, as determined in subparagraph (ii) of paragraph (1) of this subdivision, from the percentage change in direct care cost over trend, as determined in subparagraph (iii) of paragraph (1) of this subdivision. (ii) The modified percentage recalibration adjustment shall be equal to the result obtained by subtracting the modification to the percentage recalibration adjustment, as determined in subparagraph (i) of this paragraph, from the percentage recalibration adjustment identified in subparagraph (viii) of paragraph (2) of subdivision (b) of this section.

(iii) The modified percentage recalibration adjustment, as determined in subparagraph (ii) of this paragraph, shall not be less than 0%.

Effective Date:
Tuesday, December 17, 1991
Doc Status:
Complete

Section 86-2.32 - Nurse aide competency exam

86-2.32 Nurse aide competency exam.

(a) Definitions. For purposes of this section, the following definitions shall apply:

(1) Rate shall mean the aggregate governmental payment to the facility per patient day as defined in section 86-2.8 of this Subpart.

(2) Nurse aide trainee shall mean a person as defined in section 414.1(b)(8) of this Title.

(3) Nurse aide shall mean a person as defined in section 414.1(b)(7) of this Title.

(4) Program coordinator shall mean a person as defined in section 414.1(b)(26) of this Title.

(5) Primary instructor shall mean a person as defined in section 414.1(b)(27) of this Title.

(6) Clinical skills evaluator shall mean a person as defined in section 414.1(b)(28) of this Title who is qualified to administer the clinical section of the nurse aide competency exam.

(7) The competency examination shall mean the clinical skills examination and the written or oral competency examination required of nurse aides by section 2803-j of the Public Health Law.

(b) For the rate period July 2, 1989 through June 30, 1990 an amount shall be added to each residential health care facility's rate to compensate facilities for the cost of the fees charged facilities for the nurse aide competency exam.

(c) The estimated initial amount added to each residential health care facility's rate shall be determined as follows:

(1) The percentage of the number of full time equivalent (FTE) nurse aides in each facility to the number of FTE nurse aides in all residential health care facilities shall be calculated.

(2) This percentage shall be applied to the estimated number of nurse aides working in all residential health care facilities.

(3) The product shall then be multiplied by the estimated cost of testing for each nurse aide.

(4) This amount shall be divided by the number of patient days in each residential health care facility, multiplied by two and then added to the residential health care facility's rate.

(d) The department shall determine the actual cost of the examination for each facility and adjust the estimated initial amount to the actual amount in a rate no later than July 1, 1990.

(e) The costs of the fees of the clinical skills evaluator and/or the program coordinator/primary instructor shall consist of the estimated training fee multiplied by three. Each residential health care facility shall receive this estimated amount in the manner described in paragraph (4) of subdivision (c) of this section and the actual amount shall be determined and the rate adjusted not later than July 1, 1990.

Effective Date:
Tuesday, May 14, 1991
Doc Status:
Complete

Section 86-2.33 - Dementia pilot demonstration projects

86-2.33 Dementia pilot demonstration projects.

(a) Payment rates shall be adjusted by the addition of a per diem amount as determined by the commissioner pursuant to this section for residential health care facilities participating in pilot demonstration projects for the development of additional knowledge and experience in the area of dementia care and to improve the quality and treatment of patients with dementia.

(b) The adjustment to payment rates provided for in this section shall be made for qualifying residential health care facilities (RHCF's) applying for and receiving the approval of the commissioner for participation in such projects. Acceptable uses of such adjustments shall include but shall not be limited to:

(1) increasing the availability of programs and resources for dementia patients;

(2) training staff to manage behavior or promote effective care of dementia patients;

(3) arranging the environment in ways that produce positive outcomes for dementia patients; and/or

(4) maintaining and promoting autonomy and decisionmaking on the part of dementia patients.

(c) Individual facilities or groups of facilities may participate in pilot demonstration projects pursuant to this subdivision.

Doc Status:
Complete

Section 86-2.34 - Affiliation changes

86-2.34 Affiliation changes.

