

New York
Contents

SUBPART 86-2

RESIDENTIAL HEALTH CARE FACILITIES

(Statutory authority: Public Health Law, §§2803[2], 2808)

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TN #86-4

Supersedes TN ---

Approval Date July 29, 1987

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New York
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1905(a)(4)(A) Nursing Facility Services

Across-the-Board Reductions to Payments – Effective 9/16/10 – 3/31/11

- (1) For dates of service on and after September 16, 2010, through and including March 31, 2011, payments for services as specified in paragraph (2) of this Attachment ~~shall~~ will be reduced by 1.1%, provided payment is made no later than March 31, 2011.
- (2) Payments in this Attachment subject to the reduction in paragraph (1) include the following:

Part I – Residential Health Care Facilities

- a) Voluntary Health Care Facility Right Sizing Program. Page 16
- b) Services provided by Residential Health Care Facilities, excluding proportionate share payments to non-state operated public facilities (found on page 47(x)(2)(b)). Pages 17-87

Part III – Methods and Standards for Establishing Payment Rates (Out of State Services) – Nursing Facilities

- c) Services provided by nursing facilities out of state. Page 1

2% Across-the-Board Reductions to Payments - Effective 4/1/2011-3/31/2013

- (1) For dates of service on and after April 1, 2011, and ending on March 31, 2013, payments for services as specified in paragraph (2) of this Attachment will be reduced by 2%.
- (2) Payments in this Attachment subject to the reduction in paragraph (1) are the following:

Part III – Methods and Standards for Establishing Payment Rates (Out of State Services) – Nursing Facilities

- d) Services provided by nursing facilities out of state. Page 1

Across the Board Increase

- (1) For dates of service on and after November 1, 2018, the operating component of the rates of reimbursement for Article 28 nursing homes, will be adjusted to reflect an across-the-board increase of one and one-half percent (1.5%).
 - a. Sections subjected to the one and one-half percent (1.5%) increase are as follows:
 - i. Nursing Home Reimbursement
 - ii. Specialty care facilities
 - b. The capital component of the rates ~~are~~ is not subject to the one and one-half percent (1.5%) increase.
- (2) For dates of service on and after April 1, 2022, the operating component of the rates of reimbursement for Article 28 nursing homes, will be adjusted to reflect an across-the-board increase of one percent (1%).
 - b. Sections subjected to the one (1%) increase are as follows:
 - i. Nursing Home Reimbursement
 - ii. Specialty care facilities
 - c. The capital component of the rates is not subject to the one percent (1%) increase.

TN #22-0057 Approval Date April 10, 2023

Supersedes TN #18-0063 Effective Date April 1, 2022

**New York
A(a.1)**

1905(a)(4)(A) Nursing Facility Services

Across the Board Increase

For dates of service on and after April 1, 2023, the operating component of the rates of reimbursement for Article 28 nursing homes, will be adjusted to reflect an across-the-board increase of seven and a half percent (7.5%).

- a. Sections subjected to the seven and a half percent (7.5%) increase are as follows:
 - i. Nursing Home Reimbursement
 - ii. Specialty care facilities
- b. The capital component of the rates is not subject to the seven and a half percent (7.5%) increase.

TN **#23-0042**

Supersedes TN **NEW**

Approval Date **September 24, 2024**

Effective Date **April 1, 2023**

**New York
A(1)**

Supplemental Payments

- (1) Effective July 1, 2015 and State Fiscal Years thereafter, supplemental payments will be distributed to all nursing home facilities through lump sum [or monthly] payments and calculated as follows:
 - a) An individual facility revenue will be calculated by taking each facility's promulgated rate in effect for the given period multiplied by actual Medicaid days for the corresponding period as reported in the facility's cost report or an estimate of Medicaid days based on most recent available data. If a facility fails to submit a timely filed cost report, the most recent cost report will be utilized.
 - b) The resulting individual facility revenue will be divided by total Medicaid revenues of all facilities. The result will be multiplied by the appropriate total dollar amount to be distributed per the chart below to determine each facility's portion of the supplemental payment.
- 2) After the end of each State Fiscal Year, a reconciliation of any estimated Medicaid days to actual Medicaid days will be conducted. Any resulting payment adjustments will be made within the 2-year claiming rule.

Supplemental Payment Schedule

State Fiscal Year	Rate Period	Amount in Millions	Distribution
2018-2019	07/01/15 - 12/31/15	\$52.5	Lump Sum
2018-2019	01/01/16 - 12/31/16	\$70.0	Lump Sum
2018-2019	01/01/17 - 03/31/17	\$17.5	Lump Sum
Total		\$140.0	
2019-2020	04/01/17 - 12/31/17	\$52.5	Lump Sum
2019-2020	01/01/18 - 12/31/18	\$70.0	Lump Sum
2019-2020	01/01/19 - 03/31/19	\$17.5	Lump Sum
Total		\$140.0	
2020-2021	04/01/19 - 12/31/19	\$52.5	Lump Sum
2020-2021	01/01/20 - 03/31/20	\$17.5	Lump Sum
2020-2021	04/01/20 - [12/31/20] 10/31/20	[\$52.5] \$40.8	[Monthly] Lump Sum
2020-2021	11/1/20 - 12/31/20	\$64.2	Lump Sum
2020-2021	01/01/21 - 03/31/21	[\$17.5] \$35.0	[Monthly] Lump Sum
Total		[\$140.0] \$210.0	
2021-2022	04/01/21 - 12/31/21	[\$105.0] \$157.5	[Monthly] Lump Sum
2021-2022	01/01/22 - 03/31/22	[\$35.0] \$52.5	[Monthly] Lump Sum
Total		[\$140.00] \$210.0	
2022-2023 and SFYs thereafter	04/01/22 - 12/31/22	[\$52.5] \$105.0	[Monthly] Lump Sum
2022-2023 and SFYs thereafter	01/01/23 - 03/31/23	[\$17.5] \$35.0	[Monthly] Lump Sum
Total		[\$70.00] \$140.0	

TN #20-0072

Supersedes TN #15-0056

Approval Date June 21, 2021

Effective Date November 1, 2020

New York
A(1)(i)

1% Across-the-Board Reductions to Payments – Effective January 1, 2020 – March 31, 2022

- (1) For dates of service January 1, 2020 – March 31, 2022, the rates of reimbursement for Article 28 nursing homes will be adjusted to reflect an across the board reduction of one percent (1%).
- (2) For dates of service April 2, 2020 – March 31, 2022, the rates of reimbursement for Article 28 nursing homes will be adjusted by an additional one-half percent (0.5%) to reflect an across the board reduction of one and one half percent (1.5%).
 - a. Sections subjected to the one percent (1%) and one and one half percent (1.5%) reduction are as follows:
 - i. Nursing Home Reimbursement
 - ii. Specialty Care Facilities

TN #22-0056 Approval Date December 7, 2023

Supersedes TN #20-0053 Effective Date April 1, 2022

New York
1(a)

New York State provides public access to governmental records, including data and the methodology used in establishing payment rates for nursing facilities under Medicaid. The State Freedom of Information Law (Public Officers Law, Article 6) is the principal statute providing public access to information and records. Regulations related to the process of obtaining access to the Department of Health's records are contained in Sub-part 50-1 of Title 10NYCRR. These records include, but are not limited to, facility cost reports, case mix indices and the methodologies by which reimbursement rates are set for hospitals, nursing homes and other health care providers.

Anyone wishing to inspect or obtain public records must apply to the Department's Records Access Officer in writing. The officer is responsible for insuring appropriate agency response to requests for public access to records, and will coordinate the Department's response as per the process contained in the New York State Department of Health Administrative Policy and Procedure Manual, 100.0 – RELEASE OF INFO TO OUTSIDE GROUP/FREEDOM OF INFO/RECORD ACCESS.

TN <u>#90-10</u>	Approval Date <u>October 1, 1990</u>
Supersedes TN <u>NEW</u>	Effective Date <u>October 1, 1990</u>

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Section 86-2.1 Definitions.

As used in this Subpart, the following definitions shall apply:

- [(1)] (a) Residential health care facility, medical facility or facility shall mean all facilities or organizations covered by the term nursing home [or health-related facility] 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.
- [(2)] (b) Patient classification groups shall mean patient categories contained in the classification system, Resources Utilization Groups – II (RUG-II), which identifies the relative resource consumption required by different types of long term care patients as specified in Appendix [6] 13-A, infra.
- [(3)] (c) Case mix shall mean the patient population of a facility as classified and aggregated into patient classification groups.

TN <u>#90-10</u>	Approval Date <u>October 1, 1990</u>
Supersedes TN <u>#86-4</u>	Effective Date <u>October 1, 1990</u>

New York
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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 freestanding pursuant to subdivision (a) of section 86-2.34 of this Subpart shall complete and file the freestanding 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.

TN #88-47

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New York
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- (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

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the same may be extended pursuant to subdivision (b) of this section, the State Commissioner of Health shall reduce the current rate 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 said 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 or 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 section 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 [six-month] 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 [six-month] 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 the date of receipt of notification to provide the corrected or additional data. Failure to file the

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corrected or additional data that was previously required within that period will result in a reduction of the current rate in accordance with subdivision (c) of this section. Lack of the respective certifications by both the operator and accountant, as required pursuant to section 86-2.5 and 86-2.6 of this Subpart, shall render a financial and statistical report incomplete, and the facility shall not be entitled to the 30-day period to submit the certifications.

- (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 a reduction of the current rate in accordance with subdivision (c) of this section, unless the residential health care facility can prove by documentary evidence that the data being requested is not available.

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New York
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- [(h) each residential health care facility shall file with the New York State Department of Health a complete copy of the Department of the Treasury, Internal Revenue Service Form 990, for that facility. The Form 990 shall be submitted to the department no later than 30 days following the annual filing with the Internal Revenue Service. Failure to submit the Form 990 shall result in application of the provisions set forth in subdivision (c) of this section.]

RESERVED

TN #97-04

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New York
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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 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 set forth in Article 9 of Subchapter A of Chapter V of this Title for financial presentation purposes.
- (c) Rate schedules shall not be certified by the Commissioner of Health unless residential health care facilities are in full compliance with the reporting requirements of this Subpart, section 414.13 and Article 9 of Subchapter A of Chapter V of this Title. For the purpose of certifying rates, compliance with reporting requirements of Article 9 of Subchapter A of Chapter V of this Title will include, but not be limited to, the timely filing of properly certified reports which are complete and accurate in all material respects.

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- (d) Failure of residential health care facility to file the reports required pursuant to this section will subject to residential health care facility to a rate reduction as set forth in section 86-2.2 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, with respect to the report for such reporting period, 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 year in which the report was required to be filed.

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86-2.4 Generally accepted accounting principles.

The completion of the financial and statistical report form 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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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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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 reports forms provided by the State Commissioner of Health.

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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 after or adjusted rate will be construed to represent the audited rate.
- (b) Subsequent to the filing of required fiscal and statistical reports, field audits shall be conducted by the records of residential health care facilities, in a time, manner and place to be determined by the State Department of Health.
- (c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department or from the date when due, whichever is later. This limitation shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this section.
- (d) Upon completion of the audit the residential health care facility shall be afforded a closing conference. The residential health care facility

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may appear in person or by anyone authorized in writing to act on behalf of the residential health care facility. The residential health care facility shall be afforded an opportunity at such conference to produce additional documentation in support of any modifications requested in the audit.

- (e) The residential health care facility shall be provided with the audit report and the rate computation sheet per audit. The audit report shall be final unless within 30 days of receipt of the audit report, the residential health care facility initiates a bureau review by notifying the Division of Health Care Financing by registered or certified mail, detailing the specific items of the audit report with which the provider disagrees and such other material as the provider wishes to submit in its behalf and forwarding all material documentation in support of the residential health care facility's position.
- (f) The residential health care facility shall be notified in writing of the determination of the controverted items of the final audit report, including a statement of the reasons for such adjustments and the appropriate citation to applicable law, regulation and policy. The audit finding as adjusted in accordance with the determination of the bureau review shall be final, except that the residential health care facility may, within 30 days of receipt of the determination of the bureau review, initiate a hearing to refute those items of the audit report adverse to the interests of the residential health care facility presenting a factual issue by serving on the commissioner, by certified or register mail, a notice containing a statement

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of the legal authority and jurisdiction under which the hearing should be held, a reference to the particular sections of the statutes and rules involved and a statement of the controverted items of the audit report and bureau determination, together with copies of any documentation relied on by the residential health care facility in support of its position.

- (1) Upon receipt of such notice the commissioner shall:
 - (i) designate a hearing officer to hear and recommend;
 - (ii) establish a time and place for such hearing;
 - (iii) notify the residential health care facility of the time and place of such hearing at least 15 days prior thereto; and
 - (iv) include in a notice of hearing those issues of the audit report which are controverted in the notice served on the commissioner by the residential health care facility.
- (2) The issues and documentation presented by the residential health care facility at such hearing shall be limited to the factual issues and documentation presented at the bureau review.
- (3) The audit report shall be presumptive evidence of its content. The burden of proof at any such hearing shall be upon the residential health care facility to prove by substantial evidence that the items therein contained are incorrect. At such hearing, the residential health care facility shall have the obligation to initially present such evidence in support of its position. Failure to do so shall result in termination of the hearing.

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- (4) The hearing shall be conducted in conformity with section 12-a of the Public Health Law and State Administrative Procedure Act.
- (5) At the conclusion of the hearing the residential health care facility may submit memoranda on any legal issues which it deems relevant to the proceeding. Such memoranda shall be come part of the official record of the hearing.
- (g) Rate revisions resulting from the procedure set forth in this section shall be made retroactive to the period or periods during which the rates based on the periods audited were established. Any resulting overpayment or underpayment shall be satisfied by either retroactive adjustment of the provisional rate paid based on the period audited, or prospective adjustment of the current certified rate at the discretion of the State Commissioner of Health.
- (h) All overpayments resulting from rate revisions shall be subject to such penalties as the Commissioner of Health may impose for incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions. The penalties assessed under this section are separate from and shall not be construed to be in mitigation of damages which may be recovered pursuant to section 145-b of the Social Services Law.

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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 day of readmission.]

TN #10-22-A
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The voluntary health care facility right-sizing program is intended to address excess capacity in residential health care facilities. Under this program, a residential health care facility may apply to temporarily decertify, or permanently convert, a portion of its existing certified beds to another level of care. The Commissioner of Health may approve temporary decertification and permanent bed conversions, which total no more than [2,500] 5,000 residential health care beds on a statewide basis.

A residential health care facility may temporarily decertify beds for up to five years. Temporarily decertified beds will remain on the facility's license during and after the five-year period.

The following adjustments to the calculation of Medicaid rates of payment for residential health care centers will be made for facilities that have temporarily decertified beds under this program:

- Capital cost reimbursement will be adjusted to reflect the new bed capacity;
- The facility's peer group assignment for indirect cost reimbursement will be based upon total certified beds less the number of temporarily decertified beds; and
- The facility's vacancy rate, for the purpose of determining eligibility for reserved bed day payments, will be calculated on the basis of the facility's total certified beds less the number of temporarily decertified beds. Payments for reserved bed days for facilities that have temporarily decertified beds will be in an amount that is fifty percent of the otherwise applicable payment amount for such beds.

TN #10-29

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Effective Date August 1, 2010

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86-2.10 Computation of basic rate.

(a) Definitions.

For the 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

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of medicaid patients which shall include a Direct, Indirect Non-Comparable and Capital component.

- (7) Operating portion of the rate shall mean the portion of the rate consisting of the Direct, Indirect and Non-Comparable components after application of the roll factor promulgated by the department.
- (8) Role 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

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Administration (HCFA) to be hospital based or hospital rated (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 for 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. Beginning with the annual cost report filed for 2005 and for each year thereafter; in the event the operating costs reported by a facility are less than 90 percent of the operating costs reported in the cost report utilized to compute the facility's rates, trended to 2005 and each year thereafter, the facility's rates shall be recalculated utilizing the more recent reported operating cost data.

TN #06-18
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- (ii) Consist of the following four separate and distinct components, as defined in this section.
 - (a) Direct
 - (b) Indirect
 - (c) Non-comparable
 - (d) Capital
- (2) The operating portion of the rate for 1986 and subsequent rate years shall consist of the sum of the Direct, Indirect and Non-Comparable 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 stepdown method of cost allocation as defined in section 451.249 of Article 9 of Subchapter A of Chapter V 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 6a infra.
 - (iii) Reported Costs of 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

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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) or 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) laundry and linen]

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- (vii) speech and hearing therapy – (speech therapy portion only);
 - (viii) [pharmacy;
 - (ix)] central service supply; and
 - [(x)](ix) 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 (1) of this section.
- (3) [Except as provided for in subparagraph (4) (viii) of this subdivision. the] 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 scaled of each level of employee.
 - (ii) The statewide distribution of patients in each patient classification group shall be determined for 1986 payments utilizing

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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 act 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 the aggregate statewide case mix index to the number of patient review instruments received pursuant to section 86-2.00 of this Subpart.

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- (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.

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- (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.

TN #91-25

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25(a)

- (1) 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 effective January 1, 1996 and thereafter. The base factor referred to in clause (f) of this subparagraph shall be approximately 90 percent for the period January 1, 1987 through December 31, 1987, such factor shall be approximately 90 percent. For the period January 1, 1988 through December 31, 1992, such factor shall be increased to approximately 95 percent. For the period January 1, 1993 through December 31, 1995 such factor shall be 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.

TN #96-04
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Effective Date January 1, 1996

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(iii) For the period January 1, 1986 through December 31, 1986, the base factor and ceiling factor contained in this clause shall initially be determined to result in a 20 percent corridor. The ceiling factor shall then be increased by 5 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 31, 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

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determined by multiplying the statewide base 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.

- (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.

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- (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 price per day pursuant to the following table:

<u>Facility Specific Cost based Direct Price Per Day</u>	<u>Facility Specific Direct Adjusted Payment Price Per Day</u>
<u>Below Facility Specific Base Direct Price Per Day</u>	<u>Facility Specific Base Direct Price Per Day</u>
<u>Between Facility Specific Base Direct Price Per Day and Facility Specific Ceiling Direct Price Per Day</u>	<u>Facility Specific Cost Based Direct Price Per Day</u>
<u>Above Facility Specific Ceiling Direct Price Per Day</u>	<u>Facility Specific Ceiling Direct Price Per Day</u>

TN #86-4

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Effective Date January 1, 1986

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- (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:
- (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.
- (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.

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[RESERVED]

TN #91-25
Supersedes TN #90-10

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(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 [facilities] 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 [most recent] PRI's submitted by each facility [prior to January 1st] 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 a 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[s] centers indicated in subdivision (c) of this section to the total costs of such direct care cost centers.

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(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 (v) of paragraph (4) 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 section 86-2.10(4)(i) 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

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their facility specific adjusted payment price per day for 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;
 - [(vi)](vii) housekeeping;
 - [(vii)](viii) patient food services;
 - [(viii)](ix) cafeteria;
 - [(ix)](x) non-physician education;
 - [(x)](xi) medical education;
 - [(xi)](xii) housing; and
 - [(xii)](xiii) medical records.

