STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

December 8, 2008

Subject: 2009 Initial Rates

Dear Administrator:

This letter provides formal notice that the initial Medicaid rates for your facility effective for the period January 1, 2009 through December 31, 2009 ("Initial 2009 Medicaid Rates") are now available on the Health Provider Network (HPN). The rate is an all-inclusive rate for health care services provided at your facility. The rate reflects the rebasing provisions implemented by Chapter 109 of the Laws of 2006 (NYS) and made effective January 1, 2009. These provisions and the associated rate computations are described below. Please see the end of this letter for additional detailed information on how to obtain assistance in understanding the computation of your initial 2009 rates.

The 2009 Medicaid rate methodology continues to employ a modified pricing system, which combines the aspects of a pure pricing system with the principles of a cost-based system. The direct and indirect components of the rate utilize portions of both systems, by comparing a facility's allowable operating costs to a base (minimum) and ceiling (maximum) price. The facility receives the higher of the base price or its cost up to the ceiling price.

IMPORTANT DATES

The following schedule provides important dates regarding Hotline and appeal filing dates which includes the filing of revised cost reports for both the operating and capital components of the 2009 rate.

Important Dates	
Deadline for filing a 2009 Hotline Appeal. Includes the filing of **certified 2007 Cost Reports** for 2009 capital issues.	January 15, 2009 Using the current appeal forms DOH-2466 First Attachment
Deadline for filing appeals to the 2009 Initial Rate. Includes the filing of **certified 2002 Cost Reports** for calculating the operating component of a facility's 2009 rate. Includes the filing of **certified 'off year' Cost Reports** for facilities with a 2009 rate based on a cost report subsequent to 2002 for calculating the operating component of a facility's 2009 rate. Includes the filing of **certified 2007 Cost Reports** for 2009 capital issues.	April 15, 2009 Using the new electronic appeals submission system (see **2009 Rate Appeals** for additional information)

REBASING PROVISIONS

The following information provides a summary of the rate setting methodology for the initial 2009 rates.

- ✓ ***Updating the base year:*** Effective January 1, 2009, the basis for the operating component of the rate (the sum of direct, indirect and non-comparable components) is the 2002 base year allowable costs from the 2002 cost report adjusted for inflation. The operating component of the rate for facilities which currently have a rebased rate which utilizes a cost report subsequent to 2002 are based on the allowable costs from the applicable base year cost report adjusted for inflation. (PHL §2808 2-b(b)(i)).

    - o Allowable operating costs from the 2002 cost report are used to calculate the direct, indirect and non-comparable components of the rate. The allowable operating costs for facilities with rates based on a base year that is subsequent to 2002 have been down trended from the base period to 2002 using the applicable Consumer Price Index (CPI) for the period. The base year costs for all facilities, 2002 or applicable down trended base costs, have been trended forward by the CPI (adjusted for Legislative amendments for the period 2003-2009 (see ***Trend Factor*** for additional details).

- ✓ ***Hold Harmless Provisions:*** Facilities which do not benefit from the use of the 2002 base year or subsequent base year are held harmless and receive their 2008 operating rate trended to 2009. In addition, the 2008 rate will not be lowered by the value of the productivity and efficiency expenditures as provide by PHL §2808 2-2(b)(i). The 2008 rate used in the hold harmless comparison for the initial 2009 rate contains the full 2008 trend factor of 2.3 percent. Pursuant to statute the 2008 rate will be adjusted to reflect the thirty-five (35) percent trend factor reduction effective April 1, 2008, therefore the hold harmless comparison will be re-calculated using the adjusted 2008 trend factor of 1.5 percent, in the 2008 rate, prior to the publishing of the 2009 rates for reimbursement.

- ✓ ***Real Property Taxes and Payment in Lieu of Taxes (PILOT):*** Effective January 1, 2009, the capital component of the rate reflects property taxes and/or payments in lieu of property taxes reported in the facility's cost report two years prior to the rate year. Real Estate costs reflected in the operating component will be eliminated (PHL §2808 2-b(b)(i)).

    - o The capital component of the rate is computed to reflect the full value, after application of the appropriate traceback percentage, of real estate taxes and payments made in lieu of real estate taxes as reported in the 2007 RHCF-4 cost report or other such report used as the basis to establish the real property component of the 2009 rate.