(a) A hospital-based residential health care facility as defined in section 86-2.10(a)(13) of this Subpart whose affiliated hospital closes its acute care beds shall notify the department within 30 days of actual complete closure of such beds. Such residential health care facility shall have its affiliation status changed to free-standing effective as of the date of actual complete closure.

(b) For purposes of establishing the allowable indirect component of the rate pursuant to subdivision (d) of section 86-2.10 of this Subpart, a hospital-based residential health care facility whose affiliation changes to free-standing under circumstances described in subdivision (a) of this section may apply to the department at the same time notice of closure is given pursuant to subdivision (a) of this section for a three year phase in of its free-standing affiliation for reimbursement purposes effective the beginning of the next calendar year following actual complete closure of its acute care beds.

(1) For the rate effective January 1 of the calendar year following actual complete closure of the affiliated hospital's acute care beds, the mean indirect price per day determined pursuant to section 86-2.10(d)(4)(i) of this Subpart shall be determined by summing the product of multiplying the mean indirect price per day of the appropriate hospital-based peer group by .75 and the product of multiplying the mean indirect price per day of the appropriate free-standing peer group by .25.

(2) For the rate effective January 1 of the second calendar year following actual complete closure of the affiliated hospital's acute care beds, the mean indirect price per day determined pursuant to section 86-2.10(d)(4)(i) of this Subpart shall be determined by summing the product of multiplying the mean indirect price per day of the appropriate hospital-based peer group by .50 and the product of multiplying the mean indirect price per day of the appropriate free-standing peer group by .50.

(3) For the rate effective January 1 of the third calendar year following actual complete closure of the affiliated hospital's acute care beds, the mean indirect price per day determined pursuant to section 86-2.10(d)(4)(i) of this Subpart shall be determined by summing the product of multiplying the mean indirect price per day of the appropriate hospital-based peer group by .25 and the product of multiplying the mean indirect price per day of the appropriate free-standing peer group by .75.

(c) For purposes of establishing the factor determined pursuant to section 86-2.12(a) of this Subpart, a hospital-based residential health care facility whose affiliation changes to free-standing under circumstances described in subdivision (a) of this section and has applied for a three-year phase-in of the free-standing indirect component pursuant to subdivision (b) of this section shall continue to be classified as hospital-based for a period of three calendar years following the actual complete closure of the affiliated hospital's acute care beds.

(d) A hospital-based residential health care facility whose affiliation changed to free-standing under the circumstances described in subdivision (a) of this section that fails to notify the department within 30 days from the date of actual complete closure of the acute care beds shall not be eligible for the provisions of subdivision (b) and subdivision (c) of this section. Such facilities shall be designated free-standing, for rate calculation purposes, pursuant to this Subpart retroactive to the date of actual complete closure of the acute care beds of the affiliated hospital.

Effective Date:
Sunday, January 1, 1989

Doc Status:
Complete

Section 86-2.36 - Scheduled short term care

86-2.36 Scheduled Short term care.

(a) Residential health care facilities which provide scheduled short term care for residents in accordance with Part 410 of this Title shall be paid a per diem rate of reimbursement for such services which is the average per diem rate of reimbursement for the facility as established pursuant to this Subpart.

(b) The requirements of Sections 86-2.11 and 86-2.30 relating to resident assessments and the submission of case mix information to the Department shall not apply to scheduled short term care in accordance with Part 410 of this Title.

Effective Date:
Wednesday, November 20, 1991
Doc Status:
Complete

Section 86-2.37 - Submission of resident assessments

86-2.37 Submission of resident assessments.

(a) Effective November 1, 1992 and thereafter, residential health care facilities shall submit to the department the data contained in the comprehensive assessment and review of assessments (quarterly reviews) required to be completed by facilities in accordance with section 415.11 of this Title and section 483.20 of 42 CFR, (Minimum Data Set Plus for Nursing Home Resident Assessment and Care Screening (MDS+)), using a telecommunications process based on electronic mail or if directed by the department, other electronic medium such as computer tape or floppy disc. This submission shall be made consistent with the department's data submission specifications for the MDS+ and shall use the department-provided submission preparation computer software when preparing the MDS+ data for transmission.

(1) Electronic submission of the MDS+ data shall occur no later than six weeks after the assessment start date which the facility indicates in section A of the MDS+ document.