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For the purposes of establishing the indirect component of the rate of payment for services provided on or after April 1, 1995 through March 31, 1999 and for services provided on or after July 1, 1999 through [March] December 31, 2006, the reimbursable base year costs as reported in the fiscal services and administrative services functional cost centers as specified in subparagraphs (i) and (ii) of this paragraph of a provider of services, excluding a provider of services reimbursed on an initial budget basis, shall not, except as otherwise provided in this paragraph, exceed the statewide average of total reimbursable base year administrative and fiscal service costs. For the purposes of this paragraph, reimbursable base year administrative and fiscal service costs shall mean those base year administrative and fiscal services costs remaining after application of all other efficiency standards, including but not limited to, peer group ceilings or guidelines. Effective for rates of payment commencing July 1, 2000, a separate statewide average of total reimbursable base year administrative and fiscal services costs shall be determined for each of those facilities wherein eighty percent or more of its patients are classified with a patient acuity equal to or less than .83 which is used as the basis for a facility's case mix adjustment. For the period July 1, 2000 through March 31, 2001, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average plus one and one-half percentage points. For annual periods thereafter through [March] December 31, 2006, the total reimbursable base year administrative and fiscal services costs of such facilities shall not exceed such separate statewide average. In no event shall the calculation of this separate statewide average result in a change in the statewide average determined pursuant to this paragraph. The limitation on reimbursement for provider administration and general expenses provided by this paragraph shall be expressed as a percentage reduction of the operating cost component to the rate promulgated for each residential health care facility.

TN #06-21

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- (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 costs 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 (6) of this subdivision.

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- (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 effective January 1, 1996 and thereafter. 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 December 31, 1992, such factor shall be increased to approximately 97.5 percent. For the period January 1, 1993 through December 31, 1995 such factor shall be 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 factor contained in subparagraph (ii) of this paragraph, shall result in a 20 percent corridor. For the

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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 deducting 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:

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Facility Adjusted Costs <u>Divided by Patient Days</u>	Facility Specific Indirect Adjusted Payment <u>Price Per Day</u>
<u>Below Base Indirect Price Per Day</u>	<u>Base Indirect Price Per Day</u>
<u>Between Base Indirect Price Per Day and Ceiling Indirect Price Per Day</u>	<u>Report Adjusted Costs Per Day</u>
<u>Above Ceiling Indirect Price Per Day</u>	<u>Ceiling Indirect Price Per Day</u>

- (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 operation 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;
- (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

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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 (c) 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

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38(a)

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.

[(5)] (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.

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

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

[(b)] (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 [most recent] PRI's submitted by each facility [prior to January 1st], 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

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[(c)] (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:**

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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 costs 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 loss.

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- (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 costs 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 cost per day shall be determined by using a composite of 50% of the Regional and 50% 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% of the Regional and 25% 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.

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Effective Date January 1, 1986

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(f) Non-comparable Component of the Rate:

- (1) The non-comparable 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 non-comparable 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 cost 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

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- xii. Utilization Review
 - xiii. Other Ancillary
 - xiv. Plant Operations and maintenance – (cost for facilities and real estate and occupancy taxes only).
- (3) The allowable facility specific non-comparable component of the rate will be reimbursed at a payment rate equal to adjusted reported non-comparable 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 will include allowable capital costs determined in accordance with section 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 non-trendable divided by the facility's patient days in the base year determined applicable by the department.

- (g)(1) Effective on and after April 2, 2020, the capital component of all Medicaid rates for residential health care facilities will be reduced by 5%.
- (g)(2) Effective on and after April 1, 2024, the capital component of all Medicaid rates for residential health care facilities (excluding pediatric residential health care facilities) will be reduced by 10%, after all prior enacted increases and reductions are applied.
- (h) A facility's payment rate for 1986 and subsequent rate years will be equal to the sum of the operating portion of the rate as defined in paragraph (2) of subdivision (b) 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 will be considered

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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.

(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 [six-month] 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 [six-month] twelve-month period covered by the report. Failure to comply with this subdivision shall result in [a reduction of the current rate in accordance with] 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 86-2.30 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.

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- (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 which are not considered new operators 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[s] 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

New York
44(a)

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 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 establishment of a new operator on or after the effective date of this paragraph.

(I) **Adjustments to the opening 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 1983 allowable costs for the direct and indirect components.

TN #02-04

Approval Date August 8, 2002

Supersedes TN #93-04

Effective Date March 13, 2002

New York
44(b)

(I) **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 offered 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.

TN #89-24
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New York
45

- (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:

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- (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 facilities 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

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47

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 amount 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.**

**New York
47(a)**

- (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, be based on the regional average dollar per hour (RAP) calculated using the financial and statistical data required by §86-2.2 of this Subpart, reported solely for 1983 calendar year operations, adjusted as follows:
- (i) RAP's 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 §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 in greater than the percentage calculated using the same data reported for the 1983 calendar year operations, (1983 RAP), the factors shall be determined utilizing 1987 RAPs and adjusted pursuant to subparagraph (i), (ii) and (iii) of this paragraph.

New York
47(a)(1)

- (a) Notwithstanding this subparagraph if the utilization of 1987 RAPS to determine the factors would, for any facility within a region described in this subparagraph, 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.
- (v) For purposes of establishing rates of payment by governmental agencies for residential health care facilities for services provided on and after January 1, 1998, the regional direct and indirect input price adjustment factors to be applied to any such facility's rate calculation shall be based upon the utilization of either 1983, 1987 or 1993 calendar year financial and statistical data. The determination of which calendar year's data to utilize shall be based upon a methodology that ensures that the particular year chosen by each facility results in a factor that yields no less reimbursement to the facility than would result from the use of either of the other two years' data. Such methodology shall utilize the 1983 and 1987 regional direct and indirect input price adjustment factor corridor percentages in existence on January 1, 1997 as well as 1993 regional direct and indirect input price adjustment factor corridor percentage calculated in the same manner as the 1983 and 1987 direct and indirect input price adjustment factor corridor percentages in existence on January 1, 1997.
- (vi) For purposes of establishing rates of payment for residential health care facilities for services provided on and after April 1, 2004, the regional direct and indirect input price adjustment factors to be applied to any such facility's rate calculation shall be based upon the utilization of either 1983, 1987, 1993 or 2001 calendar year financial and statistical data provided, however, the total amount of rate increases attributable to the utilization of 2001 calendar year data shall be no more than \$47.5 million on a pro rata basis per calendar year. The determination of which calendar year's data to utilize shall be based upon a methodology that ensures that the particular year chosen by each facility results in a factor that yields no less reimbursement to the facility than would result from the use of the other three years' data. Such methodology shall utilize the 1983 and 1987 regional direct and indirect input price adjustment factor corridor percentages in existence on January 1, 1997, as well as the 1993 regional direct and indirect input price adjustment factor corridor percentage in existence on January 1, 2004, as well as a 2001 regional direct and indirect input price adjustment factor corridor percentage calculated in the same manner as the 1993 direct and indirect input price adjustment factor corridor percentage in existence of January 1, 2004.

New York
47(b)

- (2) The corridor established in paragraph (1) of this subdivision shall be applied in each region as follows:
- (i) The regional corridor percentage referred to in subparagraph (iii) of paragraph (1) of this subdivision, shall be applied, both negatively and positively to the RAP to arrive at an amount which when added to or subtracted from the RAP shall represent the maximum and minimum regional dollar per hour, for the region hereafter referred to as the maximum and minimum respectively.
 - (ii) The facility in each region with the highest facility wage and fringe benefit dollar per hour shall be assigned a facility RAP equivalent to the maximum.
 - (iii) The facility in each region with the lowest facility wage and fringe benefit dollar per hour shall be assigned a facility RAP equivalent to the minimum.
 - (iv) Facilities in a region with facility wage and fringe benefit dollars per hour between the highest and lowest facility wage and fringe benefit dollar per hour in such region shall be assigned a facility RAP on a sliding scale, based on the relatively of such facility's labor costs to the RAP and to the highest or lowest labor costs in the region, as applicable.

New York
47(c)

(n) Long-term inpatient rehabilitation program for traumatic brain-injured residents (TBI).

[Adjustments to the operating portion of the rates for facilities] Facilities which have been approved to operate discrete units for care of [patients] residents under the long-term inpatient rehabilitation program for [head-injured patients HI] TBI patients [established pursuant to section 416.11 of this Title] shall [be made] have separate and distinct payment rates for such units calculated pursuant to this section except as follows:

- (1) In determining the facility-specific direct [adjustment] adjusted payment price per day pursuant to paragraph (c)(4) of this section for [patient] residents meeting the criteria for and residing in [the HI] a TBI unit, [separate and distinct statewide mean, base and ceiling prices shall be calculated and applied by multiplying the case mix proxy for such patients established by this subdivision times the statewide mean, base and ceiling direct case mix neutral cost per day, respectively.] 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

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New York
47(c)(1)

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.

- (a) 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 the Department to operate a TBI unit. A current period audit of current expenses may result in a negative adjustment to the increment on a prospective basis. An audit of prior period expenses may result in a retrospective negative adjustment to the increment.
- (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

New York
47(c)(2)

determined pursuant to subdivision (f) of this section utilizing the cost report filed pursuant to section 86-2.2(e) of this [section] Subpart including approved actual costs in such cost report for personnel identified in required by section 415.36 of this title Appendix 1 of this State Plan that would be reported in the functional cost centers identified in subdivision (f) of this section.

~~[(4) The provisions of this subdivision will expire on December 31, 1994.]~~

TN	<u>#95-04</u>	Approval Date	<u>June 4, 1999</u>
Supersedes TN	<u>#93-04</u>	Effective Date	<u>January 1, 1995</u>

New York
47d

- (o) (1) [For rate year 1988,] 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 [in 1988,] 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 positive outcomes are not demonstrated.

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New York
47e

- (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 diagnosis and related codes and descriptions are taken from the International Classification of Diseases, 9th Revision, Clinical Modification, volume 3 (ICD-9-CM).

<u>ICD-9-CM Code</u>	<u>ICD-9-CM Diagnosis</u>
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 Jakob-Croutzfeldt disease Pick's disease of the brain
290.10	Presenile dementia Uncomplicated presenile dementia NOS, simple type
290.11	Presenile dementia with delirium
290.12	Presenile dementia with acute confusional state Presenile dementia with delusional feature

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47f

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 (non-alcoholic)
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 non-psychotic mental disorders, following organic brain damage

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New York
47g

310.9	Unspecified non-psychotic 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

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New York
47(h)

(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 [designated AIDS beds and/or] a residential health care facility designated as an AIDS facility or having a discrete AIDS unit[s] 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 [primary] medical [problem] condition is [Acquired Immune Deficiency Syndrome (AIDS) as defined in section 416.12, section 421.14 and section 422.1 of of this Title.] HIV Infection Symptomatic. Such patients shall hereinafter be referred to as [an] 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. [For residential health care facilities (RHCF), adjustments to payment rates shall be made as follows:]
 - (i) [In determining the] The facility specific direct adjusted price per day shall be determined pursuant to paragraphs (3) and (4) of subdivision (c) of this section and further adjusted as follows [for an AIDS patient, the statewide mean, base and ceiling prices shall be calculated and applied by multiplying the case mix proxy for such patients established by this paragraph times the statewide mean, base and ceiling direct case mix neutral cost per day respectively. The case mix proxy for an AIDS patient shall be determined as follows:
 - (a) An AIDS patient shall be assigned a case mix proxy based on the sum of the 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:

ADL	CASE MIX
TOTAL	PROXY

New York
47(i)

- (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 [c]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. Effective April 1, 2009, however, the operating component shall not reflect an occupancy factor increase.
- (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 [c]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.

New York
47(j)

-Deleted -

TN #90-10
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New York
47(k)

-Deleted -

TN #90-10

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Approval Date October 1, 1990

Effective Date October 1, 1990

New York
47(l)

- (3) [A cost report shall be filed in accordance with section 86-2.2 of this Subpart for the first six month period during which a new facility which has been certified for the purpose of providing services solely to AIDS patients has received an overall average utilization of at least 80 percent of bed capacity. This report shall be properly certified within 60 days

TN #91-25

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New York
47(m)

following the end of the six month period covered by the report. Failure to comply with this subparagraph shall result in a reduction of the current rate in accordance with subdivision (c) of section 86-2.2 of this Subpart.] 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.

TN #91-25

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Effective Date April 1, 1991

New York
47(q)

(q) Long term ventilator dependent residents.

[Adjustments to the operating portion of rates for facilities] Facilities which have been approved to operate discrete units for the care of long-term ventilator dependent residents [as established pursuant to section 416.13 of this Title] shall [be made] 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:

[(1)] (a) In determining the facility specific direct adjusted payment price per day pursuant to paragraph (4) of subdivision (c) of this section for [patients] residents meeting the criteria [established in section 416.13 of this Title] and residing in a discrete unit for the care of long-term ventilator dependent [patients] residents, [separate and distinct statewide mean, base, and ceiling prices shall be calculated and applied by multiplying the case mix proxy for such patients established by this subdivision times the statewide mean, base, and ceiling direct case mix neutral cost per day respectively.] 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.

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New York
47(q)(1)

- (b) The increments 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 the Department to operate a ventilator-dependent unit. A current period audit of current expenses may result in a negative adjustment to the increment on a prospective basis. An audit of prior period expenses may result in a retrospective negative adjustment to this increment.
 - (c) 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.
 - (d) 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) For purposes of this subdivision, the case mix proxy solely for patients residing in a discrete unit for the care of long term ventilator dependent patients shall be defined as a case mix index of 2.52.]
- (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.

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New York
47(q)(2)

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 per group established pursuant to clause (d)(2)(iii)(a) 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 ~~part~~ Subpart including approved actual costs in such cost report for personnel ~~required by~~ identified in ~~section 415.38 of this title~~ Appendix 2 of this State Plan that would be reported in the functional cost centers identified in subdivision (f) of this section.

~~{(4) The provisions of this subdivision will expire on December 31, 1994.}~~

TN #95-04

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New York
47(r)

(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 the available 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 1988 shall be determined based upon available 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) The adjusted base shall be determined by the 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.

New York
47(s)

- (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 and added to the operating portion of the rate.

TN #89-24
Supersedes TN NEW

Approval Date May 16, 1990
Effective Date July 1, 1989

New York
47(s)(i)

Huntington's disease

For periods on and after July 1, 2011, Medicaid rates of payments for inpatient services provided by existing residential health care facilities with more than 40 beds that operate discrete units for the treatment of residents with Huntington's disease will be increased by a rate add-on amount. The aggregate amount of such rate add-ons for the period July 1, 2011 through December 31, 2011 will be \$850,000 and for calendar year 2012 and each year thereafter will be \$1,700,000. Payments will be calculated as follows:

- (1) Amounts will be allocated to each eligible residential health care facility proportionally based on the number of beds in each facility's discrete unit for treatment of Huntington's disease relative to the total number of such beds in all such units based on the bed capacity reported in certified cost reports submitted to the Department of Health for the calendar year period two years prior to the applicable rate year.
- (2) Rate add-ons will be computed utilizing reported Medicaid days from certified cost reports as submitted to the Department of Health for the calendar year period two years prior to the applicable rate year.
- (3) Rate add-ons shall not be subject to subsequent adjustment or reconciliation.
- (4) Payments under this section end on October 31, 2016.

Specialized programs for residents with neurodegenerative disease providing care to patients diagnosed with Huntington's disease and Amyotrophic Lateral Sclerosis (ALS) Disease.

Effective November 1, 2016, new and existing facilities which have been approved to operate discrete specialty units specifically designated for the purpose of providing care to residents with Huntington's disease and amyotrophic lateral sclerosis, will have rates calculated for Medicaid reimbursement separate and distinct from the general nursing home rate. Rates established in these new specialty units will be based on budgeted cost as submitted by the facility and approved by the department. Budgeted rates will be in effect until such time the specialty facility files a calendar year certified cost report reflecting such specialty unit's first twelve months of operation at an occupancy level of 90% or more. The department will thereafter issue such facilities rates with non-capital components reflecting such cost report and such rates will be effective as of January 1 of the calendar year in which the facility reaches at least a 90% occupancy rate based on a filed cost report of that given year. The capital component will be a continuation of the budget updated for current indebtedness. Should a facility fail to reach 90% occupancy after five (5) years, the Department will review the continued need for a specialty unit in that facility.

The facility specific rate will be calculated as follows:

TN #16-0009

Approval Date January 30, 2017

Supersedes TN #11-0010

Effective Date November 1, 2016

New York
47(s)(ii)

- a. The facility specific direct component of the rate will include allowable 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) laundry and linen;
- (viii) speech and hearing therapy – (speech therapy portion only);
- (ix) central service supply; and
- (x) specialty unit.

Direct component costs are not subject to case mix adjustment.

- b. The facility specific indirect component of the rate will 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

- c. The facility specific noncomparable component of the rate will include allowable 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 cost and allowable items not subject to trending:

TN #16-0009 Approval Date January 30, 2017
Supersedes TN NEW Effective Date November 30, 2016

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- 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 facilities and real estate and occupancy taxes only).

Nothing in this subparagraph will 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.

TN #16-0009

Approval Date January 30, 2017

Supersedes TN NEW

Effective Date November 1, 2016

**New York
47(t)**

The Commissioner of Health shall adjust medical assistance rates of payment for services provided on or after April 1, 2002, established pursuant to this section for non-public residential health care facilities for purposes of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

For non-public residential health care facilities, \$53.5 million on an annualized basis for the period April 1, 2002 through December 31, 2002; \$83.3 million on an annualized basis for the period January 1, 2003 through December 31, 2003; \$115.8 million on an annualized basis for the period January 1, 2004 through December 31, 2006; \$57.9 million for the period January 1, 2007 through June 30, 2007; \$57.9 million for the period July 1, 2007 through March 31, 2008; and \$64.8 million for the period May 8, 2008 through March 31, 2009[, and \$26.2 million for the period April 1, 2009 through March 31, 2010].

For periods through June 30, 2007, for non-public residential health care facilities, such increases shall be allocated proportionally based on each non-public residential health care facility's reported total gross salary and fringe benefit costs on exhibit H of the 1999 RHCF-4 cost report or exhibit 11 of the 1999 institutional cost report as submitted on or before November 1, 2001, where applicable, to the total of such reported costs for all non-public residential health care facilities.

For periods on and after July 1, 2007, for non-public residential health care facilities, 50% of such increases shall be allocated proportionally based on each such facility's salary and fringe benefit costs as reported on Exhibit H in the 1999 cost report submitted prior to November 1, 2001, to the total of such costs for all non-public facilities. The remaining 50% of such increases shall be allocated proportionally based on each non-public facility's Medicaid revenue as reported in the applicable 2005 cost report submitted prior to November 1, 2006, to the total of such Medicaid revenue for all non-public facilities.

Non-public residential health care facilities in operation as of April 1, 2002, which have not submitted 1999 RHCF-4 cost reports or 1999 institutional cost reports, but which have submitted such reports for cost years subsequent to 1999, shall have such increases allocated based on total gross salary and fringe benefit costs on exhibit H of the earliest subsequently submitted RHCF-4 cost report or exhibit 11 of the earliest subsequently submitted institutional cost report, as trended downward to 1999 using authorized trend factors. These trend factors shall be developed in accordance with Page 51(a) of this Attachment and will be consistent with those used in the calculation of the facility's reimbursement rates.