✓ ***Adjustments to the Direct Component of the Operating Component:*** The direct component of the 2009 rate is subject to case mix adjustment through the application of the relative resource utilization groups system of patient classification (RUG-III) employed by the Federal Government with regard to payments to skilled nursing facilities pursuant to Title XVIII of the Federal Social Security Act (Medicare). (See the Minimum Data Set section for additional details). The direct component of the 2009 rate, the higher of the base price or facility cost up to the ceiling price is adjusted by the percentage change in case mix from the base period case mix, 2002 or subsequent base period, to the 2009 rate year case mix. For the initial 2009 rates the 2006 Minimum Data Set (MDS) data is used as a temporary proxy for the case mix adjustment for the January 2009 MDS data. Pursuant to statute, the January 2009 MDS data will retroactively replace the 2006 MDS data for case mix adjustment when it becomes available for processing in the first half of 2009.

The direct operating component includes allowable therapy costs and associated overhead costs. Administrative overhead costs related to Pharmacy Services, the costs of non-prescription drugs, supplies and associated overhead is reflected in the non-comparable component of the rate (PHL §2808 2-b(b)(v)).

- Overhead expenses from the relevant indirect cost accounts are reallocated to the physical, occupational, and speech therapy direct cost accounts. The basis of the allocation is determined by the costs and statistics from a facility's base year cost report. For example, net square feet is the statistic (Exhibit J of the RHCF-4) associated with Plant Maintenance. Five hundred net square feet of a facility's 50,000 net square feet is allocated to the physical therapy department, or one percent of the total net square feet. Thus, one percent of the plant maintenance allowable cost, net of all associated adjustments and allocations, is the overhead amount allocated from the plant maintenance account to the physical therapy account.
- The method to allocate fiscal and administrative service cost accounts, which do not have an associated statistic as reported on Exhibit H of the RHCF-4, is explained by the following example. Assume total reported physical therapy cost less associated capital is $200,000. The total reported facility costs, less capital as identified on line 001, 002 and 003 of Exhibit H are $16,000,000. Finding the percentage of therapy cost to total is

  $$\$200,000 / \$16,000,000 = 1.25\ \%$$

  Thus, 1.25% of allowable fiscal and administrative costs, net of all associated adjustments and reallocations, is the overhead amount allocated to the physical therapy account. The administrative services overhead applicable to the pharmacy account is similarly calculated and reimbursed as a portion of the non-comparable component.
- The cost for medicine cabinet drugs, as reported on Schedule 6 of the RHCF-4, is used to determine the amount of non-prescription drugs which is reimbursed through the non-comparable component of the rate.

✓ ***Peer Group Ceilings:*** For the purpose of computing peer group cost ceilings for both the direct and indirect components of the operating component of the rate, facilities are grouped by the following peer groups (PHL §2808 2-b(b)(vi)):

- Free-standing facilities with less than 300 certified beds
- Free-standing facilities with 300 or more certified beds
- Hospital-based facilities

In addition, peer group ceilings for both the direct and indirect components of the operating component of the rate are calculated for the following specialty unit/facilities:

- Discrete AIDS
- Ventilator Dependent
- Traumatic Brain Injury
- Behavioral Intervention

Pediatric specialty unit/facilities continue to be exempt from peer group ceiling adjustments.

✓ ***Ceiling adjustment for all public facilities, and non-public facilities with fewer than 80 beds:*** Public facilities, and non-public facilities with fewer than 80 certified beds, which have direct or indirect costs over the ceiling receive a rate add-on of 50% of the difference between the facility specific direct (or indirect) cost per day and the direct (or indirect) ceiling cost per day (PHL §2808 2-b(b)(xi)).

✓ ***Corridors for each Direct and Indirect Statewide Mean Price:*** Pursuant to statute (PHL §2808 2-b(b)(vii)) the methodology to establish corridors around each statewide direct and indirect mean price is to:

- Establish a base that is no less than 85 percent and no greater than 90 percent of each mean direct and indirect price
- Establish a ceiling that is no greater than 115 percent of and no less than 110 percent of each mean direct and indirect price
- Realize a total financial impact of the application of the ceiling that is substantially equal to the total financial impact of the application of the base

The corridors established for the initial 2009 rates **do not meet** the financial impact requirements as outlined above and will therefore be adjusted to meet the financial impact as required by statute prior to publishing the 2009 rates for reimbursement.