(2) The electronic submissions shall include all assessments and quarterly reviews with an assessment start date of November 1, 1992 and thereafter, completed by the facilities in accordance with section 415.11 of this Title.

(b) Residential health care facilities shall reproduce the MDS+ Discharge Notification, supplied initially by the Department, in sufficient numbers and submit to the department the data contained

therein for each resident when the resident is permanently discharged from the facility. The facility shall submit such data within four weeks of discharge using a telecommunications process based on electronic mail or, if directed by the department, other electronic medium such as computer tape or floppy disc.

Effective Date:
Monday, December 20, 1993
Doc Status:
Complete

Section 86-2.38 - Nursing home incentive payment

86-2.38 Nursing home incentive payment. (a) The commissioner shall make rate adjustments, subject to the availability of funds therefore, to certain residential health care facilities who demonstrate to the satisfaction of the commissioner that they can meet or exceed defined quality measures.

(b) Initial awards shall be based on a residential health care facility's performance for pressure ulcer quality of care for chronic care residents.

(c) The commissioner shall make two sets of awards as follows:

(1) An award shall be made for the best performers for the evaluation period;

(2) An award shall be made to residential health care facilities with the best improvement in pressure ulcer care between a base and evaluation period except that facilities in the bottom quarter percentile of all eligible residential health care facilities for this evaluation period shall not be eligible for such an award if, even after their improvement in pressure ulcer care, they still remain in the bottom quarter percentile of all eligible residential health care facilities; and

(3) Residential health care facilities that qualify are eligible to receive an award in both categories of awards.

(d)(1) The evaluation period for the award for best performers shall be January 1, 2007 through December 31, 2007.

(2) The base period for the award for best improvement shall be July 1, 2006 through June 30, 2007, which shall be compared to the period July 1, 2007 through June 30, 2008.

(e) The following factors shall be considered by the commissioner in making awards pursuant to this section:

(1) The quality measure of pressure ulcer care shall be risk adjusted using such patient health factors to include but not be limited to: coma, malnutrition, diseases and conditions related to pressure ulcer, low body mass index, and plegia (paraplegia or hemiplegia);

(2) Pressure ulcer rates shall be considered only for chronic care residential health care facility residents;

(3) In order to be eligible to be considered for a rate enhancement, a residential health care facility must have averaged more than one prevented pressure ulcer per quarter of the evaluation period identified in subdivision (d) of this section as calculated by comparing the actual number of residents with a pressure ulcer to the expected number of residents with a pressure ulcer, based on the facility's risk adjusted pressure ulcer rate developed pursuant to this subdivision; and

(4) Any residential health care facility receiving a written deficiency for substandard quality of care, as defined in federal regulation 42 C.F.R. §488. 301, during the evaluation periods contained in this section shall be excluded from receiving an award under this section.

(f) Rate adjustments made pursuant to this section for residential health care facilities receiving monetary awards shall be made based on the residential health care facility's percent of patient days of care attributable to patients eligible for medical assistance pursuant to title eleven of article five of the social services law.

(g) Residential health care facilities chosen to receive rate enhancements pursuant to this section shall, prior to the rate enhancement, inform the commissioner in writing as to their proposed use of the additional monies to further improve quality and care of patients in the residential health care facility.

Effective Date:
Wednesday, April 23, 2008
Doc Status:
Complete

Section 86-2.39 - Closures, mergers, acquisitions, consolidations and restructurings

86-2.39 Closures, mergers, acquisitions, consolidations and restructurings. (a) The commissioner may grant approval of a temporary adjustment to the non-capital components of rates calculated pursuant to this subpart for eligible residential health care facilities.

(b) Eligible facilities shall include:

(1) facilities undergoing closure;

(2) facilities impacted by the closure of other health care facilities;

(3) facilities subject to mergers, acquisitions, consolidations or restructuring; or

(4) facilities impacted by the merger, acquisition, consolidation or restructuring of other health care facilities.