TN <u>#09-12-B</u>	Approval Date <u>January 25, 2011</u>
Supersedes TN <u>#08-25</u>	Effective Date <u>April 1, 2009</u>

**New York
47(t)(1)**

Non-public residential health care facilities in operation as of April 1, 2002, which have not submitted 1999 or subsequent RHCF-4 cost reports or institutional cost reports, shall have such increases allocated based on imputed total gross salary and fringe benefit costs reflecting the average of such 1999 actual reported costs in the region in which each facility is located. Facilities receiving allocations pursuant to this paragraph which subsequently submit RHCF-4 cost reports or institutional cost reports shall, for the purpose of setting medical assistance rates of payment, have such allocations adjusted to reflect costs which were incurred in connection with such allocations and which are contained in such cost reports.

These amounts shall be included as a reimbursable cost add-on to medical assistance fee-for-service rates of payment established pursuant to this section, based on Medicaid utilization data in each facility's annual cost report submitted two years prior to the rate year or projected Medicaid utilization data for those facilities that have not submitted an annual cost report for the period two years prior to the rate year. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

TN #07-36

Approval Date December 19, 2007

Supersedes TN #06-69

Effective Date July 1, 2007

New York
47(t)(2)

Criminal Background Checks

Effective April 1, 2005, residential health care facility providers must obtain a criminal history record check from the United States Attorney General for any prospective unlicensed direct care employee. This includes obtaining, as part of an application for employment, all information from a prospective employee necessary for initiating the criminal history record check, including, but not limited to, a fingerprint card of the prospective employee. The federal fee and the costs associated with obtaining the fingerprint card shall be separately identified on any report of costs submitted to the Department of Health and shall be deemed an allowable cost for Medicaid rates of payment. Reimbursement for the period April 1, 2005 through March 31, 2006 and for the period April 1, 2006 through August 31, 2006, shall be made retrospectively based upon cost reports submitted for the 2005 and 2006 rate years respectively. For new providers or existing providers for which cost report data are unavailable, payment will be based on budgeted costs and subsequently adjusted to reflect actual costs. Reimbursement for all types of providers shall total no more than \$5,000,000 for the April 1, 2005 through March 31, 2006 period and no more than \$13,400,000 for the April 1, 2006 through August 31, 2006 period. Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current rates of payment and will be determined by the percent of Medicaid utilization to total utilization for each provider. If the total cost for these criminal background checks for all types of providers exceeds the amounts set forth for the specified period, provider specific reimbursement will be reduced proportionally.

Effective September 1, 2006, residential health care facilities shall request criminal history background checks from the Department of Health for unlicensed prospective employees who will provide direct care or supervision to patients, residents, or clients of such providers. The criminal history information will consist of both a state and a national criminal history check.

Residential health care facilities may claim as reimbursable costs under the medical assistance program, costs reflecting the fee established pursuant to law by the NYS Division of Criminal Justice Services for processing a state criminal history information check, the fee imposed by the Federal Bureau of Investigation for a national criminal history check, and certain other costs associated with obtaining the fingerprints. These costs shall be separately identified on any report of costs submitted to the Department of Health.

Reimbursement for the Medicaid share of these costs shall be in the form of an add-on to the current Medicaid rate of payment based on the costs reported for the period two years prior to the rate period and will be determined by the percent of Medicaid utilization to total utilization for each provider.

TN #07-36

Supersedes TN #06-69

Approval Date December 19, 2007

Effective Date July 1, 2007

New York
47(u)

- (s) Adjustment of rates pursuant to methodology changes effective October 1, 1990 and April 1, 1991.
- (1) Rate changes resulting from the [Amendments] amendments to sections 86-2.1(a), 86 -2.9(c), 86-2.10(a)(3), (c)(1)-(5), (d)(1) & (2) and (p)(2) [,] and (3) [& (4)], 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 [reflected in 1990 and 1991 rates pursuant to the following schedule] as follows:
- (i) For rates with effective dates commencing between October 1, 1990 to [March 31, 1991] and June 30, 1992, [actual rate change shall not exceed 0 percent] 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 between April 1, 1991 to June 30, 1991, actual rate change shall not exceed 2 percent.
- (iii) For rates with effective dates commencing between July 1, 1991 to September 30, 1991, actual rate changes shall not exceed 4 percent.
- (iv)] (ii) For rates with effective dates commencing on or after [October 1, 1991] July 1, 1992, the full impact of the [methodology] rate changes [effective on October 1, 1990] 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 [March 31, 1991] 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.
- (3) Notwithstanding the provisions of paragraph (1) of this subdivision, residential health care facilities which have been identified by the department as requiring registered nurse staffing increases to provide seven days a week, eight hours per day of day shift registered nurse coverage shall receive rate changes effective October 1, 1990 at a level sufficient to compensate

TN #91-25

Approval Date July 11, 1994

Supersedes TN #90-10

Effective Date April 1, 1991

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47(v)

facilities for additional expenses of expanding registered nurse coverage based upon a survey of costs to be incurred by affected facilities.

- (4) Nothing within this subdivision shall preclude the Department from fully implementing rate adjustments on or after October 1, 1990, which are unrelated to methodology changes referenced in paragraph (1) of this subdivision.

(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

* for rates effective July 1, 1992

TN <u>#91-25</u>	Approval Date <u>July 11, 1994</u>
Supersedes TN <u>#90-10</u>	Effective Date <u>April 1, 1991</u>

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47(w)

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 aide 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.

TN #97-03

Supersedes TN #96-03

Approval Date June 30, 1997

Effective Date October 1, 1997

**New York
47(w)(1)**

- (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.¹

¹ Trend factors are computed in accordance with Section 86-2.12 of this Plan.

TN <u>#97-03</u>	Approval Date <u>June 30, 1997</u>
Supersedes TN <u>NEW</u>	Effective Date <u>October 1, 1997</u>

New York
47(w)(2)

Description of the Specific Methodology Used in Determining the Adjustment.

In order to determine the impact of the federal law on New York facilities, a cost estimate was made for each added code requirement. The total average additional cost was determined to be 45 cents per patient day.

Resident Assessments

Since New York State facilities were required prior to the new federal code to conduct accurate and comprehensive assessments, the additional cost pertains to completion of the MDS+² document and RN coordination and certification of completeness. No discipline other than RN is required, although facilities may choose to assign portions of the MDS+ to various disciplines as appropriate. Physician responsibilities remain the same prior to the new code.

Comprehensive assessments include those performed on initial admission, annually, and upon significant change in resident status. It is estimated that there will be 1.48 comprehensive assessments per bed in 1991. This was based on an estimated significant change rate of 50% of the beds per year, and a 45% turnover rate per year. One twelfth of the annual assessments will be completed each month. Similarly, one twelfth of the assessments necessitated by the 45% turnover rate and the 50% significant change rate will also be completed each month. Half of the time, either of the latter two assessments will occur before the scheduled annual assessments of the resident in that bed, and the scheduled annual assessment will therefore not be necessary for that resident. The number of scheduled annual assessments not necessary under this methodology equals half of the new admit assessments and residents with a significant change, or (.5) $((.45) + (.5) = .48$. The total number of assessments per bed would be $1.48 = 1.48$.

² MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)

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**New York
47(w)(3)**

Based on a time study of the MDS³, it was estimated that each comprehensive assessment would require one hour and forty five minutes, or forty five minutes longer than current practice. An average RN hourly salary rate of \$24.00 as reported by industry representatives was used to make this calculation. The total cost was estimated as follows:

(# assessments/bed) (# beds) (incremental time/assessment)

(1.48) (105,000) (.75) (\$24) = \$2,797,200 for comprehensive assessments

Quarterly resident assessment reviews are estimated to be 2.2 per bed per year, at 30 minutes per assessment, with the remaining assumptions the same as for comprehensive assessments.

(2.2) (105,000) (.5) (\$24) = \$2,772,000 for quarterly assessments

³ MDS (Minimum Data Set)

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New York
47(w)(4)

Comprehensive Care Plan

The incremental cost of comprehensive care plans for all residents was estimated by determining the added time of each participating discipline and multiplying by the average salary rate for that discipline. Physician participation in the care planning process has been a standard of practice in this State, and no additional time should be necessary under the new code. Based on an analysis of 1990 Patient Review Instrument (PRI) data, physical therapy (provided by a licensed physical therapist) was received by 21% of residents, and 9% received occupational therapy. Based on the new code requirements, it is estimated that twice this number or 42% PT and 18% OT, will require additional care planning participation by these therapists. For those residents requiring PT/OT services an additional half hour of PT/OT time will now be required. At an industry estimated hourly rate of \$31.50 for physical therapists and \$30.00 for occupational therapists, the added cost would be \$15.74 for PT and \$15.00 for OT for care plans for patients receiving therapy. The nursing home industry estimated that RN, social worker, dietician, and activities worker care planning time for 100 of care plans would each increase by .5 hour. The hourly rates provided by the industry for RNs were \$24.00, for social workers \$15.40, for dieticians \$21.00, for activities workers \$10.00. Based on 1.48 care plans per bed (using the number of comprehensive assessments per year), the calculation as follows:

(# plans/bed) (#beds for all residents) (incremental time for each discipline x hourly rate x percent of care plans involving discipline) = statewide cost

$(1.48) (105,000) ((.5 \times \$24 \times 100\%) + (.5 \times \$15.40 \times 100\%) + (.5 \times \$21.00 \times 100\%) + (.5 \times \$10.00 \times 100\%) + (.5 \times \$31.50 \times 42\%) + (.5 \times \$30.00 \times 18\%)) = \$6,917,631$

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47(w)(5)

Quarterly Plan Reviews

Only an RN is involved in the incremental activities required by OBRA. The industry's estimate of 2.2 quarterly care plans per year at an incremental cost of \$6.00 per review was used:

(# care plans/bed) (# beds) (incremental cost/plan) = statewide cost

(2.2) (105,000) (\$6.00) = \$1,386,000

Training on MDS+⁴ Assessment

An estimate of 70,020 was used, based on the industry's estimate which was found acceptable

Cost of training for up to 80 beds	\$229,950
80 bed increments	<u>\$140,070</u>
	\$370,020

⁴ MDS+ (Minimum Data Set Plus For Nursing Home Residents Assessment and Care Screening)

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New York
47(w)(6)

Quality Assurance

The meeting and preparation time for quarterly Quality Assurance meetings, including committee members of a physician, director of nursing, administrator or designee and three other staff was estimated by the industry. This was offset by the elimination of separate pharmacy reviews and infection control meetings, as well as the existing utilization review assessment and U/R committee meetings. Three added staff involved in meetings are assumed to be the physical therapist, social services director and a representative from medical records. The net added expense estimated by the industry was \$600, 264.

Recertification of Nurse Aides

The number of aides who must be recertified by 1/92 is 17,381. The cost of recertification is \$25.00 per aide. The total recertification cost is \$434, 525.

Psychotropic Drug Reviews

The code requires that all residents receiving psychotropic medications be reviewed with the intent of minimizing the usage of such drugs. These reviews are assumed to involve the physician and take about .5 hours per resident. It is estimated that 20% of residents will need such review at physician cost of \$150 per hour.

$$105,000 \times 20\% \times .5 \times \$150 = \$1,575,000$$

TN #97-03

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Approval Date June 30, 1997

Effective Date October 1, 1997

New York
47(w)(7)

Surety Bonds

The industry has estimated that \$189,000 of added cost will be incurred for this requirement and was found acceptable.

SUMMARY OF INCREMENTAL CODE COSTS TO BE REIMBURSED

Total incremental federal code cost to be recognized in facility 1991 rates is \$17,041,640.

Comprehensive Resident Assessment	\$2,797,200
Quarterly Resident Assessment	2,772,000
Comprehensive Care Plan	6,917,631
Quarterly Care Plan Review	1,386,000
Training of MDS+ ⁵ Assessment	370,020
Quality Assurance	600,264
Nurse Aide	434,525
Psychotropic Drug Review	1,575,000
Surety Bonds	<u>189,000</u>
Total Incremental Cost	\$17,041,640

⁵ MDS+ (Minimum Data Set Plans for Nursing Home Residents Assessment and Care Screening)

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47(w)(8)**

Costs are to be reflected in facility rates beginning July 1, 1991, so that the nine months of incremental cost from April 1, 1991 to December 1991 will be reflected in the six month rate period July to December 1991. Total incremental costs were converted to a per diem add-on to be included in a facility's rate by dividing total incremental costs by available beds, and adjusting to days by dividing by 365. The calculation is as follows:

$$\text{\$17,041,640} / 105,000 / 365 = .45 \text{ add-on}$$

This statewide add-on will be adjusted for each facility to reflect regional differences in RN salary levels for calendar year 1987. Such regional adjustments are currently used in the determination of the direct and indirect components of facility rates. For 1992 and forward, the incremental cost add-on will be increased by the appropriate trend factor.⁶

⁶ Trend factors are computed in accordance with Section 86-2.12 of this Plan.

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New York
47(w)(9)

Description of Methodologies for the Physical, Mental, and Psychosocial Well Being Requirement

The State of New York reimbursement rates match payment with intensity of care, thus providing facilities with adequate reimbursement for patients requiring more intensive supportive, medical or rehabilitative care. The RUG II patient classification system classifies each patient into one of sixteen patient categories which are each different in terms of clinical characteristics and are statistically different in terms of costs of care.

The system uses a hierarchy of patient types and secondary subgroup format based on Activities of Daily Living (ADL) function levels. The five hierarchical groups, from the highest to lowest resource consumption, are as follows:

1. Special Care
2. Rehabilitation
3. Clinically Complex
4. Severe Behavioral Problems
5. Reduced Physical Functions

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47(w)(10)**

Each of the above clinical groups is further divided by the ADL index score into subgroups. The ADL index is comprised of three ADL variables, eating, toileting, and transfer, which were determined to be the key predictors of resource consumption within each clinical group. For each of the sixteen patient classification categories, a relative resource "weight" representing the resource consumption of patients in that category relative to the average patient, is used to adjust the direct component of the payment rate.

The RUGS system thus allows a more precise and equitable means of directing available fiscal resources to nursing homes that care for residents with the heaviest care needs. By recognizing the resources required to provide more intensive rehabilitative and support services, the reimbursement methodology encourages nursing homes to establish restorative care programs. This can result in more active intervention for eligible patients, and earlier improvement and discharge.

October 1, 1992

For rates effective January 1, 1992 and thereafter, the per diem add-on described herein will be increased by a trend factor as defined in Section 86-2.12 of this Plan.

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New York
47(w)(11)

Description of the specific methodology for determining the adjustment Bloodborne Pathogens

Hepatitis B Vaccination:

Beginning January 1, 1993 and thereafter, provider rates contain a facility specific adjustment to reimburse the cost of the Hepatitis B vaccine administered to employees. Provider-specific adjustments are based upon each facility's actual costs recognized up to a maximum cost for the vaccine. The facility specific adjustment will be determined using costs reported by the providers two years prior to the state of the rate year. The maximum cost for the vaccine that is recognized when setting the facility specific adjustment is \$128.50 for a three vial series per employee.

Gloves:

For rates effective on April 1, 1994 for the 1994 calendar year and each calendar year thereafter, and \$.18 per diem adjustment will be included in provider's rates for the incremental cost of gloves.

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Reserved.

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New York
47(x)(1)

- (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 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 which shall mean a person who is at least three months post-injury and who has been diagnosed as having a cognitive and/or physical condition that has resulted from traumatically acquired, non-degenerative, structural brain damage, or anoxia, and who in addition has participated in an intensive inpatient rehabilitation program for persons with TBI in a hospital or nursing home and has been assessed by a neurologist or physiatrist who determined that the individual would no longer benefit from an intensive rehabilitation program. 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 by 365 days to determine the annual TBI amount. The annual TBI amount shall then be adjusted by the facility RPIDAF, 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.

TN #95-04

Approval Date June 4, 1999

Supersedes TN #94-44

Effective Date January 1, 1995

New York
47(x)(2)

Rates of payment for non-state operated public residential health care facilities shall be increased in an aggregate amount of \$100 million for payments for services provided during the period July 1, 1995 through March 31, 1996. To be eligible, the facility must be operating at the time the pool is distributed. Payment to each eligible facility shall be in proportion to the facility's 1994 Medicaid days relative to the sum of 1994 Medicaid days for all eligible facilities.

TN #95-24-A
Supersedes TN NEW

Approval Date March 27, 1997
Effective Date July 1, 1995

New York
47(x)(2)(a)

For the period August 1, 1996 through March 31, 1997, proportionate share payments in the aggregate amount of \$257 million shall be made under the medical assistance program to non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. Payments shall be made as a lump sum payment to each eligible residential health care facility.

The amount allocated to each eligible public residential health care facility shall be calculated as the result of \$257 million multiplied by the ratio of 1994 facility Medicaid patient days for all eligible public residential health care facilities. The payments are made contingent upon receipt of all approvals required by federal law or regulation.

TN <u>#96-28</u>	Approval Date <u>May 18, 1998</u>
Supersedes TN <u>NEW</u>	Effective Date <u>August 1, 1996</u>

**New York
47(x)(2)(b)**

1905(a)(4)(A) Nursing Facility Services

For the period April 1, 1997, through March 31, 1999, proportionate share payments in an annual aggregate amount of \$631.1 million will be made under the medical assistance program to non-state public operated residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For the period April 1, 1999, through March 31, 2000, proportionate share payments in an annual aggregate amount of \$982 million will be made under the medical assistance program to non-state operated public residential health care facilities, excluding public residential health care facilities operated by a town or city within a county. For annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and April 1, 2005, through March 31, 2009, proportionate share payments in an annual aggregate amount of up to \$991.5 million and \$150.0 million, respectively, for state fiscal year April 1, 2009 through March 31, 2010, \$167 million, and for state fiscal years commencing April 1, 2010 through March 31, 2011, \$189 million in an annual aggregate amount, and for the period April 1, 2011 through March 31, 2012 an aggregate amount of \$172.5 million and for state fiscal years commencing April 1, 2012 through March 31, 2013, an aggregate amount of \$293,147,494, and for the period April 1, 2013 through March 31, 2014, \$246,522,355, and for the period April 1, 2014 through March 31, 2015, \$305,254,832, and for the period April 1, 2015 through March 31, 2016, \$255,208,911, for the period April 1, 2016 through March 31, 2017, \$198,758,133 in an annual aggregate amount, and for the period April 1, 2017 through March 31, 2018, the aggregate amount of \$167,600,071, will be paid semi-annually in September and March, and for the period April 1, 2018 through March 31, 2019, the aggregate amount of \$225,104,113, will be paid semi-annually in September and March, and for the period April 1, 2019 through March 31, 2020, the aggregate amount of \$196,055,358 will be paid semi-annually in September and March, and for the period April 1, 2020 through March 31, 2021, the aggregate amount of \$112,885,261 will be paid semi-annually in September and March, and for the period April 1, 2021 through March 31, 2022, the aggregate amount of \$110,086,302 will be paid semi-annually in September and March, and for the period April 1, 2022 through March 31, 2023, the aggregate amount of \$184.5 million will be paid semi-annually in September and March, and for the period April 1, 2023 through March 31, 2024, the aggregate amount of \$212,803,476 will be paid semi-annually in September and March, which will be made under the medical assistance program to non-state operated public residential health care facilities, including public residential health care facilities located in the counties of Erie, Nassau and Westchester, but excluding public residential health care facilities operated by a town or city within a county.