✓ ***2009 Per Diem Add-ons and applicable base year allowable cost adjustments:*** The operating component of the rate is adjusted to reflect per diem add-ons of:

- $8.00 per day trended from 2006 to 2009 (and thereafter) for each resident using the relevant MDS data:
  - qualifies under **both** the RUG-III impaired cognition **and** the behavioral problems categories **or**
  - has been diagnosed with Alzheimer's disease or dementia , **and** is classified in the RUG-III reduced physical functions A, B, or C categories, **or** is classified in the RUG-III behavioral problems A or B categories; **and** has an activities of daily living index score of ten or less. (PHL §2808 2-b(b)(viii))

- $17.00 per day trended from 2006 to 2009 (and thereafter) for each resident whose Body Mass Index (BMI), using the relevant MDS data, is greater than thirty-five (35). (PHL §2808 2-b(b)(ix). Residents with a BMI greater than 35 have been identified using the weight and height data from the relevant MDS data. The Department is employing the formula used by the National Institute of Health to calculate a resident's BMI:

  Weight-lbs / (Height-inches [squared]) x703

  Because of reporting problems with the weight and height data used to calculate a resident's BMI the Department has imposed the following limits to more accurately identify residents who qualify for the BMI adjustment:

  - Height must equal at least 48 inches
  - Weight cannot be greater than 825 lbs.
  - Calculated BMI must be greater than 35 AND less than 100

- $35.41 per day ($25.00 trended from 1996 to 2006) trended from 2006 to 2009 (and thereafter) for each resident identified as Traumatic Brain Injury – Extended Care (TBI-Extended Care) (PHL §2808 2-b(b)(iii). TBI-Extended Care Residents have been identified by matching the applicable year Patient Review Instrument (PRI) data submitted by each facility.

An adjustment to remove the cost of residents eligible for the enhanced reimbursement add-ons identified above was made to the applicable base year cost to prevent duplicate reimbursement.

✓ ***Hepatitis B Vaccine:*** Pursuant to statute (PHL §2808 2-b(b)(iii)) the operating component of the rate is adjusted for the costs of Hepatitis B vaccination. The Hepatitis B vaccination adjustment **is not** included in the initial 2009 rates. The Hepatitis B vaccination adjustment will be calculated as required by statute and included in the 2009 rates prior to publishing for reimbursement.

- ✓ ***Wage Equalization Factor (WEF):*** The WEF is utilized to compensate for wage differential in various regions across the State.
  - Effective 1/1/09 the WEF has been calculated based on employee compensation as reported in the 2002 and/or subsequent 2002 base year RHCF-4 cost report.
  - The WEF calculation includes salaries and fringe benefits for Register Nurses (RNs), Licensed Professional Nurses (LPNs), Certified Nursing Aides (Aides), Therapists, and Therapist Aides
  - The regional corridors are established pursuant to statute and adhere to a statewide value of ten (10) percent.

- ✓ ***Part B and Part D adjustments:*** The Part B and Part D offset amounts in the 2009 initial rates are a continuation of the amounts from your facility's 2008 rate. **The Department will calculation revised Part B and Part D offset per diems prior to publication of the 2009 rates for reimbursement.**

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

	2003 Final CPI	*2004 Final CPI*	*2005 Final CPI*	*2006 Final CPI*	*2007 Final CPI*	*2008 Initial CPI*	*2009 Initial CPI*
CPI	2.30	2.70	3.40	3.20	2.80	2.30	3.10
CPI w/Legislative Amendments	2.30	2.70	3.40	2.95	2.10	1.50	2.10

- ✓ ***Capital Rates-RHCF-4 Filers:*** The January 1, 2009 rates continue to reflect a capital system (which was implemented with the January 1, 2006 rates) that is designed to automate the annual calculation of the capital component for RHCF-4 filers. The automated capital system uses the data reported in the 2007 RHCF-4 cost report, in conjunction with a database developed to include the prior approved mortgages for all facilities and the historical cost / capital model data for proprietary facilities. As a result of this automation effort, incorrect or inconsistent data in the facility cost report submission may have resulted in the disallowance of certain otherwise allowable costs. In particular, depreciation and movable equipment rentals should be reviewed in conjunction with your cost report submission, to determine if there are reporting errors that need to be corrected through a cost report submission. Facilities should also review their cost report Schedule 17 for possible resubmission to properly report the current allowable mortgage information including principal, term, interest rate and amortization schedule.

Effective with the January 1, 2005 rates and continuing for 2009, traceback percentages used in the calculation of allowable capital costs on Schedule VI of the rate

sheet will use the stepdown traceback percentage from the RHCF-4 cost report being used for that rate year.