(c) Facilities seeking rate adjustments under this section shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

(1) protect or enhance access to care;

(2) protect or enhance quality of care;

(3) improve the cost effectiveness of the delivery of health care services; or

(4) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(d) (1) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment and shall include a proposed budget to achieve the goals of the proposal. Any temporary rate adjustment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the specified timeframe, the facility shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and this Subpart. The commissioner may establish, as a condition of receiving such a temporary rate adjustment, benchmarks and goals to be achieved in conformity with the facility's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment prior to the end of the specified timeframe.

(2) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

Effective Date:
Tuesday, July 3, 2012
Doc Status:
Complete

Section 86-2.35 - Reserved

Section 86-2.40 - Statewide prices for non-capital reimbursement.

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)**
	$105.79	**$52.90**	**$117.48**	**$58.74**	**$111.63**

January 1, 2012					
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÷ ((Facility Specific Wage Ratio÷ Wage Index) + 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÷((Regional Wage Ratio÷Regional Wage Index)+ 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**
	$56.18	**$28.09**	**$65.04**	**$32.52**	**$60.61**

January 1, 2013					
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÷((Facility Specific Wage Ratio÷Wage Index)+ 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÷((Regional Wage Ratio÷Region Wage Index)+ 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.

(iv) Effective 4/1/2016 a neurodegenerative specialty rate shall be established for Huntington’s disease and amyotrophic lateral sclerosis. The rate shall be based on budgeted cost 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).

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Wednesday, November 2, 2016
Doc Status:
Complete
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Public Health Law, Section 2808(2-c)

Section 86-2.41 - Sprinkler systems

86-2.41 Sprinkler systems

(a) Subject to the availability of federal financial participation, the capital cost components of the rates of eligible residential health care facilities for periods on and after the effective date of this regulation shall be adjusted in accordance with the following:

(1) For the purposes of this section, eligible facilities are those facilities which the commissioner determines are financially distressed in terms of their being unable to finance, at terms acceptable to the commissioner, the installation of automatic sprinkler systems, in conformity with the provisions of federal regulations set forth in 42 CFR 483.70(a)(8). In making such determinations of eligibility the commissioner shall consider information obtained from a facility's cost report, other more recent financial information to be provided by the facility, and such other information as may be required by the commissioner, including, but not limited to:

(i) operating profits and losses;

(ii) eligibility for funding pursuant to subdivision twenty-one of section 2808 of the Public Health Law;

(iii) unrestricted fund balances;

(iv) documentation demonstrating the inability of the facility to obtain credit, at terms acceptable to the commissioner, without the reimbursement treatment accorded pursuant to this section;

(v) working capital;

(vi) days of cash expense on hand;

(vii) days of revenue in accounts receivable;

(viii) transfers and withdrawals;

(ix) information related to the health and safety of a facility's residents;

(x) other financial information as may be required from the facility by the commissioner; and

(xi) the filing of a Notice pursuant to Subdivision 1-a of Section 2802 of the Public Health Law, or the receipt of required CON approvals, as appropriate.

(2) The capital cost component of the Medicaid rates of each eligible facility shall be adjusted in an amount, as determined by the commissioner, to reflect the costs of the annual debt service related to the financing of equipment and other capital improvements directly related to the financing of an automatic sprinkler system that will be in compliance with applicable federal regulations.

(3) As a condition for receipt of funding pursuant to this section, each eligible facility shall submit to the commissioner the costs of the project, the proposed terms of the financing, including interest rate and term of the financing, and a schedule setting forth by month the estimated debt service payable over the life of the financing. Such schedule, along with such other information as may be required by the commissioner, shall be provided to the commissioner for review and approval at least sixty days prior to the due date of such first debt service payment, or such shorter period as the commissioner may permit.

(4) As a condition for receipt of funding pursuant to this section, Medicaid revenues attributable to the rate adjustments authorized by this section and any other additional facility revenues needed to cover scheduled debt service payments relating to the financing of an automatic sprinkler system that is in compliance with federal regulation as described in this section, shall be deposited into a separate account maintained by the facility and the deposits in such account shall be used solely for the purpose of satisfying such debt service payments.

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Wednesday, January 2, 2013
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Complete

Section 86-2.42 - Residential health care facility quality pool

86-2.42 Residential health care facility quality pool.