The amount allocated to each eligible public residential health care facility for the period April 1, 1997, through March 31, 1998, will be calculated as the result of \$631.1 million multiplied by the ratio of their 1995 Medicaid days relative to the sum of 1995 Medicaid days for all eligible public residential health care facilities. The amount allocated to each eligible public residential health care facility for the period April 1, 1998, through March 31, 1999, will be calculated as the result of \$631.1 million multiplied by the ratio of their 1996 Medicaid days relative to the sum of 1996 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for the period April 1, 1999, through March 31, 2000, will be calculated as the result of \$982 million multiplied by the ratio of their 1997 Medicaid days relative to the sum of 1997 Medicaid days for all eligible public residential health care facilities. The amount allocated to each public residential health care facility for annual state fiscal year periods commencing April 1, 2000 and ending March 31, 2005, and for annual state fiscal year periods commencing April 1, 2005 through March 31, 2009, and for state fiscal years commencing April 1, 2009 through March 31, 2011; April 1, 2011 through March 31, 2012; April 1, 2012 through March 31, 2013; April 1, 2013 through March 31, 2014; and April 1, 2014 through March 31, 2015; April 1, 2015 through March 31, 2016; April 1, 2016 through March 31, 2017; April 1, 2017 through March 31, 2018; and April 1, 2018 through March 31, 2019; and April 1, 2019 through March 31, 2020; and April 1, 2020 through March 31, 2021, and April 1, 2021 through March 31, 2022, and April 1, 2022 through March 31, 2023, and April 1, 2023 through March 31, 2024 will be calculated as the result of the respective annual aggregate amount multiplied by the ratio of their Medicaid days relative to the sum of Medicaid days for all eligible public residential health care facilities for the calendar year period two years prior provided, however, that an additional amount of \$26,531,995 for the April 1, 2013 through March 2014 period will be distributed to those public residential health care facilities in the list which follows.

TN #23-0063

Approval Date September 26, 2024

Supersedes TN #22-0048

Effective Date April 1, 2023

New York
47(x)(2)(c)

The \$26,531,995 will be distributed to the following facilities in the following amounts:

Facility	2013 Additional Payment
Albany County Nursing Home	\$6,524,997
Erie County Home	\$8,697,386
Erie County Medical Center	\$1,989,503
Golden Hill Health Care Center	\$3,274,412
Monroe Community Hospital	\$2,009,348
Sullivan County Adult Care Center	\$2,102,457
Willow Point Nursing Home	\$1,933,892
TOTAL	\$26,531,995

Payments shall be made as a lump sum payment to each eligible residential health care facility.

TN #13-07 Approval Date June 30, 2014
Supersedes TN NEW Effective Date April 1, 2013

New York
47(x)(3)

prospectively reduced on a proportional basis if the commissioner determines that the actual staffing reported in the facilities cost report submitted pursuant to this Subpart is less than the staffing pattern ~~required by~~ identified in ~~section 415.39 of this title~~ Appendix 3 of this State Plan.

- (2) In determining the indirect component of a facility's rate pursuant to paragraphs (d) (4)-(6) 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 (d)(2)(iii)(a) 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 cost in such cost report for personnel that would be reported in the functional cost centers identified in subdivision (f) of this section.

~~[(4) The provision of this subdivision will expire on December 31, 1994.]~~

New York
47(x)(4)

- (x) Residential health care facility rates of payment for services provided on or after July 1, 1995 through March 31, 1996 shall be reduced by the Commissioner to reflect the elimination of operational requirements previously mandated by law or regulation or the Commissioner or other governmental agency, by a factor determined as follows:
- (i) an aggregate reduction shall be calculated for each residential health care facility as the result of (a) up to fifty-six million dollars on an annualized basis for 1995, trended to the rate year by the trend factor for projection of reimbursable costs to the rate year, multiplied by (b) the ratio of patient days for patients eligible for payments made by government agencies provided in a base year two years prior to the rate years by a residential health care facility, divided by the total of such patient days summed for all residential health care facilities; and
 - (ii) the result for each residential health care facility shall be divided by such patient days for patients eligible for payment made by governmental agencies provided in the residential health care facility, for a per diem reduction in rates of payment for such residential health care facility for patients eligible for payments made by governmental agencies.
 - (iii) Effective April 1, 1996 through March 31, 1999 and on or after July 1, 1999 through [March] December 31, 2006 residential health care facility rates of payment shall be reduced by an annual aggregate amount of fifty-six million dollars to encourage improved productivity and efficiency. Actual reduction in rates within such aggregate amounts will be allocated among facilities based upon each facility's ratio of Medicaid utilization to total statewide Medicaid utilization for all residential health care facilities.

TN #06-21

Supersedes TN #05-32

Approval Date October 10, 2006

Effective Date April 1, 2006

New York
47(x)(5)

(w) Specialized programs for residents requiring behavioral interventions.

Facilities which have been approved to operate discrete units specifically designed 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 (c)(4) 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 (c)(3)(iii) of this section for such residents shall be increased by an increment of 1.40. In determining the case mix adjustment pursuant to paragraph (c)(6) 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) Specific interventions that the Department has approved which qualify for payment are a combination of medical and behavioral interventions such as counseling, recreation and exercise carried out in a therapeutic environment and provided on-site.

Nursing resident criteria to be used in determining eligibility for payment include assessment of whether the resident is a danger to self or others and displays violent or aggressive behaviors which are typically exhibited as physical or verbal aggression such as clear threats of violence. The behavior may be unpredictable, recurrent for no apparent reason, and typically exhibited as assaultive, combative, disruptive or socially inappropriate behavior such as sexual molestation or fire setting.

(ii) The increment established in paragraph (1) of this subdivision shall be audited and such increment shall be retrospectively or

New York
47(x)(6)

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 below.

A current period audit of current period expenses will result in an incremental adjustment implemented on a prospective basis. An audit of prior period expenses will result in a retrospective adjustment in a lump sum payment. The staffing pattern required by the department is as follows:

- (a) The unit shall be managed by a program coordinator;
 - (b) A physician shall be responsible for medical director and oversight of the program;
 - (c) A qualified specialist in psychiatry, a psychologist and a social worker shall be available on staff on a consulting basis;
 - (d) Other than the program coordinator, there shall be at least one registered professional nurse on each shift.
- (2) In determining the indirect component of a facility's rate pursuant to paragraphs (d)(4) - (6) 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 (d)(2)(iii)(a) 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 cost 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.
- (4) The provision of this subdivision will expire on December 31, 1994.

TN #94-04

Supersedes TN NEW

Approval Date September 8, 1998

Effective Date March 16, 1994

New York
47(x)(7)

Medicare Utilization.

- (1) (a) Prior to February 1, 1996 the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to Medicare beneficiaries, divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period commencing July 1, 1995 to the last date for which such data is available and reasonably accurate. This value shall be called the 1995 statewide target percentage.
- (b) Prior to February 1, 1997, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period commencing January 1, 1996 through November 30, 1996 based on such data for such period as is available and reasonably accurate. This value shall be called the 1996 statewide target percentage.
- (c) Prior to February 1, 1998, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal

TN #99-35

Approval Date June 6, 2001

Supersedes TN #97-24

Effective Date July 1, 1999

New York
47(x)(8)

social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1997 through November 30, 1997 based on such data as is available and reasonably accurate. This value shall be called the 1997 statewide target percentage.

- (d) Prior to February 1, 1999, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of Title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1988 through November 30, 1998 based on such data as is available and reasonably accurate for such period. This value shall be called the 1998 target percentage.
- (e) Prior to February 1, 2000 the commissioner of health shall calculate the result of the statewide total of residential health care

TN #99-35

Approval Date June 6, 2001

Supersedes TN #97-24

Effective Date July 1, 1999

New York
47(x)(9)

facility days of care provided to beneficiaries of Title XVIII of the Social Security Act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1999 through November 30, 1999, based on such data for such period. This value [shall] will be called the 1999 statewide target percentage.

- (f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008, February 1, 2009, February 1, 2010, February 1, 2011, February 1, 2012, February 1, 2013, February 1, 2014, February 1, 2015, February 1, 2016, February 1, 2017, February 1, 2018, [and] February 1, 2019, February 1, 2020, and thereafter the Commissioner of Health will calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of Title XVIII of the Social Security Act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value [shall] will be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020, and thereafter the statewide target percentage respectively.
- (2) Prior to February 1, 1996, the Commissioner of Health will calculate the results of the statewide total of health care facility

TN #19-0043

Supersedes TN #17-0035

Approval Date August 20, 2019

Effective Date April 01, 2019

New York
47(x)(10)

days of care provided to Medicare beneficiaries, divided by the sum of days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period April 1, 1994 through March 31, 1995. This value shall be called the statewide base percentage.

- (3) (a) If the 1995 statewide target percentage is not at least one percentage point higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the 1995 statewide target percentage is not at least one percentage point higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1995 statewide reduction percentage. If the statewide target percentage is at least one percentage point higher than the statewide base percentage, the statewide reduction percentage shall be zero.
- (b) If the 1996 statewide target percentage is not at least two percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the 1996 statewide target percentage is not at least two percentage points higher than the statewide base percentage. The percentage calculated pursuant to this subdivision shall be called the 1996 statewide reduction percentage. If the

**New York
47(x)(11)**

1996 statewide target percentage is at least two percentage points higher than the statewide base percentage, the 1996 statewide reduction percentage will be zero.

- (c) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, and thereafter statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the Commissioner of Health will determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph will be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, and thereafter statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, and 2019 statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year will be zero.
- (d) If the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage, the Commissioner of Health will determine the percentage by which the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph will be called the 1999 statewide reduction percentage. If the 1999 statewide target percentage is at least two and one-quarter percentage points higher than the statewide base percentage, the 1999 statewide reduction percentage will be zero.

New York
47(x)(12)

- (4) (a) The 1995 statewide reduction percentage will be multiplied by \$34 million to determine the 1995 statewide aggregate reduction amount. If the 1995 statewide reduction percentage will be zero, there will be no reduction amount.
- (b) The 1996 statewide reduction percentage will be multiplied by \$68 million to determine the 1996 statewide aggregate reduction amount. If the 1996 statewide reduction percentage will be zero, there will be no reduction amount.
- (c) The 1997 statewide reduction percentage will be multiplied by \$102 million to determine the 1997 statewide aggregate reduction amount. If the 1997 statewide reduction percentage will be zero, there will be no 1997 reduction amount.
- (d) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020, and thereafter statewide reduction percentage will be multiplied by \$102 million respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016 and 2017 statewide aggregate reduction amount. If the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020, and thereafter, statewide reduction percentage will be zero respectively, there will be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020, and thereafter statewide reduction amount.

New York
47(x)(13)

- (e) The 1999 statewide reduction percentage will be multiplied by \$76.5 million to determine the 1999 statewide aggregate reduction amount. If the 1999 statewide reduction percentage will be zero, there will be no 1999 reduction amount.
- (5) (a) The 1995 statewide aggregate reduction amount will be allocated by the Commissioner of Health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law on the basis of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage. This amount will be called the 1995 facility specific reduction amount.
- (b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter statewide aggregate reduction amounts will for each year be allocated by the Commissioner of Health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to Title 11 of Article 5 of the Social Services Law on the basis of the extent of each facility's failure to achieve a two percentage point increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020, and thereafter target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage point increase in the 1996, a three percentage point increase in the 1997, and a

**New York
47(x)(14)**

three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter target percentage compared to the base percentage. These amounts will be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, [and] 2019, 2020 and thereafter facility specific reduction amounts respectively.

(6) The facility specific reduction amounts will be due to

New York
47(x)(15)

the state from each residential health care facility and may be recouped by the state in a lump sum amount from payments due to the residential health care facility pursuant to title 11 of article 5 of the social services law.

- (7) Residential health care facilities shall submit such utilization data and information as the commissioner of health may require for purposes of this section. The commissioner of health may use utilization data available from third party payers.
- (8) (a) On or about June 1, 1996, the commissioner of health shall calculate for the period July 1, 1995 through March 31, 1996 statewide target percentage, statewide aggregate reduction amount, and a facility specific reduction amount in accordance with the methodology provided in paragraphs 1(a), 3(a), 4(a) and 5(a) of this provision. The facility specific reduction amount calculated in accordance with this paragraph shall be compared to the 1995 facility specific reduction amount calculated in accordance with paragraph 5(a) of this provision. Any amount in excess of the amount determined in accordance with paragraph 5(a) of this provision shall be due to the state from each residential health care facility and may be recouped in the same manner as specified in paragraph 6 of this provision.
If

New York
47(x)(16)

the amount is less than the amount determined in accordance with paragraph 5(a) of this provision, the difference shall be refunded to the residential health care facility by the state no later than July 15 1996. Residential health care facilities shall submit utilization data for the period July 1, 1995 through March 31, 1996 to the commissioner of health by April 15, 1996.

- (b) On or about June 1, 1997, the commissioner of health shall calculate for the period January 1, 1996 through November 30, 1996 a statewide target percentage, a statewide reduction percentage, a statewide aggregate reduction amount, and a facility specific reduction amount in accordance with the methodology provided in paragraph 1(b), 3(b), 4(b) and 5(b) of this provision. The facility specific reduction amount calculated in accordance with this paragraph shall be compared to the 1996 facility specific reduction amount calculated in accordance with paragraph 5(b) of this provision. Any amount in excess of the amount determined in accordance with paragraph 5(b) of this provision shall be due to the state from each residential health care facility and may be recouped in the same manner as specified in paragraph 6 of this provision. If the amount is less than the amount determined in accordance with paragraph 5(b) of this provision, the difference shall be refunded to the residential health care facility by the state no later than

TN #00-04

Approval Date June 6, 2001

Supersedes TN #99-35

Effective Date January 1, 2000 April 1, 2000

New York
47(x)(17)

July 15, 1997. Residential health care facilities shall submit utilization data for the period January 1, 1996 through November 30, 1996 to the commissioner of health by April 15, 1997.

TN	<u>#00-04</u>	Approval Date	<u>June 6, 2001</u>
Supersedes TN	<u>NEW</u>	Effective Date	<u>January 1, 2000 April 1, 2000</u>

New York
47(y)

Description of the Specific Methodology Used in Determining the Adjustment

In order to determine the impact of the federal law on New York facilities, a cost estimate was made for each added code requirement. The total average additional cost was determined to be 45 cents per patient day.

Resident Assessments

Since New York State facilities were required prior to the new federal code to conduct accurate and compressive assessments, the additional cost pertains to completion of the MDS+² document and RN coordination and certification of completeness. No discipline other than RN is required, although facilities may choose to assign portions of the MDS+ to various disciplines as appropriate. Physician responsibilities remain the same as prior to the new code.

Comprehensive assessments include those performed on initial admission, annually, and upon significant change in resident status. It is estimated that there will be 1.48 comprehensive assessments per bed in 1991. This was based on an estimated significant change rate of 50% of the beds per year, and a 45% turnover rate per year. One twelfth of the annual assessments will be completed each month. Similarly, one twelfth of the assessments necessitated by the 45% turnover rate and the 50% significant change rate will also be completed each month. Half of the time, either of the latter two assessments will occur before the scheduled annual assessment of the resident in that bed, and the scheduled annual assessment will therefore not be necessary for that resident. The number of scheduled annual assessments not necessary under this methodology equals half of the new admit assessments and residents with a significant change, or (.5) $((.45) + (.5)) - .48$. The total number of assessments per bed would be $1 + .48 = 1.48$.

²MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)

TN #96-03

Approval Date June 26, 1996

Supersedes TN #95-03

Effective Date October 1, 1996

New York
47(z)

Based on a time study of the MDS³, it was estimated that each comprehensive assessment would require one hour and forty five minutes, or forty five minutes longer than current practice. An average RN hourly salary rate of \$24.00 as reported by industry representatives was used to make this calculation. The total cost was estimated as follows:

(# assessments/bed) (# beds) (incremental time/assessment)

(1.48) (105,000) (.75) (\$24) = \$2,797,200 for comprehensive assessments

Quarterly resident assessment reviews are estimated to be 2.2 per bed per year, at 30 minutes per assessment, with the remaining assumptions the same as for comprehensive assessments.

(2.2) (105,000) (.5) (\$24) = \$2,772,000 for quarterly assessments

³MDS (Minimum Data Set)

TN #96-03

Approval Date June 26, 1996

Supersedes TN #95-03

Effective Date October 1, 1996

New York
47(z1)

Comprehensive Care Plan

The incremental cost of comprehensive care plans for all residents was estimated by determining the added time of each participating discipline and multiplying by the average salary rate for that discipline. Physician participation in the care planning process has been a standard of practice in this State, and no additional time should be necessary under the new code. Based on an analysis of 1990 Patient Review Instrument (PRI) data, physical therapy (provided by a licensed physical therapist) was received by 21% of residents, and 9% received Occupational Therapy. Based on the new code requirements, it is estimated that twice this number, or 42% PT and 18% OT, will require additional care planning participation by these therapists. For those residents requiring PT/OT services, an additional half hour of PT/OT time will now be required. At an industry estimated hourly rate of \$31.50 for physical therapists and \$30.00 for occupational therapists, the added cost would be \$15.74 for PT and \$15.00 for OT for care plans for patients receiving therapy. The nursing home industry estimated that RN, social worker, dietician, and activates worker care planning time for 100% of care plans would each increase by .5 hour. The hourly rates provided by the industry for RNs were \$24.00, for social workers \$15.40, for dieticians \$21.00, for activates workers \$10.00. Based on 1.48 care plans per bed (using the number of comprehensive assessments per year), the calculation is as follows:

(#plans/bed) (# beds for all residents) (incremental time for EACH discipline X hourly rate X percent of care plans involving discipline) = statewide cost

$(1.48) (105,000) ((.5 \times \$24 \times 100\%) + (.5 \times \$15.40 \times 100\%) + (.5 \times \$21.00 \times 100\%) + (.5 \times \$10.00 \times 100\%) + (.5 \times \$31.50 \times 42\%) + (.5 \times \$30.00 \times 18\%)) = \$6,917,631$

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47(z2)

Quarterly Plan Reviews

Only an RN is involved in the incremental activities required by OBRA. The industry's estimate of 2.2 quarterly care plans per year at an incremental cost of \$6.00 per review was used:

(# care plans/bed) (#beds) (incremental cost/plan) – statewide cost

(2.2) (105,000) (\$6.00) = \$1,386,000

Training on MDS+⁴ Assessment

An estimate of \$370,020 was used, based on the industry's estimate which was found acceptable:

Cost of training for up to 80 beds	\$229,950
80 bed increments	<u>\$140,070</u>
	\$370,020

⁴MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)

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47(z3)

Quality Assurance

The meeting and preparation time for quarterly Quality Assurance meetings, including committee members of a physician, director of nursing, administrator or designee and three other staff was estimated by the industry. This was offset by the elimination of separate pharmacy reviews and infection control meetings, as well as the existing utilization review assessment and U/R committee meetings. Three added staff involved in meetings are assumed to be the physical therapist, social services director, and a representative from medical records. The net added expense estimated by the industry was \$600,264.

Recertification of Nurse Aides

The number of aides who must be recertified by 1/92 is 17,381. The cost of recertification is \$25.00 per aide. The total recertification cost is \$434,525.