In accordance with Part 86-2.2(f) of the Commissioner's Administrative Rules and Regulations (CARR), lack of respective certifications by both the operator and accountant, as required pursuant to Sections 86-2.5 and 86-2.6 of this Subpart, and related company financial statements shall render the financial and statistical report incomplete. For facilities that have not submitted a properly filed cost report, the capital component of their rate is zero. If an acceptable cost report including all certifications and financial statements is received by January 15, 2009, the capital component will be updated utilizing the acceptable 2007 RHCF cost report and will be incorporated when the 2009 rates are issued.

Any appeal items that alter the 2007 cost data require that the annual reports be re-filed through the HPN no later than April 15, 2009. The revised reports must have a new Declaration Control Number (DCN) and must be re-certified by both the operator and the independent accountant. Revised cost reports will not be used for appeal adjustments unless an appeal is filed. The following items, where applicable, are included in the calculation of the capital component of the rate:

- The rate of return on net investment for 2009 is 1.87% based upon the 26 week U.S. Treasury bill rate in effect on September 10, 2008 in accordance with Part 86-2.28.
- The rate of return on real property equity, calculated pursuant to Part 86-2.21 is 4.22 % for 2009.
- The rate used to calculate the threshold for working capital as 10.25%

✓ ***Capital Rates-RHCF-2 Filers:*** For facilities that file the RHCF-2 report, the January 1, 2009 rates reflect reimbursable property costs determined based on the step-down of cost to the nursing home per the 2007 Institutional Cost Report (ICR) filing.

MINIMUM DATA SET

✓ ***Base Year Minimum Data Set (MDS):*** Pursuant to statute, the 2009 Medicaid rates are subject to case mix adjustments through application of the relative resource utilization groups system of patient classification (RUG-III) employed by the Federal Government for payments to skilled nursing facilities pursuant to Title XVIII of the Federal Social Security Act (Medicare). The reimbursement system will employ the MDS 2.0 or subsequent revisions as approved by the CMS. The reimbursement system will also employ the 53 Group RUG-III Classification System model version 5.20.

For facilities with a 2002 base year cost report a 2002 MDS database was developed using a four quarter mid-point methodology which identified each resident's MDS by the assessment reference date (ARD) closest to the mid-point of each quarter. For facilities with a base year cost report subsequent to 2002 an MDS database was developed using a four quarter mid-point methodology which identified each resident's

MDS by the ARD closest to the mid-point of each quarter matching the 12 month ('off-year') cost report period.

If more than one MDS was identified for a resident within a quarter, the MDS with the ARD closest to the midpoint was selected. In cases where two MDS submissions for the same resident were equal distance from the midpoint the earlier MDS with an ARD before the midpoint was selected. This methodology was used for all four quarters of the applicable base year, 2002 or off-year, consequently the MDS counts in the base year data used for rates effective 2009 contain more MDSs than beds.

Each facility's base year MDSs were RUGed, using the 53 Group RUG-III Classification System, Index Maximization, and New York State specific weights resulting in each facility's 'frozen' base year MDS case mix index.

Residents eligible for specialty unit/facility reimbursement for discrete AIDS, Ventilator Dependent, Traumatic Brain Injured, and Behavioral Intervention are identified by matching the frozen base year MDS data to the applicable year Patient Review Instrument (PRI) data submitted by each facility. Residents eligible for the enhanced reimbursement "add-on" for Traumatic Brain Injured – Extended Care are also identified by matching the frozen base year MDS data to the applicable year PRI data submitted by each facility.

✓ ***New York State Specific Weights for 53 Group RUG-III Classification System :***) New York State specific weights have been developed that reflect New York State wages and fringe benefits increased by the statutory amounts for residents in the impaired cognition A, impaired cognition B, and reduced physical function B categories.

The data used to determine the relative weights was developed using the 2002 base year MDS database, the Federal staffing minutes for RN, LPN, Aides, Therapists, and Therapists Aides for each RUG group from the 1995 and 1997 time study, and the statewide dollar per hour for all the job categories listed above from the 2002 Medicaid cost reports.

Each RUG category is assigned an index score that represents the amount of nursing time and rehabilitation treatment time associated with caring for the residents who qualify for the groups.