(a) For the calendar year 2013 and thereafter, the Commissioner shall establish a residential health care facility quality pool for the purpose of making quality incentive payments to facilities meeting the criteria set forth in this section. In furtherance of such payments the Commissioner shall calculate a quality score for each non-specialty residential health care facility. For the purposes of calculating such score, the Commissioner shall exclude non-Medicaid facilities, CMS Special Focus facilities, Continuing Care Retirement facilities, Transitional Care Units, and other specialty facilities and specialty units within facilities. Specialty facility shall mean: AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children. The quality score for each non-specialty facility shall be calculated using the following measurements as defined in this section:

(1) quality;

(2) compliance;

(3) potentially avoidable hospitalizations;

(4) rate adjustments to fund quality pool;

(5) facilities not eligible for 2013 payments;

(6) per diem transition adjustments;

(7) per diem reduction;

(8) other provisions.

(b) Quality. (1) The maximum points a facility may be awarded pursuant to this component is 60 points. For each facility each quality measure assigned to the first quintile shall be awarded 4.29 points; each quality measure assigned to the second quintile shall be awarded 2.57 points; each quality measure assigned to the third quintile shall be awarded 0.86 points; and zero points shall be awarded to each quality measure assigned to the fourth and fifth quintiles. All non-specialty facilities subject to this section shall be evaluated and comparatively ranked and grouped into quintiles with regard to each of the following 14 quality measures:

(i) Percent of long stay high risk residents with pressure ulcers, subject to risk adjustments as determined by the Commissioner;

(ii) Percent of long stay residents assessed and appropriately given the pneumococcal vaccine, provided that for the purposes of a facility's quality score, maximum (4.29) points shall be awarded if the rate of appropriate vaccination is 85% or greater and zero points if the rate is less than 85% rather than assignment to a quintile;

(iii) Percent of long stay residents assessed and appropriately given the seasonal flu vaccine, provided that for the purposes of a facility's quality score, maximum (4.29) points shall be awarded if the rate of appropriate vaccination is 85% or greater and zero points if the rate is less than 85% rather than assignment to a quintile;

(iv) Percent of long stay residents experiencing one or more falls with major injury;

(v) Percent of long stay residents who have depressive symptoms;

(vi) Percent of low risk long stay residents who lose control of their bowels or bladder;

(vii) Percent of long stay residents who lose too much weight, subject to risk adjustments as determined by the Commissioner;

(viii) Percent of long stay residents who received an antipsychotic medication, subject to risk adjustments as determined by the Commissioner;

(ix) Percent of long stay residents who self-report moderate to severe pain, subject to risk adjustments as determined by the Commissioner;

(x) Percent of long stay residents whose need for help with daily activities has increased;

(xi) Percent of long stay residents with a urinary tract infection;

(xii) Percent of employees vaccinated for influenza;

(xiii) Annual percent level of temporary contract staff;

(xiv) CMS five-star rating for staffing.

(2) When a facility's rate is risk adjusted, the expected rate is the rate the facility would have had if the facility's patient mix was identical to the patient mix of the state. The expected rate is determined through the risk-adjusted model. The facility-specific, risk-adjusted rate is the ratio of observed to expected measure rates multiplied by the overall statewide measure rate. For the Percent of long stay residents who self-report moderate to severe pain, DOH follows the CMS risk adjustment methodology found in the Minimum Data Set (MDS) 3.0 Quality Measures User's Manual, Appendix A-1. The remaining two risk adjusted quality measures follow a methodology developed by DOH.

(3) Redistribution of Quality Points: Due to limitations of the nursing home cost reports, DOH cannot accurately calculate the Annual Percent Level of Temporary Contract Staff for certain facilities. In these cases, this measure will be suppressed and the quality points will be redistributed to the remaining quality measures.

(4) Superstorm Sandy had an impact on some facilities' ability to immunize their healthcare workers. For these facilities, the Percent of Employees Vaccinated for Influenza measure will be suppressed if the suppression results in a higher overall score for the facility affected. In this case, the quality points will be redistributed across the remaining quality measures.