Psychotropic Drug Reviews

The code requires that all residents receiving psychotropic medications be reviewed with the intent of minimizing the usage of such drugs. These reviews are assumed to involve the physician and take about .5 hours per resident. It is estimated that 20% of residents will need such review at a physician cost of \$150 per hour.

$$105,000 \times 20\% \times .5 \times 150 = \$1,575,000$$

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New York
47(z4)

Surety Bonds

The industry has estimated that \$189,000 of added cost will be incurred for this requirement and was found acceptable.

SUMMARY OF INCREMENTAL CODE COSTS TO BE REIMBURSED

Total incremental federal code cost to be recognized in facility 1991 rates is \$17,041,640.

Comprehensive Resident Assessment	\$ 2,797,200
Quarterly Resident Assessment	\$ 2,772,000
Comprehensive Care Plan	\$ 6,917,631
Quarterly Care Plan Review	\$ 1,386,000
Training of MDS+ ⁵ Assessment	\$ 370,020
Quality Assurance	\$ 600,264
Nurse Aide	\$ 434,525
Psychotropic Drug Review	\$ 1,575,000
Surety Bonds	<u>\$ 189,000</u>
Total Incremental Cost	\$17,041,640

⁵MDS+ (Minimum Data Set Plus for Nursing Home Residents Assessment and Care Screening)

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47(z5)

Costs are to be reflected in facility rates beginning July 1 1991, so that the nine months of incremental cost from April 1, 1991 to December 1991 will be reflected in the six month rate period July to December 1991. Total incremental costs were converted to a per diem add-on to be included in a facility's rate by dividing total incremental costs by available beds, and adjusting to days by dividing by 365. The calculation is as follows:

$$\$17,041,640 / 105,000 / 365 = .45 \text{ add-on}$$

This statewide add-on will be adjusted for each facility to reflect regional differences in RN salary levels for calendar year 1987. Such regional adjustments are currently used in the determination of the direct and indirect components of facility rates. For 1992 and forward, the incremental cost add-on will be by the appropriate trend factor.⁶

⁶Trend factors are computed in accordance with Section 86-2.12.

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47(z6)

Description of Methodologies for the Physical, Mental, and Psychosocial Well Being Requirement

The State of New York reimbursement rates match payment with intensity of care, thus providing facilities with adequate reimbursement for patients requiring more intensive supportive, medical or rehabilitative care. The RUG II patient classification system classifies each patient into one of sixteen patient categories which are each different in terms of clinical characteristics and are statistically different in terms of costs of care.

The system uses a hierarchy of patient types and secondary subgroup format based on Activities of Daily Living (ADL) function levels. The five hierarchical groups, from the highest to lowest resource consumption, are as follows:

1. Special Care
2. Rehabilitation
3. Clinically Complex
4. Severe Behavioral Problems
5. Reduced Physical Functions

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47(z7)**

Each of the above clinical groups is further divided by the ADL index score into subgroups. The ADL index is comprised of three ADL variables, eating, toileting, and transfer, which were determined to be the key predictors of resource consumption within each clinical group. For each of the sixteen patient classification categories, a relative resource "weight" representing the resource consumption of patients in that category relative to the average patient, is used to adjust the direct component of the payment rate.

The RUGS system thus allows a more precise and equitable means of directing available fiscal resources to nursing homes that care for residents with the heaviest care needs. By recognizing the resources required to provide more intensive rehabilitative and support services, the reimbursement methodology encourages nursing homes to establish restorative care programs. This can result in more active intervention for eligible patients, and earlier improvement and discharge.

October 1, 1992

For rates effective January 1, 1992 and thereafter, the per diem add-on described herein will be increased by a trend factor as defined in Section 86-2.12.

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47(z8)

Description of the specific methodology for determining the adjustment –
Bloodborne Pathogens

Hepatitis B Vaccination:

Beginning January 1, 1993 and thereafter, provider rates contain a facility-specific adjustment to reimburse the cost of the Hepatitis B vaccine administered to employees. Provider-specific adjustments are based upon each facility's actual costs recognized up to a maximum cost for the vaccine. The facility specific adjustment will be determined using costs reposted by the providers two years prior to the state of the rate year. The maximum cost for the vaccine that is recognized when setting the facility specific adjustment is \$128.50 for a three vial series per employee.

Gloves:

For rates effective on April 1, 1994 for the 1994 calendar year and each calendar year thereafter, an \$.18 per diem adjustment will be included in provider's rates for the incremental cost of gloves.

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New York
47(aa)

Rate Adjustment for Financially Disadvantaged RHCs

- (a) The Commissioner of Health shall adjust medical assistance rates of payment for services provided on and after October 1, 2004 through December 31, 2004 and annually thereafter for services provided on and after January 1, 2005 through April 30, 2011, and on and after May 1, 2012 to include a rate adjustment to assist qualifying Residential Health Care Facilities (RHCs) pursuant to this section, provided that public RHCs shall not be eligible for rate adjustments pursuant to this subdivision for rate periods on and after April 1, 2009.

Facilities that receive a rate adjustment for the period May 1, 2010 through April 30, 2011, will have their rates reduced for the rate period December 1, 2011 through December 31, 2011, by an amount equal to the payment generated by the May 1, 2010 through April 30, 2011, rate adjustment.

- (b) Eligibility for such rate adjustments shall be determined on the basis of each RHC's operating margin over the most recent three-year period for which financial data are available from the RHC-4 cost report or the institutional cost report. For purposes of the adjustments made for the period October 1, 2004 through December 31, 2004, financial information for the calendar years 2000 through 2002 shall be utilized. For each subsequent rate year, the financial data for the three-year period ending two years prior to the applicable rate year shall be utilized for this purpose.
- (c) Each facility's operating margin for the three-year period shall be calculated by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by the total operating revenues for the three-year period, with the result expressed as a percentage. For hospital-based RHC's, for which an operating margin cannot be calculated on the basis of the submitted cost reports, the sponsoring hospital's overall three-year operating margin, as reported in the institutional cost report, shall be utilized for this purpose. All facilities with negative operating margins calculated in this way over the three-year period shall be arrayed into quartiles based on the magnitude of the operating margin. Any facility with a positive operating margin for the most recent three-year period, a negative operating margin that places the facility in the quartile of facilities with the smallest negative operating margins, a positive total margin in the most recent year of the three-year period or an average Medicaid utilization percentage of 50% or less during the most recent year of the three-year period shall be disqualified from receiving an adjustment pursuant to this section, provided that for rate periods on and after April 1, 2009, such disqualification:
- i. shall not be applied solely on the basis of a facility's having a positive total margin in the most recent year of such three-year period;

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47(aa)(1)

- ii. shall be extended to those facilities in the quartile of facilities with the second smallest negative operating margins; and
 - iii. shall also be extended to those facilities with an average Medicaid utilization percentage of less than 70% during the most recent year of the three-year period.
- (d) For each facility remaining after the exclusions made pursuant to paragraph (c) of this section, the Commissioner of Health shall calculate the average annual operating loss for the three-year period by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by three provided, that for periods on and after April 1, 2009, the amount of such average annual operating loss shall be reduced by an amount equal to the amount received through per diem add-on amounts received in the 2007 and 2008 rate periods. For this purpose, for hospital-based RHCFs for which the average annual operating loss cannot be calculated on the basis of submitted cost reports, the sponsoring hospital's overall average annual operating loss for the three-year period shall be apportioned to the RHCF based on the proportion the RHCF's total revenues for the period bears to the total revenues reported by the sponsoring hospital, and such apportioned average annual operating loss shall then be reduced by an amount equal to the amount received through per diem add-on amounts received in the 2007 and 2008 rate periods.
- (e) For periods prior to April 1, 2009, each such facility's qualifying operating loss shall be determined by multiplying the facility's average annual operating loss for the three-year period as calculated pursuant to paragraph (d) of this section by the applicable percentage shown in the tables below for the quartile in which the facility's negative operating margin for the three-year period is assigned.
- i. For a facility located in a county with a total population of 200,000 or more as determined by the 2000 U.S. Census:

First Quartile (lowest operating margins):	30 percent
Second Quartile	15 percent
Third Quartile	7.5 percent
 - ii. For a facility located in a county with a total population of fewer than 200,000 as determined by the 2000 U.S. Census:

First Quartile (lowest operating margins):	35 percent
Second Quartile	20 percent
Third Quartile	12.5 percent

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47(aa)(2)

- (f) The amount of any facility's financially disadvantaged RHCF distribution calculated in accordance with this section shall be reduced by the facility's rate year benefit of the 2001 update to the regional input price adjustment factors provided that such reduction shall not be applied with regard to rate periods on and after April 1, 2009. After all other adjustments to a facility's financially disadvantaged RHCF distribution have been made in accordance with this section, the amount of each facility's distribution shall be limited to no more than \$400,000 during the period October 1, 2004 through December 31, 2004, and on an annualized basis, for rate periods through March 31, 2009, and no more than one million dollars for the period April 1, 2009 through December 31, 2009, and for each annual rate period thereafter.
- (g) The adjustment made to each qualifying facility's Medicaid rate of payment determined pursuant to the section shall be calculated by dividing the facility's financially disadvantaged RHCF distribution calculated in accordance with this section by the facility's total Medicaid patient days reported in the cost report submitted two years prior to the rate year, provided however, that such rate adjustments for the period October 1, 2004 through December 31, 2004, shall be calculated based on 25% of each facility's reported total Medicaid patient days as reported in the applicable 2002 cost report. Such amounts will not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.
- (h) The total amount of funds to be allocated and distributed as medical assistance for financially disadvantaged RHCF rate adjustments to eligible facilities for a rate period in accordance with this section shall be \$30 million on and after January 1, 2009 through March 31, 2013.

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New York
47(aa)(3)

- (i) For periods on and after April 1, 2009, Residential Health Care Facilities (RHCs), which are otherwise eligible for rate adjustments pursuant to this subdivision shall also, as a condition for receipt of such rate adjustments, submit to the Commissioner a written restructuring plan that is acceptable to the Commissioner and which is in accord with the following:
- i. Such an acceptable plan shall be submitted to the Commissioner within sixty days of the facility's receipt of rate adjustments pursuant to this subdivision for a rate period subsequent to March 31, 2008, provided that facilities which are allocated \$400,000 or less on an annualized basis shall be required to submit such plans within 120 days, and further provided that these periods may be extended by the Commissioner by no more than thirty days, for good cause shown; and
 - ii. Such plan shall provide a detailed description of the steps the facility will take to improve operational efficiency and align its expenditures with its revenues, and shall include a projected schedule of quantifiable benchmarks to be achieved in the implementation of the plan; and
 - iii. Such plan shall require periodic reports to the Commissioner, in accordance with a schedule acceptable to the Commissioner, setting forth the progress the facility has made in implementing its plan; and
 - iv. Such plan may include the facility's retention of a qualified chief restructuring officer to assist in the implementation of the plan, provided that this requirement may be waived by the Commissioner, for good cause shown, upon written application by the facility.
- (j) If a facility fails to submit an acceptable restructuring plan in accordance with the provisions of paragraph (i) of this subdivision, the facility shall, from that time forward, be precluded from receipt of all further rate adjustments made pursuant to this subdivision and shall be deemed ineligible from any future re-application for such adjustments. The Commissioner will annually review each facility's efforts in achieving substantial progress in implementing its plan or achieving the benchmarks set forth in such plan. Further, if the Commissioner determines that a facility has failed to make a good faith effort in achieving substantial progress in implementing its plan or in achieving the benchmarks set forth in such plan, then the Commissioner will, upon thirty days notice to that facility, disqualify the facility from further participation in the rate adjustments authorized by this subdivision and the Commissioner will require the facility to repay some or all of the previous rate adjustments. During such thirty-day notification period, a facility may submit to the Commissioner additional information which may be used by the Commissioner to reconsider his or her determination that the facility be disqualified from further participation and required to repay some or all of the rate adjustments. The amount required to be repaid from such a facility shall be commensurate with the degree to which a facility has not made progress in implementing its plan or achieving the benchmarks set forth in such plan. Rate adjustments applicable to distributions made for periods prior to 2009 shall not be subject to repayment.

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**New York
47(aa)(3.1)**

1905(a)(4)(A) Nursing Facility Services

Temporary Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – Nursing Homes Workforce

A temporary lump sum payment will be provided to eligible residential health care providers that may be in danger of closing or significant restructuring. The payment is intended to protect and enhance access to, and quality of, care as vulnerable facilities confront ongoing workforce challenges in the wake of the COVID-19 pandemic. Low staff retention is a significant driver of those workforce challenges and retaining experienced direct care workers is a critical element of ensuring that quality care can be delivered. The pandemic compounded this challenge as it particularly stressed providers who have invested in providing comprehensive health benefits to their staff.

Eligible residential health care providers, the amount of the payment, and the duration of each payment shall be listed in the table which follows. Eligible facilities must:

- (1) Have proprietary or voluntary ownership; and
- (2) Participate in a comprehensive health, retirement, and training benefit fund covering at least 100 nursing homes to address direct-care staff turnover and demonstrate evidence of employer investment in retention; and
- (3) Demonstrate financial challenges, described above, evidenced as a three-year average operating margin lower than 1%, as shown on RHCF-4 cost reports

The temporary payment made under this section will be lump-sum payment made to such facilities twice annually, once in October and once in March. Receipt of the temporary payment made under this section does not preclude receipt of other Vital Access Program (VAP) funds, as well as the Advanced Training Initiative (ATI) funds.

In order to remain eligible, participating providers must submit periodic reports to the Department of Health that attest to their achievement of benchmarks and goals, including continued participation in a comprehensive benefit program and data on their retention of staff, by title. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals will result in termination of the provider's payment.

Temporary lump-sum adjustments have been approved for the following providers in the amounts and for the effective periods listed.

Nursing Homes:

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
Acadia Center for Nursing and Rehabilitation	\$202,627	10/01/2022 – 03/31/2023
	\$405,256	04/01/2023 – 03/31/2024
	\$405,256	04/01/2024 – 03/31/2025
Amsterdam Nursing Home Corp (Amsterdam House)	\$764,913	10/01/2022 – 03/31/2023
	\$1,529,826	04/01/2023 – 03/31/2024
	\$1,529,826	04/01/2024 – 03/31/2025

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**New York
47(aa)(3.2)**

1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
Andrus On Hudson	\$398,255	10/01/2022 – 03/31/2023
	\$796,511	04/01/2023 – 03/31/2024
	\$796,511	04/01/2024 – 03/31/2025
Bainbridge Nursing And Rehabilitation Center	\$490,948	10/01/2022 – 03/31/2023
	\$981,895	04/01/2023 – 03/31/2024
	\$981,895	04/01/2024 – 03/31/2025
Beach Gardens Rehab and Nursing Center	\$224,509	10/01/2022 – 03/31/2023
	\$449,017	04/01/2023 – 03/31/2024
	\$449,017	04/01/2024 – 03/31/2025
Beacon Rehabilitation and Nursing Center	\$199,615	10/01/2022 – 03/31/2023
	\$399,232	04/01/2023 – 03/31/2024
	\$399,232	04/01/2024 – 03/31/2025
Beth Abraham Health Services	\$1,074,874	10/01/2022 – 03/31/2023
	\$2,149,750	04/01/2023 – 03/31/2024
	\$2,149,750	04/01/2024 – 03/31/2025
Bethel Nursing and Rehabilitation Center	\$304,882	10/01/2022 – 03/31/2023
	\$609,763	04/01/2023 – 03/31/2024
	\$609,763	04/01/2024 – 03/31/2025
Bethel Nursing Home Company Inc	\$63,433	10/01/2022 – 03/31/2023
	\$126,868	04/01/2023 – 03/31/2024
	\$126,868	04/01/2024 – 03/31/2025
Bridge View Nursing Home	\$287,728	10/01/2022 – 03/31/2023
	\$575,458	04/01/2023 – 03/31/2024
	\$575,458	04/01/2024 – 03/31/2025
Bronx Gardens Rehabilitation and Nursing Center	\$406,610	10/01/2022 – 03/31/2023
	\$813,221	04/01/2023 – 03/31/2024
	\$813,221	04/01/2024 – 03/31/2025
Bronx-Lebanon Special Care Center	\$614,114	10/01/2022 – 03/31/2023
	\$1,228,226	04/01/2023 – 03/31/2024
	\$1,228,226	04/01/2024 – 03/31/2025

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**New York
47(aa)(3.3)**

1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
Brooklyn Center for Rehabilitation and Residential Health	\$337,882	10/01/2022 – 03/31/2023
	\$675,766	04/01/2023 – 03/31/2024
	\$675,766	04/01/2024 – 03/31/2025
Brooklyn Gardens Nursing & Rehabilitation Center	\$556,754	10/01/2022 – 03/31/2023
	\$1,113,506	04/01/2023 – 03/31/2024
	\$1,113,506	04/01/2024 – 03/31/2025
Brooklyn United Methodist Church Home	\$278,923	10/01/2022 – 03/31/2023
	\$557,845	04/01/2023 – 03/31/2024
	\$557,845	04/01/2024 – 03/31/2025
Brooklyn-Queens Nursing Home	\$322,666	10/01/2022 – 03/31/2023
	\$645,334	04/01/2023 – 03/31/2024
	\$645,334	04/01/2024 – 03/31/2025
Carillon Nursing and Rehabilitation Center	\$504,694	10/01/2022 – 03/31/2023
	\$1,009,390	04/01/2023 – 03/31/2024
	\$1,009,390	04/01/2024 – 03/31/2025
Caton Park Nursing Home	\$201,209	10/01/2022 – 03/31/2023
	\$402,416	04/01/2023 – 03/31/2024
	\$402,416	04/01/2024 – 03/31/2025
Cedar Manor Nursing & Rehabilitation Center	\$209,677	10/01/2022 – 03/31/2023
	\$419,356	04/01/2023 – 03/31/2024
	\$419,356	04/01/2024 – 03/31/2025
Central Island Healthcare	\$286,719	10/01/2022 – 03/31/2023
	\$573,438	04/01/2023 – 03/31/2024
	\$573,438	04/01/2024 – 03/31/2025
Chapin Home For The Aging	\$350,039	10/01/2022 – 03/31/2023
	\$700,076	04/01/2023 – 03/31/2024
	\$700,076	04/01/2024 – 03/31/2025
Clove Lakes Health Care and Rehabilitation Center	\$785,751	10/01/2022 – 03/31/2023
	\$1,571,502	04/01/2023 – 03/31/2024
	\$1,571,502	04/01/2024 – 03/31/2025