The methodology to determine the relative weight of each Rug group:

- Determine the number or residents per RUG category using MDS Hierarchical scoring
- Multiply total minutes by the statewide average dollar per minute resulting in the overall average cost
- The overall average cost is then multiplied by the resident count of MDSs and all five staffing levels are added together resulting in the total staffing cost per resident
- The total staffing cost per resident is then divided by the resident counts to determine an average cost per resident

- The relative weight is determined based on each RUG category's average cost as compared to the total average cost

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

However, as part of the overall policy and procedure regarding the transition to the MDS data for Medicaid reimbursement, developed in collaboration with the Nursing Home Reimbursement Workgroup, the Department is using 2006 MDS data as a proxy for the initial January 2009 case mix adjustment. Since 2006 MDS data is being used as a temporary update for case mix changes subsequent to the base period MDS data, actual MDS data from the January 2009 update will retroactively replace the 2006 case mix adjustment when it becomes available for processing in the first half of 2009.

The 2006 MDS database was created using the same methodology developed for the base year MDS database as described above. In addition the methodology used to identify residents eligible for specialty unit/facility Medicaid reimbursement and identify residents eligible for enhanced Medicaid rate reimbursement add-ons for specific conditions is the same as that used to identify these residents in the base period as described above.

AUDITS

As a reminder, please note that cost reports submitted for the 2002 calendar year or any subsequent year used to determine the operating component of the 2009 rate will be subject to audit through December 31, 2014. (PHL § 2808-2b(d)).

ADULT DAY HEALTH CARE RATES

In accordance with Part 86-2.9 of the Commissioner's Administrative Rules and Regulations and §2808 (23) of the Public Health Law, the Department has calculated Adult Day Health Care (ADHC) rates effective January 1, 2009. The 2009 ADHC rates have been held to a ceiling and your budget/cost based ADHC per visit rates for 2009 have been increased to reflect the trend factor adjustments noted above for your nursing facility rate. The capital component of a cost based ADHC rate has been updated to reflect the applicable portion of facility allowable capital costs as determined from the financial and statistical data submitted in the 2007 RHCF-4 cost report for RHCF-4 filers or as allocated from the ICR for RHCF-2 filers.

HOTLINE PROCESS

All facilities will have until January 15, 2009 to file a Hotline appeal on the same required appeal forms that have been used in past years (see first attachment). The Department will only attempt to address all **non-methodology** issues presented. This will

provide you with time to review your proposed rate, submit any cost report corrections and certifications and provide the Department with current information to process as many items as possible before assigning an appeal control number. Due to the hold harmless provision included in the new rebased operating rates and staff resources to process appeals, operating rate appeals will **not** be accepted during the Hotline Process. Like last year, the hotline period will be limited to items related to the capital component of a facility's rate, and are limited to the following two categories.

- Facilities that did not receive a capital rate component in the initial rate, and
- Facilities that have historically received mortgage reimbursement that is not reflected in the initial rate.

The above two items must be received by the Department by January 15, 2009. Facilities will also have until January 15, 2009 to file a revised certified 2007 Cost Report to address these issues.

All Hotline appeals must be on forms supplied by this office and must include the following information.

1. A cover letter, signed by the Operator or Chief Executive Officer, containing a summary of the items of appeal. Cover letters from attorneys or fiscal consultants representing the nursing facility are not acceptable.

2. The appeal packet, form DOH-2466 must be completed. The facility should complete items 1-6 on page 1. Page 2 should be duplicated as many times as necessary so that only one item of appeal appears on each page of Section 10. If more space is needed, summarize the item of appeal on page 2 and attach any further detail on your own schedule. Make sure the facility name appears on each page 2. All information on the form should be typed.

3. Supporting schedules or any other pertinent data <u>not</u> related to the annual cost report may be attached.

4. Any item of appeal that alters the cost data for the 2007 annual cost report must be filed through the HPN. The revised report must have a new Declaration Control Number and must be re-certified by the operator and the independent accountant. (See Parts 86-2.5 and 86-2.6.) Do not forward a hard copy or disk of the cost report. This data is not used and will be discarded.

When submitting an appeal, please be advised that the New York State Commissioner of Health may consider only those applications for revisions of certified rates which are set forth in Sections 86-2.13 and 86-2.14 of the Commissioner's Administrative Rules and Regulations. Issues raised in a request for appeal that do not meet the criteria of an acceptable appeal under 86-2.13 or 86-2.14 but rather pertain to the methodology used to promulgate Medicaid rates will be rejected. The Medicaid rate methodology is based on the provisions of Subpart 86-2 and objections to regulatory provisions are not issues that can be resolved through the administrative rate appeal process. Attachment 2 provides a **non-**

exhaustive list of methodology issues. The Department will determine if an item of appeal is considered a methodology issue on a case by case basis.