(5) For quality measures with a denominator of less than 30, the measure will be suppressed and the quality points will be redistributed to the remaining quality measures.

(6) Facilities with a missing CMS Five-Star Rating for Staffing will have this measure suppressed and the quality points redistributed to the remaining quality measures.

(c) Compliance. (1) The maximum points a facility may receive for the compliance component is twenty points. Points shall be awarded as follows:

(i) For the CMS Five-Star Ratings for Health Inspections, facilities that receive five stars shall be awarded ten points; facilities that receive four stars shall be awarded seven points; facilities that receive three stars shall be awarded four points; facilities that receive two stars shall be awarded two points; facilities that receive one star shall be awarded zero points;

(ii) Facilities that timely submit a certified and complete cost report shall receive five points, provided that facilities that fail to timely submit a cost report will receive zero points;

(iii) Facilities that timely submit employee influenza immunization data shall receive five points, provided that facilities that fail to timely submit flu immunization data will receive zero points.

(2) Superstorm Sandy had an impact on some facilities' ability to submit their employee immunization data by the designated deadline. Facilities that do not submit timely employee flu

immunization data due to Superstorm Sandy will not be penalized. In these cases, the points will be redistributed to the timely submission of nursing home certified cost reports measure. This measure will be worth 10 points instead of five.

(3) Facilities with a missing CMS Five-Star Rating for Health Inspections will have compliance points redistributed to the remaining timely submission measures. In these cases each measure will be worth 10 points.

(d) Potentially avoidable hospitalizations component. (1) The maximum points a facility may receive for the potentially avoidable hospitalizations component is twenty points. The rates of potentially avoidable hospitalizations shall be determined for each facility and facilities shall be ranked and grouped into quintiles with twenty points awarded to facilities in the first quintile; sixteen points awarded to facilities in the second quintile; twelve points awarded to facilities in the third quintile; four points awarded to facilities in the fourth quintile; and zero points awarded to facilities in the fifth quintile.

(2) The Potentially Avoidable Hospitalizations measure is subject to risk adjustments as determined by the Commissioner;

(3) A potentially avoidable hospitalization is found by matching a discharge assessment in the MDS 3.0 data to its hospital record in the Statewide Planning and Research Cooperative System (SPARCS). The following admitting six conditions on the SPARCS hospital record are potentially avoidable: sepsis, urinary tract infection, respiratory infection, congestive heart failure, anemia, and electrolyte imbalance.

(e) The following rate adjustments, which shall be applicable to the 2013 calendar year, shall be made to fund the quality pool and to make quality payments based upon the scores calculated as described above.

(1) Specialty facilities are excluded from the Quality Pool. Specialty facility shall mean: AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children.

(2) Each non-specialty facility shall be subject to a negative per diem adjustment to fund the quality pool. Non-specialty shall mean all other facilities not defined as a specialty facility. The negative per diem adjustment shall be calculated as follows:

(i) For each such facility, Medicaid revenues, calculated by multiplying each facility's promulgated rate in effect for such period by reported Medicaid days, as reported in a facility's 2012 cost report, will be divided by total Medicaid revenues of all non-specialty facilities. The result will be multiplied by the $50 million dollars, and divided by each facility's most recently reported Medicaid days. If a facility fails to submit a timely filed 2012 cost report, the previous year's cost report will be used.

(ii) The total quality scores as calculated above for each such facility shall be ranked and grouped by quintile. Each of the top three quintiles shall be allocated a share of the $50 million quality pool

and each such facility within such top three quintiles shall receive a quality payment. Such quality payment shall be paid as a per diem adjustment for the 2013 calendar year. Such shares and payments shall be calculated as follows:

Distribution of Quality Pool and Quality Payments			
Facilities Grouped by Quintile	A Facility's Medicaid Revenue Multiplied by Award Factor	B Share of $50 Million Quality Pool Allocated to Facility	C Facility Per Diem Quality Payment
1st Quintile	Each facility's 2012 Medicaid days multiplied by 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by an award factor of 3	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's 2012 Medicaid days
2nd Quintile	Each facility's 2012 Medicaid days multiplied by 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by an award factor of 2.25	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's 2012 Medicaid days
3rd Quintile	Each facility's 2012 Medicaid days multiplied by 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by an award factor of 1.5	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's 2012 Medicaid days