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1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
Cold Spring Hills Center for Nursing and Rehabilitation	\$854,272	10/01/2022 – 03/31/2023
	\$1,708,546	04/01/2023 – 03/31/2024
	\$1,708,546	04/01/2024 – 03/31/2025
Concourse Rehabilitation and Nursing Center	\$456,749	10/01/2022 – 03/31/2023
	\$913,496	04/01/2023 – 03/31/2024
	\$913,496	04/01/2024 – 03/31/2025
Crown Heights Center for Nursing and Rehabilitation	\$575,548	10/01/2022 – 03/31/2023
	\$1,151,095	04/01/2023 – 03/31/2024
	\$1,151,095	04/01/2024 – 03/31/2025
Daleview Care Center	\$182,053	10/01/2022 – 03/31/2023
	\$364,105	04/01/2023 – 03/31/2024
	\$364,105	04/01/2024 – 03/31/2025
Ditmas Park Care Center	\$169,831	10/01/2022 – 03/31/2023
	\$339,664	04/01/2023 – 03/31/2024
	\$339,664	04/01/2024 – 03/31/2025
East Haven Nursing And Rehabilitation Center	\$442,254	10/01/2022 – 03/31/2023
	\$884,508	04/01/2023 – 03/31/2024
	\$884,508	04/01/2024 – 03/31/2025
Eastchester Rehabilitation and Health Care Center	\$405,141	10/01/2022 – 03/31/2023
	\$810,282	04/01/2023 – 03/31/2024
	\$810,282	04/01/2024 – 03/31/2025
Eger Health Care and Rehabilitation Center	\$649,561	10/01/2022 – 03/31/2023
	\$1,299,121	04/01/2023 – 03/31/2024
	\$1,299,121	04/01/2024 – 03/31/2025
Emerge Nursing and Rehabilitation at Glen Cove	\$62,268	10/01/2022 – 03/31/2023
	\$124,536	04/01/2023 – 03/31/2024
	\$124,536	04/01/2024 – 03/31/2025
Excel at Woodbury for Rehabilitation and Nursing LLC	\$68,776	10/01/2022 – 03/31/2023
	\$137,554	04/01/2023 – 03/31/2024
	\$137,554	04/01/2024 – 03/31/2025

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47(aa)(3.5)**

1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
Ferncliff Nursing Home Co Inc	\$734,365	10/01/2022 – 03/31/2023
	\$1,468,732	04/01/2023 – 03/31/2024
	\$1,468,732	04/01/2024 – 03/31/2025
Fordham Nursing and Rehabilitation Center	\$535,833	10/01/2022 – 03/31/2023
	\$1,071,666	04/01/2023 – 03/31/2024
	\$1,071,666	04/01/2024 – 03/31/2025
Fort Tryon Center for Rehabilitation and Nursing	\$465,695	10/01/2022 – 03/31/2023
	\$931,388	04/01/2023 – 03/31/2024
	\$931,388	04/01/2024 – 03/31/2025
Friedwald Center for Rehabilitation & Nursing LLC	\$280,662	10/01/2022 – 03/31/2023
	\$561,324	04/01/2023 – 03/31/2024
	\$561,324	04/01/2024 – 03/31/2025
Fulton Commons Care Center Inc	\$319,621	10/01/2022 – 03/31/2023
	\$639,244	04/01/2023 – 03/31/2024
	\$639,244	04/01/2024 – 03/31/2025
Glen Arden Inc	\$5,212	10/01/2022 – 03/31/2023
	\$10,423	04/01/2023 – 03/31/2024
	\$10,423	04/01/2024 – 03/31/2025
Glen Island Center for Nursing and Rehabilitation	\$380,856	10/01/2022 – 03/31/2023
	\$761,712	04/01/2023 – 03/31/2024
	\$761,712	04/01/2024 – 03/31/2025
Hamilton Park Nursing and Rehabilitation Center	\$290,051	10/01/2022 – 03/31/2023
	\$580,103	04/01/2023 – 03/31/2024
	\$580,103	04/01/2024 – 03/31/2025
Haven Manor Health Care Center LLC	\$572,511	10/01/2022 – 03/31/2023
	\$1,145,022	04/01/2023 – 03/31/2024
	\$1,145,022	04/01/2024 – 03/31/2025
Hebrew Home For The Aged At Riverdale	\$1,529,521	10/01/2022 – 03/31/2023
	\$3,059,044	04/01/2023 – 03/31/2024
	\$3,059,044	04/01/2024 – 03/31/2025

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**New York
47(aa)(3.6)**

1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
Hempstead Park Nursing Home	\$575,719	10/01/2022 – 03/31/2023
	\$1,151,440	04/01/2023 – 03/31/2024
	\$1,151,440	04/01/2024 – 03/31/2025
Hilaire Rehab & Nursing	\$94,499	10/01/2022 – 03/31/2023
	\$188,996	04/01/2023 – 03/31/2024
	\$188,996	04/01/2024 – 03/31/2025
Hollis Park Manor Nursing	\$161,419	10/01/2022 – 03/31/2023
	\$322,840	04/01/2023 – 03/31/2024
	\$322,840	04/01/2024 – 03/31/2025
Hudson Pointe at Riverdale Center for Nursing and Rehabilitation	\$359,090	10/01/2022 – 03/31/2023
	\$718,181	04/01/2023 – 03/31/2024
	\$718,181	04/01/2024 – 03/31/2025
Incarnation Children's Center	\$43,399	10/01/2022 – 03/31/2023
	\$86,800	04/01/2023 – 03/31/2024
	\$86,800	04/01/2024 – 03/31/2025
Isabella Geriatric Center Inc	\$1,388,054	10/01/2022 – 03/31/2023
	\$2,776,109	04/01/2023 – 03/31/2024
	\$2,776,109	04/01/2024 – 03/31/2025
Jamaica Hospital Nursing Home Co Inc	\$394,858	10/01/2022 – 03/31/2023
	\$789,715	04/01/2023 – 03/31/2024
	\$789,715	04/01/2024 – 03/31/2025
King David Center for Nursing and Rehabilitation	\$486,417	10/01/2022 – 03/31/2023
	\$972,834	04/01/2023 – 03/31/2024
	\$972,834	04/01/2024 – 03/31/2025
Lawrence Nursing Care Center Inc	\$467,196	10/01/2022 – 03/31/2023
	\$934,392	04/01/2023 – 03/31/2024
	\$934,392	04/01/2024 – 03/31/2025
Livingston Hills Nursing and Rehabilitation Center	\$245,872	10/01/2022 – 03/31/2023
	\$491,743	04/01/2023 – 03/31/2024
	\$491,743	04/01/2024 – 03/31/2025

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**New York
47(aa)(3.7)**

1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
Lynbrook Restorative Therapy and Nursing	\$45,451	10/01/2022 – 03/31/2023
	\$90,904	04/01/2023 – 03/31/2024
	\$90,904	04/01/2024 – 03/31/2025
Mary Manning Walsh Nursing Home Co Inc	\$450,725	10/01/2022 – 03/31/2023
	\$901,448	04/01/2023 – 03/31/2024
	\$901,448	04/01/2024 – 03/31/2025
Mayfair Care Center	\$283,880	10/01/2022 – 03/31/2023
	\$567,760	04/01/2023 – 03/31/2024
	\$567,760	04/01/2024 – 03/31/2025
Menorah Home & Hospital for Aged & Infirm	\$743,853	10/01/2022 – 03/31/2023
	\$1,487,706	04/01/2023 – 03/31/2024
	\$1,487,706	04/01/2024 – 03/31/2025
Methodist Home For Nursing and Rehabilitation	\$138,653	10/01/2022 – 03/31/2023
	\$277,306	04/01/2023 – 03/31/2024
	\$277,306	04/01/2024 – 03/31/2025
Midway Nursing Home	\$270,699	10/01/2022 – 03/31/2023
	\$541,398	04/01/2023 – 03/31/2024
	\$541,398	04/01/2024 – 03/31/2025
Montgomery Nursing and Rehabilitation Center	\$137,364	10/01/2022 – 03/31/2023
	\$274,728	04/01/2023 – 03/31/2024
	\$274,728	04/01/2024 – 03/31/2025
Mosholu Parkway Nursing and Rehabilitation Center	\$264,978	10/01/2022 – 03/31/2023
	\$529,956	04/01/2023 – 03/31/2024
	\$529,956	04/01/2024 – 03/31/2025
New Carlton Rehab and Nursing Center LLC	\$301,410	10/01/2022 – 03/31/2023
	\$602,820	04/01/2023 – 03/31/2024
	\$602,820	04/01/2024 – 03/31/2025
New York Congregational Nursing Center Inc	\$368,545	10/01/2022 – 03/31/2023
	\$737,090	04/01/2023 – 03/31/2024
	\$737,090	04/01/2024 – 03/31/2025

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**New York
47(aa)(3.8)**

1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
North Westchester Restorative Therapy and Nursing	\$94,900	10/01/2022 – 03/31/2023
	\$189,800	04/01/2023 – 03/31/2024
	\$189,800	04/01/2024 – 03/31/2025
Northern Manor Geriatric Center Inc	\$516,661	10/01/2022 – 03/31/2023
	\$1,033,321	04/01/2023 – 03/31/2024
	\$1,033,321	04/01/2024 – 03/31/2025
Northern Metropolitan Residential Health Care Facility Inc	\$230,163	10/01/2022 – 03/31/2023
	\$460,326	04/01/2023 – 03/31/2024
	\$460,326	04/01/2024 – 03/31/2025
Norwegian Christian Home and Health Center	\$247,981	10/01/2022 – 03/31/2023
	\$495,962	04/01/2023 – 03/31/2024
	\$495,962	04/01/2024 – 03/31/2025
Oasis Rehabilitation and Nursing LLC	\$65,715	10/01/2022 – 03/31/2023
	\$131,430	04/01/2023 – 03/31/2024
	\$131,430	04/01/2024 – 03/31/2025
Parker Jewish Institute for Health Care and Rehabilitation	\$907,784	10/01/2022 – 03/31/2023
	\$1,815,569	04/01/2023 – 03/31/2024
	\$1,815,569	04/01/2024 – 03/31/2025
Pelham Parkway Nursing and Rehabilitation Facility	\$451,766	10/01/2022 – 03/31/2023
	\$903,533	04/01/2023 – 03/31/2024
	\$903,533	04/01/2024 – 03/31/2025
Peninsula Nursing and Rehabilitation Center	\$429,082	10/01/2022 – 03/31/2023
	\$858,163	04/01/2023 – 03/31/2024
	\$858,163	04/01/2024 – 03/31/2025
Providence Rest	\$331,793	10/01/2022 – 03/31/2023
	\$663,587	04/01/2023 – 03/31/2024
	\$663,587	04/01/2024 – 03/31/2025
Putnam Nursing & Rehabilitation Center	\$215,661	10/01/2022 – 03/31/2023
	\$431,322	04/01/2023 – 03/31/2024
	\$431,322	04/01/2024 – 03/31/2025

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**New York
47(aa)(3.9)**

1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
Regal Heights Rehabilitation and Health Care Center	\$538,566	10/01/2022 – 03/31/2023
	\$1,077,132	04/01/2023 – 03/31/2024
	\$1,077,132	04/01/2024 – 03/31/2025
Rego Park Nursing Home	\$369,604	10/01/2022 – 03/31/2023
	\$739,208	04/01/2023 – 03/31/2024
	\$739,208	04/01/2024 – 03/31/2025
Resort Nursing Home	\$500,123	10/01/2022 – 03/31/2023
	\$1,000,247	04/01/2023 – 03/31/2024
	\$1,000,247	04/01/2024 – 03/31/2025
Rockaway Care Center	\$470,692	10/01/2022 – 03/31/2023
	\$941,384	04/01/2023 – 03/31/2024
	\$941,384	04/01/2024 – 03/31/2025
Ross Center for Nursing and Rehabilitation	\$242,778	10/01/2022 – 03/31/2023
	\$485,556	04/01/2023 – 03/31/2024
	\$485,556	04/01/2024 – 03/31/2025
Rutland Nursing Home Co Inc	\$1,098,905	10/01/2022 – 03/31/2023
	\$2,197,811	04/01/2023 – 03/31/2024
	\$2,197,811	04/01/2024 – 03/31/2025
Saint Mary's Episcopal Center	\$97,715	10/01/2022 – 03/31/2023
	\$195,431	04/01/2023 – 03/31/2024
	\$195,431	04/01/2024 – 03/31/2025
Saints Joachim & Anne Nursing and Rehabilitation Center	\$346,697	10/01/2022 – 03/31/2023
	\$693,395	04/01/2023 – 03/31/2024
	\$693,395	04/01/2024 – 03/31/2025
San Simeon by the Sound Center for Nursing and Rehabilitation & Adult Day Health Care	\$181,191	10/01/2022 – 03/31/2023
	\$362,382	04/01/2023 – 03/31/2024
	\$362,382	04/01/2024 – 03/31/2025
Sands Point Center For Health And Rehabilitation	\$263,714	10/01/2022 – 03/31/2023
	\$527,429	04/01/2023 – 03/31/2024
	\$527,429	04/01/2024 – 03/31/2025

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**New York
47(aa)(3.10)**

1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
Schervier Nursing Care Center	\$737,640	10/01/2022 – 03/31/2023
	\$1,475,280	04/01/2023 – 03/31/2024
	\$1,475,280	04/01/2024 – 03/31/2025
Schulman and Schachne Institute for Nursing and Rehabilitation	\$999,335	10/01/2022 – 03/31/2023
	\$1,998,671	04/01/2023 – 03/31/2024
	\$1,998,671	04/01/2024 – 03/31/2025
Sea Crest Nursing and Rehabilitation Center	\$483,085	10/01/2022 – 03/31/2023
	\$966,170	04/01/2023 – 03/31/2024
	\$966,170	04/01/2024 – 03/31/2025
Shore View Nursing & Rehabilitation Center	\$478,538	10/01/2022 – 03/31/2023
	\$957,077	04/01/2023 – 03/31/2024
	\$957,077	04/01/2024 – 03/31/2025
Silver Lake Specialized Rehabilitation and Care Center	\$491,317	10/01/2022 – 03/31/2023
	\$982,634	04/01/2023 – 03/31/2024
	\$982,634	04/01/2024 – 03/31/2025
Silvercrest	\$675,290	10/01/2022 – 03/31/2023
	\$1,350,580	04/01/2023 – 03/31/2024
	\$1,350,580	04/01/2024 – 03/31/2025
South Shore Rehabilitation and Nursing Center	\$127,475	10/01/2022 – 03/31/2023
	\$254,950	04/01/2023 – 03/31/2024
	\$254,950	04/01/2024 – 03/31/2025
Split Rock Rehabilitation and Health Care Center	\$589,681	10/01/2022 – 03/31/2023
	\$1,179,361	04/01/2023 – 03/31/2024
	\$1,179,361	04/01/2024 – 03/31/2025
St Cabrini Nursing Home	\$605,012	10/01/2022 – 03/31/2023
	\$1,210,024	04/01/2023 – 03/31/2024
	\$1,210,024	04/01/2024 – 03/31/2025
St Patricks Home	\$462,551	10/01/2022 – 03/31/2023
	\$925,102	04/01/2023 – 03/31/2024
	\$925,102	04/01/2024 – 03/31/2025

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**New York
47(aa)(3.11)**

1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
St Vincent Depaul Residence	\$240,488	10/01/2022 – 03/31/2023
	\$480,976	04/01/2023 – 03/31/2024
	\$480,976	04/01/2024 – 03/31/2025
Sunharbor Manor	\$257,444	10/01/2022 – 03/31/2023
	\$514,888	04/01/2023 – 03/31/2024
	\$514,888	04/01/2024 – 03/31/2025
Sunrise Manor Center for Nursing and Rehabilitation	\$156,938	10/01/2022 – 03/31/2023
	\$313,877	04/01/2023 – 03/31/2024
	\$313,877	04/01/2024 – 03/31/2025
Sutton Park Center for Nursing and Rehabilitation	\$236,598	10/01/2022 – 03/31/2023
	\$473,196	04/01/2023 – 03/31/2024
	\$473,196	04/01/2024 – 03/31/2025
Tarrytown Hall Care Center	\$203,539	10/01/2022 – 03/31/2023
	\$407,078	04/01/2023 – 03/31/2024
	\$407,078	04/01/2024 – 03/31/2025
Terence Cardinal Cooke Health Care Ctr	\$1,311,391	10/01/2022 – 03/31/2023
	\$2,622,781	04/01/2023 – 03/31/2024
	\$2,622,781	04/01/2024 – 03/31/2025
The Citadel Rehab and Nursing Center at Kingsbridge	\$818,252	10/01/2022 – 03/31/2023
	\$1,636,504	04/01/2023 – 03/31/2024
	\$1,636,504	04/01/2024 – 03/31/2025
The Emerald Peek Rehabilitation and Nursing Center	\$158,711	10/01/2022 – 03/31/2023
	\$317,423	04/01/2023 – 03/31/2024
	\$317,423	04/01/2024 – 03/31/2025
The Five Towns Premier Rehabilitation & Nursing Center	\$442,673	10/01/2022 – 03/31/2023
	\$885,346	04/01/2023 – 03/31/2024
	\$885,346	04/01/2024 – 03/31/2025
The New Jewish Home, Manhattan	\$1,019,583	10/01/2022 – 03/31/2023
	\$2,039,166	04/01/2023 – 03/31/2024
	\$2,039,166	04/01/2024 – 03/31/2025

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**New York
47(aa)(3.12)**

1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
The New Jewish Home, Sarah Neuman	\$587,161	10/01/2022 – 03/31/2023
	\$1,174,322	04/01/2023 – 03/31/2024
	\$1,174,322	04/01/2024 – 03/31/2025
The Phoenix Rehabilitation and Nursing Center	\$710,187	10/01/2022 – 03/31/2023
	\$1,420,374	04/01/2023 – 03/31/2024
	\$1,420,374	04/01/2024 – 03/31/2025
The Plaza Rehab and Nursing Center	\$1,578,142	10/01/2022 – 03/31/2023
	\$3,156,283	04/01/2023 – 03/31/2024
	\$3,156,283	04/01/2024 – 03/31/2025
The Wartburg Home	\$245,708	10/01/2022 – 03/31/2023
	\$491,416	04/01/2023 – 03/31/2024
	\$491,416	04/01/2024 – 03/31/2025
The Willows at Ramapo Rehabilitation and Nursing Center	\$328,773	10/01/2022 – 03/31/2023
	\$657,546	04/01/2023 – 03/31/2024
	\$657,546	04/01/2024 – 03/31/2025
Tolstoy Foundation Nursing Home Co Inc	\$152,704	10/01/2022 – 03/31/2023
	\$305,407	04/01/2023 – 03/31/2024
	\$305,407	04/01/2024 – 03/31/2025
United Hebrew Geriatric Center	\$579,380	10/01/2022 – 03/31/2023
	\$1,158,761	04/01/2023 – 03/31/2024
	\$1,158,761	04/01/2024 – 03/31/2025
Upper East Side Rehabilitation and Nursing Center	\$601,367	10/01/2022 – 03/31/2023
	\$1,202,735	04/01/2023 – 03/31/2024
	\$1,202,735	04/01/2024 – 03/31/2025
Verrazano Nursing Home	\$252,881	10/01/2022 – 03/31/2023
	\$505,762	04/01/2023 – 03/31/2024
	\$505,762	04/01/2024 – 03/31/2025
Villagecare Rehabilitation and Nursing Center	\$26,042	10/01/2022 – 03/31/2023
	\$52,083	04/01/2023 – 03/31/2024
	\$52,083	04/01/2024 – 03/31/2025

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**New York
47(aa)(3.13)**

1905(a)(4)(A) Nursing Facility Services

Nursing Homes (continued)

Provider Name	Gross Medicaid Lump Sum Adjustment	Effective Dates
Waterview Nursing Care Center	\$410,057	10/01/2022 – 03/31/2023
	\$820,115	04/01/2023 – 03/31/2024
	\$820,115	04/01/2024 – 03/31/2025
Wayne Center For Nursing and Rehabilitation	\$564,230	10/01/2022 – 03/31/2023
	\$1,128,459	04/01/2023 – 03/31/2024
	\$1,128,459	04/01/2024 – 03/31/2025
White Oaks Rehabilitation and Nursing Center	\$293,868	10/01/2022 – 03/31/2023
	\$587,736	04/01/2023 – 03/31/2024
	\$587,736	04/01/2024 – 03/31/2025
Wingate at Beacon	\$184,892	10/01/2022 – 03/31/2023
	\$369,785	04/01/2023 – 03/31/2024
	\$369,785	04/01/2024 – 03/31/2025
Wingate of Dutchess	\$221,841	10/01/2022 – 03/31/2023
	\$443,682	04/01/2023 – 03/31/2024
	\$443,682	04/01/2024 – 03/31/2025
Wingate of Ulster	\$134,311	10/01/2022 – 03/31/2023
	\$268,622	04/01/2023 – 03/31/2024
	\$268,622	04/01/2024 – 03/31/2025
Workmens Circle Multicare Center	\$961,730	10/01/2022 – 03/31/2023
	\$1,923,461	04/01/2023 – 03/31/2024
	\$1,923,461	04/01/2024 – 03/31/2025

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**New York
47(aa)(4)**

1905(a)(4)(A) Nursing Facility Services**Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – Nursing Homes**

A temporary rate adjustment will be provided to eligible residential health care providers that are subject to or impacted by the closure, merger, and acquisition, consolidation or restructuring of a health care provider. The rate adjustment is intended to:

- Protect or enhance access to care;
- Protect or enhance quality of care; or
- Improve the cost effectiveness.