The submission of an appeal and any related information associated with the appeal must be forwarded to Ms. Lana I. Earle, Director, Bureau of Long Term Care Reimbursement, Empire State Plaza, Corning Tower, Room 943, Albany, New York 12237-0709. Appeals sent to any address other than the above may not be recognized as an appeal.

2009 RATE APPEALS ~ ELECTRONIC APPEALS SUBMISSION SYSTEM

The Department is in the process of developing an electronic appeals submission system, anticipated to be available for use by facilities in February 2009. The electronic appeals submission process will facilitate both the submission, tracking and processing of rate appeals.

Facilities that identify an appropriate appeal item related to 2009 initial rates will be required to submit all appeals using the new electronic appeals submission system. **All 2009 rate appeals must be submitted using the electronic appeals submission system and must be transmitted on or before April 15, 2009.**

Under separate cover, the Department expects to provide additional information and instructions regarding using and submitting appeals through the new electronic appeals submission system prior to February 2009. The information required to be submitted using the current appeal forms (and those which are required to be submitted under the Hotline appeals process described above) will be substantively the same as that which will be required under the new electronic appeals submission system.

Last year, the Department implemented a process to keep current with appeals by processing current rate year appeals in an expedited timeframe. The Department intends to continue to implement the Expedited Rate Review process for 2009 appeals. However, the extent to which the Department can stay current with appeals will depend upon the number of appeals submitted to the Department, the time it takes to process and review non-appealable items that are inappropriately submitted and staff resources.

ASSISTANCE AND QUESTIONS REGARDING THE 2009 INITIAL RATES

Rate Sheet Cross Walk

Attachments 3A-3E of this letter provides you with an annotated cross walk which identifies on the summary rate sheet where on the attached schedules you can find the data and information used to calculate each component of your rate. We encourage you to review these Attachments, as it will likely address many of your questions.

Email Address

To provide you assistance in understanding the methodology used to calculate your initial rates, and to effectively manage the volume of inquiries and be responsive to your inquiries the Department has established the following email address which we are requesting you use to

submit questions and inquiries regarding the contents of this letter and the computation of your initial 2009 rate.

nfrates@health.state.ny.us

All e-mail correspondence **should include the facility name in the subject line**, along with the operating certificate number, the sender's phone number, and question(s) in the body of the e-mail. Please be advised that in addition to responding to your inquiry, the Department will be posting a general question and answer forum on the HPN.

Webinar

The Department, in conjunction with the Joint Association Task Force, will be conducting a 'Webinar' to discuss the new 2009 rate methodology. The Webinar will allow facilities to join in on an educational seminar concerning the 2009 rate methodology via the internet. We encourage you to review the Rate Sheet Cross Walk described above in advance of the Webinar Session. After each portion of the Webinar questions may be posted electronically. Each of these questions will be answered as time allows during the Webinar, and answers to all questions will be posted here on the Nursing Home section of the HPN as soon as possible.

The Webinar is scheduled for Wednesday December 10, 2008 beginning at 2:00 pm. The link is:

https://hanys.webex.com/hanys/onstage/g.php?d=712440808&t=a&EA=Iwilliam@hanys.org&ET=92445187e03b8c7d76c3960d2626a753&ETR=dc1b53a77c5289ceed7eb1542bb696e0

Click "Register"
On the registration form, enter your information and then click "Submit"

2008 ANNUAL COST REPORT

Please be advised that the software for the 2008 RHCF cost report will be available through the HPN by April 1, 2009. The deadline for filing the 2008 annual cost report will be May 31, 2009. This is to provide facilities with sufficient advance notice so that you may plan ahead and take the appropriate action necessary to ensure the timely filing of the report.

As a reminder, please submit any questions relating to the calculation of your rate by e-mail to: **nfrates@health.state.ny.us**. **Please include your facility name in the subject line**, along with the operating certificate number, phone number and your question(s).