Total	Sum of Total Medicaid Revenue for all facilities	Sum of quality pool funds: $50 million	--

(f) The following facilities shall not be eligible for 2013 quality payments and the scores of such facilities shall not be included in determining the share of the quality pool or facility quality payments:

(i) A facility with health inspection survey deficiency data showing a level J/K/L deficiency during the measurement year (2012) or the payment year (2013) up until and including June 30, 2013. Deficiencies will be reassessed on October 1, 2013 to allow a three-month window (after the June 30, 2013 cutoff date) for potential Informal Dispute Resolutions (IDR) to process. The deficiency data will be updated to reflect IDRs occurring between July 1, 2013 and September 30, 2013. Any new J/K/L deficiencies between July 1, 2013 and September 30, 2013 will not be included in the 2013 quality pool.

(g) Per Diem Transition Adjustments. (1) Over the five-year period beginning January 1, 2012, and ending December 31, 2016, non-specialty facilities shall be eligible for per diem transition rate adjustments, calculated as follows:

(i) In each year for each non-specialty 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 non-specialty facility's July 7, 2011, rate (as transmitted in the Department's Dear Administrator Letter (DAL) dated November 9, 2011) and not subject to 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 June 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 non-specialty facility's Medicaid revenue, calculated by summing the direct component, indirect component, non-comparable components of the price in effect for each non-specialty facility on January 1, 2012, and multiplying such total by the non-specialty facility's 2010 Medicaid days or the most recently available Medicaid days as of October 24, 2011.

(iii) A non-specialty facility's Medicaid revenue calculated by multiplying the non-specialty facility's July 7, 2011, rate (as communicated to facilities by Department letter dated November 9, 2011) by the non-specialty facility's 2010 Medicaid days or the most recently available Medicaid days as of October 24, 2011, and deemed not subject to subsequent reconciliation or adjustment. The Medicaid days used in the calculation provided for in subparagraphs (ii) and (iii) of this paragraph shall be identical.

(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 six, the prices calculated in this section shall not be subject to per diem transition rate adjustments.

(v) Non-specialty 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.

(h) Qualified facilities shall be subject to a per diem reduction in accordance with this subdivision. Qualified facilities are residential health care facilities other than those facilities or units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children.

(1) Effective January 1, 2013, all qualified residential health care facilities will be subject to a per diem adjustment that is calculated to reduce Medicaid payments by $24 million for the period January 1, 2013 through March 31, 2013.

(2) Effective April 1, 2013, all qualified residential health care facilities will be subject to a per diem adjustment that is calculated to reduce Medicaid payments by $19 million for each state fiscal year beginning April 1, 2013.

(3) An interim per diem adjustment for each facility will be calculated as follows:

(i) For each such facility, Medicaid revenues, calculated by multiplying each facility's promulgated rate in effect for such period by reported Medicaid days as reported in a facility's most recently available cost report, will be divided by total Medicaid revenues of all qualified facilities. The result will be multiplied by the amount of savings identified above for each such fiscal year, and divided by each facility's most recently reported Medicaid days.

(ii) Following the close of each fiscal year, the interim per diem adjustment effective January 1, 2013 through March 31, 2013, and April 1, 2013 through March 31, 2014 and in each state fiscal year thereafter will be reconciled using actual Medicaid claims data to determine the actual combined savings from the per diem adjustment and from the reduction in the payment for reserve bed days for hospitalizations from 95% to 50% of the Medicaid rate for such fiscal year. To the extent that such interim savings is greater than or less than $40 million, the per diem adjustment for each eligible provider in effect during such prior fiscal year will be adjusted proportionately such that $40 million in savings is achieved.

(i) Other provisions.

(1) The appointment of a receiver, the establishment of a new operator, or the replacement or renovation of an existing facility on or after January 1, 2012, shall not result in a revision to the operating component 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.

Effective Date:
Friday, June 16, 2017
Statutory Authority:

Public Health Law, Section 2808(2-c)(d) and Section 95 of Part H of Chapter 59 of the Laws of 2011