Eligible residential health care providers, the amount of the temporary rate adjustment, and the duration of each rate adjustment period shall be listed in the table which follows. The total adjustment amount for each period shown below will be paid quarterly during each period in equal installments. The temporary payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the quarter.

To remain eligible, providers must submit benchmarks and goals acceptable to the Commissioner and must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals will result in termination of the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's temporary rate adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in this Attachment.

Temporary rate adjustments have been approved for the following providers in the amounts and for the effective periods listed.

Nursing Homes:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Adirondack Medical Center - Mercy Living Center	\$6,694	01/01/2014 – 03/31/2014
	\$723,872	04/01/2014 – 03/31/2015
	\$918,544	06/16/2016 – 03/31/2017
	\$500,000	01/01/2022 – 03/31/2022
Adirondack Medical Center - Uihlein Living Center	\$2,273,884	01/01/2014 – 03/31/2014
	\$2,359,369	04/01/2014 – 03/31/2015
	\$821,793	04/01/2015 - 03/31/2016
	\$1,274,864	06/16/2016 – 03/31/2017
Adirondack Tri-County Nursing & Rehabilitation Center, Inc.	\$225,680	01/01/2014 – 03/31/2014
	\$1,369,690	04/01/2014 – 03/31/2015
	\$1,049,423	06/16/2016 – 03/31/2017

*Denotes provider is part of CINERGY Collaborative.

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**New York
47(aa)(5)**

1905(4)(a) Nursing Facility Services**Nursing Homes (continued):**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Amsterdam Nursing Home Corp (Amsterdam House)*	\$799,375	04/01/2022 – 03/31/2023
	\$759,406	07/01/2023 – 03/31/2024
Bronx-Lebanon Special Care Center*	\$551,640	04/01/2022 – 03/31/2023
	\$522,747	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

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**New York
47(aa)(5.1)**

1905(4)(a) Nursing Facility Services

Nursing Homes (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Brooklyn United Methodist Church Home*	\$369,825	04/01/2022 – 03/31/2023
	\$394,421	07/01/2023 – 03/31/2024
Carmel Richmond Healthcare and Rehabilitation Center*	\$615,961	04/01/2022 – 03/31/2023
	\$636,012	07/01/2023 – 03/31/2024
Chapin Home for the Aging*	\$460,231	04/01/2022 – 03/31/2023
	\$437,219	07/01/2023 - 03/31/2024

*Denotes provider is part of the CINERGY Collaborative

New York
47(aa)(6)

1905(4)(a) Nursing Facility Services

Nursing Homes (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Cobble Hill Health Center*	\$495,826	04/01/2022 – 03/31/2023
	\$527,480	07/01/2023 – 03/31/2024
Concord Nursing Home*	\$371,870	04/01/2022 – 03/31/2023
	\$395,610	07/01/2023 - 03/31/2024
Eger Health Care and Rehabilitation Center*	\$914,404	04/01/2022 – 03/31/2023
	\$909,294	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

**New York
47(aa)(6.1)**

1905(4)(a) Nursing Facility Services**Nursing Homes (continued):**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Elizabeth Seton Pediatric Center*	\$ 747,671	04/01/2022 – 03/31/2023
	\$795,402	07/01/2023 – 03/31/2024
Ferncliff Nursing Home Co Inc.*	\$747,118	04/01/2022 – 03/31/2023
	\$794,814	07/01/2023 – 03/31/2024
Fort Hudson Nursing Center	\$1,129,968	01/01/2022 – 03/31/2022
	\$118,982	04/01/2022 – 06/30/2022
	\$118,982	07/01/2022 – 09/30/2022
	\$118,983	10/01/2022 – 12/31/2022
	\$118,983	01/01/2023 – 03/31/2023
	\$137,943	04/01/2023 – 06/30/2023
	\$137,943	07/01/2023 – 09/30/2023
	\$137,943	10/01/2023 – 12/31/2023
	\$137,943	01/01/2024 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

**New York
47(aa)(6.1.a)**

1905(4)(a) Nursing Facility Services**Nursing Homes (continued):**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Good Samaritan Nursing Home*	\$353,258	04/01/2022 – 03/31/2023
	\$364,063	07/01/2023 – 03/31/2024
Greenfield Health and Rehabilitation Center	\$695,000	01/01/2022 – 03/31/2022
	\$411,875	04/01/2022 – 06/30/2022
	\$411,875	07/01/2022 – 09/30/2022
	\$411,875	10/01/2022 – 12/31/2022
	\$411,875	01/01/2023 – 03/31/2023
	\$155,000	04/01/2023 – 06/30/2023
	\$155,000	07/01/2023 – 09/30/2023
	\$155,000	10/01/2023 – 12/31/2023
	\$155,000	01/01/2024 – 03/31/2024
Gurwin Jewish Nursing and Rehabilitation Center*	\$1,351,867	04/01/2022 – 03/31/2023
	\$1,438,170	07/01/2023 – 03/31/2024
Hebrew Home for the Aged at Riverdale*	\$1,971,361	04/01/2022 – 03/31/2023
	\$1,883,465	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

**New York
47(aa)(6.2)**

1905(4)(a) Nursing Facility Services**Nursing Homes (continued):**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Incarnation Children's Center	\$224,255	10/01/2021 – 03/31/2022
Isabella Geriatric Center Inc*	\$1,749,498	04/01/2022 – 03/31/2023
	\$1,662,023	07/01/2023 – 03/31/2024
Island Nursing and Rehab Center*	\$475,830	04/01/2022 – 03/31/2023
	\$452,039	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

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New York
47(aa)(7)

1905(4)(a) Nursing Facility Services

Nursing Homes (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Jamaica Hospital Nursing Home Co Inc*	\$479,225	04/01/2022 – 03/31/2023
	\$453,918	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

**New York
47(aa)(7.1)**

**1905(a)(4)(A): Nursing Facility Services
Nursing Homes (Continued):**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Jewish Home LifeCare Sarah Neuman Center*	\$1,169,410	01/01/2015 – 03/31/2015
	\$1,185,162	04/01/2015 – 03/31/2016
	\$1,182,541	04/01/2016 – 03/31/2017
Loretto Health and Rehabilitation	\$4,747,976	01/01/2022 – 03/31/2022
	\$744,281	04/01/2022 – 06/30/2022
	\$744,281	07/01/2022 – 09/30/2022
	\$744,281	10/01/2022 – 12/31/2022
	\$744,281	01/01/2023 – 03/31/2023
Lutheran Augustana Center for Extended Care & Rehab*	\$1,016,961	01/01/2015 – 03/31/2015
	\$1,030,660	04/01/2015 – 03/31/2016
	\$1,028,381	04/01/2016 – 03/31/2017
Margaret Tietz Center For Nursing Care Inc*	\$700,877	01/01/2015 – 03/31/2015
	\$710,318	04/01/2015 – 03/31/2016
	\$708,747	04/01/2016 – 03/31/2017
	\$463,620	04/01/2020 – 03/31/2021
	\$463,620	04/01/2021 – 03/31/2022
	(\$231,810)	10/01/2021 - 03/31/2022
Mercy Living Center	\$500,000	01/01/2022 – 03/31/2022

*Denotes provider is part of CINERGY Collaborative.

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**New York
47(aa)(7.1.a)**

1905(4)(a) Nursing Facility Services

Nursing Homes (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Mary Manning Walsh Nursing Home Co Inc*	\$895,415	04/01/2022 – 03/31/2023
	\$948,383	07/01/2023 – 03/31/2024
Menorah Home And Hospital For Rehabilitation and Nursing*	\$755,890	04/01/2022 – 03/31/2023
	\$745,518	07/01/2023 – 03/31/2024
Methodist Home for Nursing and Rehabilitation*	\$275,592	04/01/2022 – 03/31/2023
	\$293,921	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

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New York
47(aa)(8)

1905(4)(a) Nursing Facility Services

Nursing Homes (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Parker Jewish Institute for Health Care and Rehabilitation*	\$1,555,295	04/01/2022 – 03/31/2023
	\$1,654,585	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

**New York
47(aa)(8.1)**

1905(4)(a) Nursing Facility Services

Nursing Homes (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Providence Rest*	\$493,614	04/01/2022 – 03/31/2023
	\$525,127	07/01/2023 – 03/31/2024
Rebekah Rehabilitation & Extended Care Center Inc*	\$343,928	04/01/2022 – 03/31/2023
	\$331,686	07/01/2023 – 03/31/2024
Rutland Nursing Home Co Inc.*	\$1,216,918	04/01/2022 – 03/31/2023
	\$19,155,100	03/01/2023 - 03/31/2023
	\$19,496,200	04/01/2023 – 03/31/2024
	\$ 1,166,928	07/01/2023 – 03/31/2024
	\$19,344,300	04/01/2024 – 03/31/2025
Saints Joachim & Anne Nursing and Rehabilitation Center*	\$402,586	04/01/2022 – 03/31/2023
	\$382,456	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

**New York
47(aa)(9)**

1905(4)(a) Nursing Facility Services**Nursing Homes (continued):**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Sarah Neuman Center for Healthcare*	\$827,832	04/01/2022 – 03/31/2023
	\$842,992	07/01/2023 – 03/31/2024
Schaffer Extended Care System*	\$308,810	04/01/2022 - 03/31/2023
	\$292,636	07/01/2023 – 03/31/2024
Shulman and Schachne Institute For Nursing	\$10,844,900	03/01/2023 – 03/31/2023
	\$10,503,800	04/01/2023 – 03/31/2024
	\$10,655,700	04/01/2024 – 03/31/2025

*Denotes provider is part of CINERGY Collaborative.

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**New York
47(aa)(9.1)**

Reserved

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**New York
47(aa)(9.2)**

1905(4)(a) Nursing Facility Services**Nursing Homes (continued):**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Schulman and Schachne Institute for Nursing and Rehabilitation*	\$1,204,270	04/01/2022 – 03/31/2023
	\$1,136,170	07/01/2023 – 03/31/2024
Silvercrest*	\$798,351	04/01/2022 – 03/31/2023
	\$770,721	07/01/2023 – 03/31/2024
St Cabrini Nursing Home*	\$788,645	04/01/2022 – 03/31/2023
	\$761,351	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

TN #23-0081
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**New York
47(aa)(9.3)**

1905(4)(a) Nursing Facility Services**Nursing Homes (continued):**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
St Johnland Nursing Center*	\$495,826	04/01/2022 – 03/31/2023
	\$527,480	07/01/2023 – 03/31/2024
St. Mary's Hospital for Children Inc.*	\$1,052,354	04/01/2022 – 03/31/2023
	\$1,114,606	07/01/2023 – 03/31/2024
St. Patrick's Home*	\$486,674	04/01/2022 – 03/31/2023
	\$459,153	07/01/2023 – 03/31/2024
St Vincent Depaul Residence*	\$3,681,188	01/01/2022 – 03/31/2022
	\$384,746	04/01/2022 – 06/30/2022
	\$384,746	07/01/2022 – 09/30/2022
	\$384,747	10/01/2022 – 12/31/2022
	\$384,747	01/01/2023 – 03/31/2023
	\$336,588	04/01/2022 – 03/31/2023
	\$337,197	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

**New York
47(aa)(10)**

1905(4)(a) Nursing Facility Services

Nursing Homes (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Terence Cardinal Cooke Health Care Ctr*	\$1,452,702	04/01/2022 – 03/31/2023
	\$1,380,067	07/01/2023 – 03/31/2024
The Jewish Home Hospital*	\$1,451,106	04/01/2022 – 03/31/2023
	\$1,572,645	07/01/2023 – 03/31/2024
The Wartburg Home*	\$769,740	04/01/2022 – 03/31/2023
	\$736,907	07/01/2023 – 03/31/2024
Trustees Eastern Star Hall and Home	\$ 869,050	01/01/2022 – 03/31/2022
United Hebrew Geriatric Center*	\$776,512	04/01/2022 – 03/31/2023
	\$749,638	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

New York
47(aa)(10.1)

1905(4)(a) Nursing Facility Services

Nursing Homes (continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
VillageCare Rehabilitation and Nursing Center*	\$597,382	04/01/2022 – 03/31/2023
	\$567,513	07/01/2023 – 03/31/2024
St. Mary's Center*	\$259,009	04/01/2022 – 03/31/2023
	\$276,235	07/01/2023 – 03/31/2024

*Denotes provider is part of CINERGY Collaborative.

New York
47(aa)(10.2)

Nursing Homes (Continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
United Helpers Canton Nursing Home, Inc.	\$11,781,222.00	09/16/2021 – 03/31/2022
	\$ 792,070.00	04/01/2022 – 03/31/2023

*Denotes provider is part of CINERGY Collaborative.

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Supersedes TN #New Effective Date September 16, 2021

**New York
47(aa)(11)**

Temporary Rate Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – Financially Distressed Nursing Homes

A temporary rate adjustment will be provided to eligible residential health care providers that are financially distressed and that are subject to or impacted by the closure, merger, and acquisition, consolidation or restructuring of a health care provider. The funds will be used to help providers achieve financial stability and advance ongoing operational changes to improve community residential long term care services for New York State's elderly population. The rate adjustment is intended to:

- Protect or enhance access to care;
- Protect or enhance quality of care; or
- Improve the cost effectiveness.

Eligible financially distressed residential health care providers, the amount of the temporary rate adjustment, and the duration of each rate adjustment period will be listed in the table which follows. The total adjustment amount for each period shown below will be paid quarterly during each period in equal installments. The temporary payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the quarter.

To remain eligible, providers must submit benchmarks and goals acceptable to the Commissioner and must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals will result in termination of the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's temporary rate adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in this Attachment.

Temporary rate adjustments have been approved for the following providers in the amounts and for the effective periods listed.

Financially Distressed Nursing Homes:

<u>Daughters of Jacob Nursing Home</u>	<u>\$3,200,000</u>	<u>04/01/2015 – 03/31/2016</u>
<u>Delaware Nursing and Rehabilitation</u>	<u>\$577,720</u>	<u>04/01/2015 - 03/31/2016</u>
<u>Meadow Park Rehabilitation and Health Care Center</u>	<u>\$2,200,000</u>	<u>04/01/2015 – 03/31/2016</u>
<u>New Surfside Nursing Home</u>	<u>\$3,100,000</u>	<u>04/01/2015 – 03/31/2016</u>
<u>Presbyterian Home for Central New York</u>	<u>\$1,340,000</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,335,000</u>	<u>04/01/2016 – 03/31/2017</u>
<u>Riverdale Nursing Home</u>	<u>\$1,000,000</u>	<u>04/01/2015 – 03/31/2016</u>

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Approval Date Aug 05, 2016

Supersedes TN #15-0046

Effective Date April 01, 2015

New York
47(aa)(12)

Financially Distressed Nursing Homes (continued):

<u>Good Shepherd Fairview Home</u>	<u>\$779,167</u>	<u>06/01/2016 – 03/31/2017</u>
	<u>\$264,167</u>	<u>04/01/2017 – 03/31/2018</u>
	<u>\$ 21,667</u>	<u>04/01/2018 – 05/31/2018</u>

TN #16-0025

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Effective Date: June 1, 2016

New York
48

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 subdivision (c) of section 2.10 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 follows:

(1) Full Reassessments:

Facilities shall, on a schedule to be established by the department, assess all their patients semi-annually 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 semi-annual 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 six months in a semi-annual period, there would be submitted approximately 1/6 of the assessments of such new admissions.

New York
49

(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 one of this subdivision and since discharged concurrent with the submissions 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 subdivision (c) of section 86-2.10 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 paragraph four of subdivision (c) of section 86-2.10 of this Subpart.

(e) Trending:

Payment rates for the operating component of the rate as defined in paragraph (2) of subdivision (b) of section 86-2.10 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.

New York
50

- (a) The operating cost component of residential health care facilities (RHCF's) rates of payment effective for the January 1, 2007 through December 31, 2007 and January 1, 2008 through December 31, 2008 rate periods, respectively, shall consist of the sum of the Direct, Indirect and Non-Comparable components of the rate
- (1) in effect as of October 1, 2006 and adjusted for inflation to the 2007 rate period;
 - (2) in effect as of December 31, 2006 and adjusted for inflation to the 2008 rate period;
 - (3) the rates shall be further adjusted as follows:
 - i. a per diem add-on reflecting the proportional amount of each facility's projected Medicaid benefit to total Medicaid benefit for all facilities of the imputed rate methodology to be effective April 1, 2009, including use of the allowable operating costs as reported in each facility's 2002 calendar year cost report, adjusted for inflation to the applicable rate period and reflecting the expiration of the productivity and efficiency limitation and the fiscal and administrative cap adjustments; and
 - ii. for those facilities which do not receive a benefit from the incorporation of 2002 allowable operating costs, rates for 2007 and 2008 shall be adjusted by a per diem add-on reflecting a proportional benefit of the expiration of the productivity and efficiency limitation and the fiscal and administrative cap adjustments.
 - (4) aggregate Medicaid payments for the rate adjustments as stated in (i) and (ii) of paragraph (3) of this section will not exceed \$137.5 million for the 2007 rate period, and \$167.5 million for the 2008 rate period, and such rate adjustments made prior to April 1, 2013 will not be subject to subsequent adjustment or reconciliation.
- (b) Additionally, the rates effective January 1, 2007 and January 1, 2008 shall
- (1) include any revisions to the 2006 rates occurring on and after January 1, 2007. Such revisions shall be incorporated into the 2007 and 2008 rate periods on an annual basis on or about November 30, 2007 and November 30, 2008, respectively. These rate adjustments shall be made on a retroactive and prospective basis;
 - (2) include the cost of local property taxes and payments made in lieu of local property taxes as reported in each facility's cost report for the period two years prior to the rate period;

New York
50(a)

- (3) not be subject to case mix adjustments; however, a facility may request such adjustment for increased case mix equal to or greater than .05 if such facility submits supporting documentation based on a full house schedule or patient review instruments, and continues to do so in accordance with its existing submission schedule for rate periods through December 31, 2008.
- (c) Voluntary not-for-profit facilities shall not be required to deposit reimbursement received for depreciation expense into a segregated depreciation account for periods on and after January 1, 2007.
- (d) Effective [January] April 1, 2009, the operating component of rates of payment shall consist of the sum of the Direct, Indirect and Non-Comparable components based on allowable operating costs and statistical data as reported in each facility's cost report for the 2002 calendar year, adjusted for inflation on an annual basis.
 - (1) For facilities which do not benefit from the use of 2002 cost report data, the operating component of the rates shall not be less than the operating component in effect for the 2008 rate period, adjusted for inflation on an annual basis.
 - (2) For facilities with an operating cost component which is based on allowable costs from a calendar year cost report subsequent to 2002, the rates shall remain on such costs.
 - (3) Effective for the period January 1, 2007 through December 31, 2011, appointment of a receiver, establishment of a new operator, or replacement or renovation of an existing facility that occurs on or after January 1, 2007, shall not result in a revised operating component of the rates unless an application for these changes is filed with the Department of Health by December 31, 2006, which is subsequently approved and which otherwise meets existing Department criteria for the establishment of a new base year for rate-setting purposes.