Sincerely,

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

Attachments

NYS DEPARTMENT OF HEALTH-OHIP
DIVISION OF HEALTH CARE FINANCING
BUREAU OF LTC REIMBURSEMENT

APPEAL FORM

1. NAME OF FACILITY:
2. ADDRESS OF FACILITY:
3. TYPE: NF
4. SPONSOR:
5. COUNTY:
6. OPCERT:

7. APPEAL NO. DATE RECEIVED ACKNOWLEDGED

8. SCHEDULE OF RATE REVISIONS DUE TO THIS APPEAL:

SERVICE	FROM	TO	EFFECTIVE PERIOD

NAME OF FACILITY:	APPEAL NO.
*Item of appeal must be fully stated below and all required documentation must be attached. Failure to do so may result in a denial of this item of appeal. *Separate page required for each item of appeal.	

10. STATEMENT OF ISSUE:

ATTACHMENT 2

NURSING FACILITY METHODOLOGY ISSUES

The following appeal issues are considered to be methodology appeals and will be denied as such by the Department if a facility appeals that issue. Note: this is a non-exhaustive list, the Department will determine if an item of appeal is considered a methodology issue on a case by case basis.

1) Recalibration
2) Nursing Recruitment and Retention
3) Reduction of Direct and/or Indirect Base Prices
4) Re-appeal of Carryover of Previously Appealed Items
5) RIPAF/WEF Methodology
6) Department of Health Audit Adjustment Rolled Forward into Promulgated Rate Periods
7) Nursing Home Quality Improvement Demonstration Program Awards
8) Health Recruitment and Retention Adjustment
   a) Calculation of Percentage Allocation
   b) Medicaid Days used in Calculation
9) Blending of Patient Days due to OBRA
10) Inclusion of Reserve Bed Days and/or Respite Care Days in Rate Calculation
11) Exclusion of Agency Nurse Salaries from WEF
12) Trend Factor
13) Rate of Return Relating to Return on and of Equity Calculation
14) Productivity and Efficiency Adjustment
15) Updating PRIs in Rate
16) Reserve Right to Review Prospective Rate Adjustment
17) Operator, Administrator, Assistant Administrator Salary Schedule
18) Issues for Previous Rate Periods which are Time Barred
19) Arms Length Lease Rent Ceiling
20) Administrative and Fiscal Cap
21) Return on Working Capital Assets
22) Status of Outstanding Appeals
23) Recoupment of NAMI Revenue
24) Costs Related to Telephone Equipment
25) Appeal to Base Year Costs for Non-Mandated Services or Increases Above the Trend Factor
26) Part D Methodology
27) 2009 Operating Reimbursement Methodology
28) 2002/2006 Minimum Data Set (MDS) Determination Methodology

ATTACHMENT 3A

GUIDE FOR REVIEWING RATE SHEETS

Rate Sheet Publication Name	Key
Base Period Dementia, BMI and TBI Adjustment	AA
2002 Base Year Price Calculations (Statewide)	BB
2009 Initial Nursing Home Capital	CC
2006 MDS Summary	DD
Base Period MDS Summary	EE
Base Period Calculation of Direct and Indirect IPAF	FF
2009 Initial Nursing Home Rate Sheets	GG

= MDS counts
xx.xx = calculated

New York State Department of Health
Office of Health Insurance Programs
Division of Health Care Financing
Bureau of Long Term Care Reimbursement

1/1/2009 Initial Rates

Opcert: xxxxxxxxx
Name: xxxxxxxxxxx

1. Total Operating Component		**GG**
A. Increased By x.xxxx (7 Year Inflation Factor)		xx.xx
B. 12/31/2008 Medicaid Rate of xxx.xx Trended by x.xxxx % to 2009		xx.xx
C. Higher of the Two Rates		xx.xx
D. 65% of Increase Due to 2002 Base Year	xx.xx	
E. Capital Component of the Rate	**CC**	
F. Misc Non Trended Items	xx.xx	
G. Total Property and Other Non Trended Items		xx.xx
2. Per Diem Adjustments		
A. Health Recruitment and Retention	xx.xx	
B. Other Misc Adjustments	xx.xx	
C. Dementia, BMI and TBI	**GG**	
D. Total Per Diem Adjustments		xx.xx
3. Medicaid Rate		xx.xx
4. Part B Offset		xx.xx
5. Medicaid Rate for Part B Eligible Patients		xx.xx
6. Part D Offset		xx.xx
7. Medicaid Rate for Part D Eligible Patients		xx.xx
8. Medicaid Rate for Part B & D Eligible Patients		xx.xx

Ancillaries Included In the Rate

( ) Prescription Drugs
( ) Physical Therapy
( ) Occupations Therapy
( ) Speech Therapy
( ) Physicians Services
( ) Dental Services
( ) Lab & X Ray Services

New York State Department of Health
Office of Health Insurance Programs
Division of Health Care Financing
Bureau of Long Term Care Reimbursement

1/1/2009 Initial Rates

Opcert: xxxxxxxxx
Name: xxxxxxxxxxx

1. Direct Component of the Rate	
A. Allowable Direct Cost Per Day	**AA**
B. Direct IPAF	**FF**
C. Direct Cost Per Day * DIPAF	xx.xx
D. % Change in Facility Case Mix	**GG**
E. Case Mix Adjusted Direct Cost Per Day	xx.xx
F. Direct Base	xx.xx
G. Direct Mean	**GG**
H. Direct Ceiling	xx.xx
I. Lower of Facility Cost or the Ceiling	xx.xx
J. Allowable Direct Cost	xx.xx
K. Facility Direct IPAF	**FF**
L. Allowable Direct Cost Adjusted for the DIPAF	xx.xx
2. Indirect Component of the Rate	
A. Allowable Indirect Cost Per Day	**AA**
B. Indirect IPAF	**FF**
C. Indirect Cost Per Day * IIPAF	xx.xx
D. Indirect Base	xx.xx
E. Indirect Mean	**GG**
F. Indirect Ceiling	xx.xx
G. Facility Allowable Cost is in the Corridor	xx.xx
H. Allowable Indirect Cost	xx.xx
I. Facility Indirect IPAF	**FF**
J. Allowable Indirect Cost Adjusted for the IIPAF	xx.xx
3. Non Comp Cost Per Day	**AA**
4. Total Operating Costs	xx.xx

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1. Dementia Diagnosed and Dementia Impaired Add on Calculation	
A. Dementia Diagnosed	##
B. Dementia Impaired	##
C. Total Dementia Patients	xx.xx
D. Per Diem Add On Amount 2808(2-b)(viii)	xx.xx
E. Trend Factor From 2006 to the Rate Period	xx.xx
F. Rate Period Add On	xx.xx
G. Daily Dementia Expense	xx.xx
H. Annual Dementia Expense	xx.xx
2. Body Mass Index (BMI) Add On Calculation	
A. Total Number of BMI Patients	##
B. Per Diem Amount 2808(2-b)(viii)	xx.xx
C. Trend Factor From 2006 to the Rate Period	xx.xx
D. Rate Period Add On	xx.xx
E. Daily BMI Expense	xx.xx
F. Annual BMI Expense	xx.xx
3. Dementia/BMI Per Diem Calculation	
A. Total Annual Dementia & BMI Expense	xx.xx
B. Total Number of Patient Days	xx.xx
C. Dementia & BMI Per Diem	xx.xx
4. Traumatic Brain Injury (TBI) Add On Calculation	
A. Total Number of TBI Patients	##
B. Per Diem Amount 2808(2-b)(viii)	xx.xx
C. Trend Factor From 2006 to the Rate Period	xx.xx
D. Rate Period Add On	xx.xx
E. Daily TBI Expense	xx.xx
F. Annual TBI Expense	xx.xx
G. Total Number of Patient Days	xx.xx
H. TBI Per Diem	xx.xx
5. Rate Add On for TBI, Dementia and BMI	
A. Total Per-Diem Dementia + BMI + TBI	xx.xx
B. 2002 DIPAF	**FF**
C. WEF Adjusted Annual Dollars	x.xx

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1. % Change in Case Mix for the Facility Per Diem	
A. Facility Frozen Case Mix	**EE**
B. Facility Current Case Mix	**DD**
C. % Change in Facility Case Mix	xx.xx
2. % Change in Case Mix for the Ceiling Calculation	
A. Statewide Frozen Case Mix	**BB**
B. Facility Current Case Mix	**DD**
C. % Change in the Statewide Price Due to Case Mix	xx.xx
3. Direct Component Base Mean and Ceiling Calculation	
A. Statewide Direct Mean Price	**BB**
B. Change in Mean Price Due to Case Mix	xx.xx
C. Facility Specific Direct Mean Price	xx.xx
D. Facility Specific Direct Base Price	xx.xx
E. Facility Specific Direct Ceiling Price	xx.xx
4. Indirect Component Base Mean and Ceiling Calculation	
A. Statewide Indirect Mean Price	**BB**
B. Statewide Indirect Base Price	xx.xx
C. Statewide Indirect Ceiling Price	xx.xx