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New York
50(b)

- ([5]) (4) Cost reports submitted by facilities for the 2002 calendar year or any subsequent year used to determine the operating component of the 2009 rate shall be subject to audit through December 31, [2014] 2018. Facilities will therefore retain all fiscal and statistical records relevant to such costs reports. Any audit of the 2002 cost report, which is commenced on or before December 31, [2014] 2018, may be completed subsequent to that date and used for adjusting the Medicaid rates that are based on such costs.
- (e) Additionally, the operating component of the rates effective April 1, 2009 shall
- (1) be subject to a case mix adjustment through application of the relative Resource Utilization Groups System (RUGS-III) used by the federal government for Medicare, revised to reflect NYS wage and fringe benefits, and based on Medicaid only patient data. New York State wages are used to determine the weight of each RUG. The cost for each RUG is calculated using the relative resources for registered nurses, licensed practical nurses, aides, therapists, and therapy aides using the 1995 – 97 federal time study. The minutes from the study are multiplied by the NY average dollar per hour to determine the fiscal resources needed to care for that patient type for one day. This amount is multiplied by the number of patients in that RUG. RUG weights are assigned based on the distance from the statewide average. The RUGS-III weights shall be increased for the following resident categories:
- (i) 30 minutes for impaired cognition A;
- (ii) 40 minutes for impaired cognition B; and
- (iii) 25 minutes for reduced physical functions B.
- Medicaid only case mix adjustments shall be made in January and July of each calendar year, except that no case mix adjustment shall be made in January 2011 and July 2011. The adjustments and related patient classifications for each facility shall be subject to audit review in accordance with regulations promulgated by the Commissioner of Health, and effective January 1, 2009 shall
- (2) incorporate the continuation, through 2009 and subsequent years, of the adjustment for extended care of persons with traumatic brain injury in accordance with the provisions of this Attachment;
- (3) incorporate the continuation, through 2009 and subsequent years, of the adjustment for the cost of providing Hepatitis B vaccinations in accordance with the provisions of this Attachment;
- (4) reflect a per diem add-on of \$8, trended from 2006 to 2009 and thereafter, for each patient who:

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New York
50(c)

- (i) qualifies under both RUG-III impaired cognition and behavioral problems categories; or
- (ii) has been diagnosed with Alzheimer's disease or dementia and is classified in reduced physical functions A, B, or C, or in behavioral problems A or B categories, and also has an activities of daily living index of ten or less;
- (5) reflect a per diem add on of \$17, trended from 2006 to 2009 and thereafter, for each patient whose body mass index is greater than thirty-five (35);
- (6) reflect the cost of local property taxes and payments in lieu of local property taxes, as reported in each facility's cost report for the period two years prior to the rate year.

(f) 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 (including associated overhead);
 - (vi) occupational therapy (including associated overhead);
 - (vii) speech therapy (including associated overhead);
 - (viii) central service supply; and
 - (ix) residential health care facility.
- (2) For purposes of calculating the direct component of the rate, the Department shall use the methodology provided in this Attachment, except as provided in subparagraph (3) of paragraph (f) regarding the determination of the allowable cost ceiling:

New York
50(d)

- (3) For purposes of computing the cost ceilings for the direct component, facilities shall be organized into peer groups consisting of:
- (i) free-standing facilities with certified bed capacities of less than 300 beds;
 - (ii) free-standing facilities with certified bed capacities of 300 beds or more; and
 - (iii) hospital-based facilities.
- (4) In determining the direct cost component, for each peer group, a corridor shall be developed around the statewide mean direct price per day, provided, however, that the corridor around each mean direct price per day shall have a base no less than eighty-five percent and no greater than ninety percent of each mean direct price per day, and a ceiling no greater than one hundred fifteen percent and no less than one hundred ten percent of each mean direct price per day, and further provided, however, that the total financial impact of the application of the ceiling shall be substantially equal to the total financial impact of the application of the base.
- (5) Public facilities, and non-public facilities with fewer than 80 certified beds, which have a facility specific direct adjusted price per day that is equal to the applicable ceiling shall have such price per day adjusted by an addition of 50% of the difference between the facility specific price per day and the ceiling price per day. The adjustment to the direct price per day shall be increased to the rate year by the applicable inflation factor, and adjusted by the regional direct input price factor.

(g) 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 on 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:

New York
50(e)

- (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 purposes of calculating the indirect component of the rate, the Department shall use the methodology provided in this Attachment, except as provided in subparagraph (3) of paragraph (g) regarding the determination of the allowable cost ceiling:
- (3) For purposes of computing the cost ceilings for the indirect component, facilities shall be organized into peer groups consisting of:
- (i) free-standing facilities with certified bed capacities of less than 300 beds;
 - (ii) free-standing facilities with certified bed capacities of 300 beds or more; and
 - (iii) hospital-based facilities.
- (4) In determining the indirect cost component, for each peer group, a corridor shall be developed around the statewide mean indirect price per day, provided, however, that the corridor around each mean indirect price per day shall have a base no less than eighty-five percent and no greater than ninety percent of each mean indirect price per day, and a ceiling no greater than one hundred fifteen percent and no less than one hundred ten percent of each

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New York
50(f)

mean indirect price per day, and further provided, however, that the total financial impact of the application of the ceiling shall be substantially equal to the total financial impact of the application of the base.

- (5) Public facilities, and non-public facilities with fewer than 80 certified beds, which have a facility specific indirect adjusted price per day that is equal to the applicable ceiling shall have such price per day adjusted by an addition of 50% of the difference between the facility specific price per day and the ceiling price per day. The adjustment to the indirect price per day shall be increased to the rate year by the applicable inflation factor, and adjusted by the regional indirect input price factor.

(h) Non-comparable component of the rate.

- (1) The non-comparable 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 non-comparable 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 cost 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
 - (xiv) plant operations and maintenance – (cost for utilities and real estate and occupancy taxes)
 - (xv) pharmacy (including administrative overhead for pharmacy and costs of non-prescription drugs and supplies).

TN #06-39

Supersedes TN NEW

Approval Date June 12, 2008

Effective Date January 1, 2007

New York
50(g)

(i) Capital component of the rate.

The allowable facility specific capital component of the rate shall include allowable capital costs determined in accordance with §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 non-trendable divided by the facility's patient days in the base year determined applicable by the Department.

- (j) (1) For rate periods on and after January 1, 2007, no less than 65% of the additional Medicaid reimbursement received by a facility from the proportional add-on related to the projected 2002 reported base year costs, must be used for recruitment and retention of non-supervisory or other direct resident care workers or for purposes authorized under the Quality Improvement Demonstration Program. However, facilities shall not be required to spend more than 75% of the additional Medicaid reimbursement for these purposes.
- (2) The Commissioner of Health is authorized to perform audits of the facilities to ensure compliance with the requirement established in subparagraph (1) of this paragraph (j), and may recoup any amount determined to be used for other purposes. The Commissioner may waive the requirements for this mandatory use of this Medicaid reimbursement on request of a facility, if it is determined that the funds are not available for these purposes because they have been used to correct deficiencies at a facility that constitute a threat to resident safety.
- (k) For the rate periods after 2009 which utilize reported costs from a base year subsequent to 2002, the following categories of facilities shall receive rates that are no less than the rates that were in effect for such facilities on December 31, 2006, trended to the applicable rate year:
- (1) AIDS facilities or discrete AIDS units;
- (2) discrete units for residents on long-term inpatient rehabilitation for traumatic brain injury;
- (3) long-term ventilator discrete units;
- (4) discrete units providing specialized programs for residents requiring behavioral interventions; and
- (5) facilities or discrete units that provide extensive nursing, medical, psychological and counseling services solely for children.

New York
50(g)(1)

Effective January 1, 2012, the non-capital component 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 Attachment 4.19-D. Such rates of payment in effect January 1, 2009, for AIDS facilities or discrete AIDS units within facilities shall be reduced by the AIDS occupancy factor.

- 1) For new specialty facilities without a January 1, 2009, rate but with a rate prior to April 1, 2009, the operating portion of the January 1, 2012, rate will be the rate in effect on the date of opening.
- 2) For new specialty facilities without a January 1, 2009, rate that open between April 1, 2009, and July 7, 2011, the operating portion of January 1, 2012, rate will be the rate in effect July 7, 2011.
- 3) For new specialty facilities without a January 1, 2009, rate that open subsequent to July 7, 2011, the operating portion of the January 1, 2012, rate will be calculated as follows:
 - i) The initial rate will be calculated using budgeted costs prepared by the facility and approved by the Department and will become effective on the date of opening.
 - ii) The facility will file a cost report for the first twelve-month period that the specialty unit or specialty facility, as applicable, achieves 90% occupancy. The rate will become effective the first day of the twelve-month report. A facility that does not achieve 90% or greater occupancy for any year within five calendar years from the date of commencing operation shall be recalculated using the facility's most recently available reported allowable costs divided by patient days imputed at 90% occupancy. The recalculated rates of payment are required to be effective January first of the sixth calendar year following the date the facility commenced operations.
- 4) There will be no case mix adjustments to specialty rates.

TN #11-23-A
Supersedes TN NEW

Approval Date June 21, 2012
Effective Date January 1, 2012

New York
50(h)

- (l) For the rate period May 1, 2009 through March 31, 2010, adjustments to the rates of payment resulting from the rebase to 2002 reported base year costs, including initial adjustments for case mix, shall be held to an aggregate increase of \$210 million. If the total adjustments are more or less than \$210 million, proportional adjustments to the rates shall be made as necessary to result in an increase in aggregate expenditures of \$210 million. Such proportional adjustments shall be based on each facility's proportionate share of total spending from the April 1, 2009 rates that reflect the impact of rebasing and Medicaid only case mix. The rate adjustment required to adjust spending to the required \$210 million amount will be reflected as the "scale back adjustment" in the rates effective May 1, 2009 through March 31, 2010. The operating component of such rates shall not be subject to the update adjustments for case mix as otherwise scheduled for January of 2010.

For the annual periods April 1, 2010 through March 31, 2012, if adjustments to the rates of payment prior to the adjustment for inflation results in an increase in total payments for such services on an annual basis, such rates shall be further adjusted proportionally as is necessary to reduce the aggregate increase to no greater than the proportionally adjusted aggregate for the period April 1, 2009 through March 31, 2010. Proportional adjustments made to rates within the aggregate expenditure limit shall not be subject to subsequent correction or reconciliation.

- (m) For the period May 1, 2011 through June 30, 2011, the non-capital components of rates will be subject to a uniform percentage reduction sufficient to reduce such rates by an aggregate amount of \$27,100,000. Such reductions will not be included in the computation of the residential health care facility cap.

TN #11-60

Supersedes TN #09-50

Approval Date July 18, 2011

Effective Date May 1, 2011

New York
50(i)

Supplemental payments

For the period May 1, 2011 through May 31, 2011, supplemental payments in the form of rate add-ons, in the amount of \$221.3 million, will be made to eligible residential health care facilities which the Commissioner has determined have experienced a net reduction in their rate for the period April 1, 2009 through March 31, 2011 as a result of the 2002 rebasing methodology, Medicaid-only case mix methodology, and the application of proportional adjustments required to be made by the application of the residential health care facility cap. In determining the net reduction, the impact of case mix adjustments applicable to July 2010 and Medicaid rate adjustments for appeals and patient review instrument (PRI) case mix updates processed for payment after October 19, 2010 will be disregarded by the Commissioner. The following facilities are eligible for such supplemental payments:

- a) Facilities which were eligible for Financially Disadvantaged distributions for the 2009 period; non-public facilities whose total operating losses equal or exceed five percent of total operating revenue and whose Medicaid utilization equals or exceeds seventy percent (based on either their 2009 cost report or their most recently available cost report); or facilities or distinct units of facilities providing services primarily to children under the age of twenty-one, will receive a supplemental payment that is equal to 100 percent of the net reduction determined above.
- b) Facilities other than eligible facilities described in paragraph (a) above will receive supplemental payments equal to 50 percent of their net reduction.
- c) Facilities described in paragraph (b) above, which after the application of the rate adjustments described in paragraph (b) remain subject to a net reduction in their inpatient Medicaid revenue that is in excess of two percent (as measured with regard to the non-capital components of facility inpatient rates in effect on March 31, 2009 computed prior to the application of trend factor adjustments attributable to the 2008 and 2009 calendar years) will have their payments further adjusted such that the net reduction does not exceed two percent.

TN #11-41
Supersedes TN NEW

Approval Date June 15, 2011
Effective Date May 1, 2011

New York
50(j)

- d) Facilities as described in paragraph (c) above which have experienced a net reduction in their inpatient rates of more than \$6 million over the period April 1, 2009 through March 31, 2011 as a result of the application of proportional adjustments required to be made by the application of the residential health care facility cap will have their payments further adjusted so that their net reduction is reduced to zero.

Additional rate adjustments, in the form of rate add-ons, will be made to the eligible facilities described above for the period May 1, 2011 through May 31, 2011 in an aggregate amount equal to 25% of the payments described above (or 25% of \$221.3 million which equals \$55.3 million). The payments will be distributed to eligible facilities in the same proportion as the total \$221.3 million of distributions made to each eligible facility.

The supplemental payments described above will not be subject to subsequent adjustment or reconciliation and will be disregarded for purposes of calculating the limitations on Medicaid rates required by the application of the residential health care facility cap.

TN #11-41
Supersedes TN NEW

Approval Date June 15, 2011
Effective Date May 1, 2011

New York
51

- (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) The methodology for developing the trend factors shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for nonsupervisory employees.

TN #91-24

Approval Date October 23, 1992

Supersedes TN #86-4

Effective Date April 1, 1991

New York
51(a)

- (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.
- (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 factor 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.
- (3) for rate periods on and after April 1, 2000, the commissioner shall establish trend factors for rates of payment for state governmental agencies to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs.
- (a) In developing trend factors for such rates of payment, the commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all urban consumers published in the Congressional Budget Office Economic and Budget Outlook after June first of the rate year prior to the year for which rates are being developed.
- (b) After the final U.S. Consumer Price Index (CPI) for all urban consumers is published by the United States Department of Labor, Bureau of Labor Statistics, for a particular rate year, the commissioner shall reconcile such final CPI to the projection used in subparagraph (a) of this paragraph and any difference will be included in the prospective trend factor for the current year.
- (c) At the time adjustments are made to the trend factors in accordance with this paragraph, adjustments shall be made to all inpatient rates of payment affected by the trend factor adjustment.

New York
51(a)(1)

- (g) For reimbursement of services provided to patients for the period April 1, 1995 through December 31, 1995, the trend factors established in accordance with subdivisions (d), (e) and (f) of this section will reflect no trend factor projections applicable to the period January 1, 1995 other than those reflected in 1994 rates of payment and provide further, that this subdivision will not apply to use of the trend factor for the January 1, 1995 through December 31, 1995 period, any interim adjustment to the trend factor for such period, or the final trend factor for such period for purposes of projection of allowable operating costs to subsequent rate periods. The Commissioner of Health will adjust such rates of payment to reflect the exclusion of trend factor projections pursuant to this subdivision. For reimbursement of services provided to patients effective April 1, 1996 through March 31, 1997, the rates will be established by the Commissioner of Health without trend factor adjustments, but will include the full or partial value of the retroactive impact of trend factor final adjustments for prior periods.* For reimbursement of services provided to patients on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, and April 1, 2017 through March 31, 2019, and April 1, 2019 through March 31, 2020 and thereafter, the rates will reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.
- (h) For reimbursement of nursing home services provided to patients beginning on and after April 1, 2006 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, and on and after April 1, 2015 through March 31, 2017, [and] April 1, 2017 through March 31, 2019, and April 1, 2019 and thereafter, the Commissioner of Health will apply a trend factor projection of 2.25% attributable to the period January 1, 2006 through December 31, 2006. Upon reconciliation of this trend factor in accordance with the previously approved state methodology, the final 2006 trend factor will be the U.S. Consumer Price Index (CPI) for all Urban Consumers, as published by the U.S. Department of Labor, Bureau of Labor Statistics, minus 0.25%.
- (i) For reimbursement of nursing home services provided on and after April 1, 2007, the Commissioner of Health will apply a trend factor equal to 75% of the otherwise applicable trend factor for calendar year 2007 as calculated in accordance with paragraph (f) of this section.

*This means that since the rates for the April 1, 1996 through March 31, 1997 period are based on 1983 base year costs trended to this period, the rate impacts of any differences between, say, the final value of the 1995 trend factor and the preliminary 1995 trend factor value that may have been used when initially calculating the rate, would be incorporated into the rates for the April 1, 1996 through March 31, 1997 rate period.

TN #19-0043
 Supersedes TN #17-0035

Approval Date August 20, 2019
 Effective Date April 1, 2019

New York
51(a)(1)(a)

- (j) For reimbursement of nursing home services provided on and after April 1, 2008, except for the nursing facilities which provide extensive nursing, medical, psychological, and counseling support services to children, the Commissioner of Health shall apply a trend factor equal to 65% of the otherwise applicable trend factor for calendar year 2008 as calculated in accordance with paragraph (f) of this section.

TN #11-12
Supersedes TN NEW

Approval Date July 18, 2011
Effective Date April 1, 2011

**New York
51(a)(2)**

1905(a)(4)(A) Nursing Facility Services

- (k) For rates of payment effective for nursing home services provided on and after January 1, 2009 through March 31, 2009, the otherwise final trend factor attributable to the 2008 calendar year period will be adjusted such that any increase to the average trend factor for the period April 1, 2008 through December 31, 2008 will be reduced, on an annualized basis, by 1.3% and no retroactive adjustment to such 2008 trend factor will be made for the period April 1, 2008 through December 31, 2008. Effective on and after April 1, 2009, the otherwise applicable final trend factor attributable to the 2008 calendar year period will be zero.
- (l) For rates of payment effective for nursing home services provided on and after January 1, 2009, through March 31, 2009, a trend factor equal to the otherwise applicable trend factor attributable to the period January 1, 2009, through December 31, 2009, as calculated in accordance with paragraph (f) of this section, less 1% will be applied. Effective on and after April 1, 2009, the otherwise applicable trend factor attributable to the 2009 calendar year period will be zero.
- (m) For rates of payment effective for nursing home services provided for the period January 1, 2010, through March 31, 2010, the otherwise applicable trend factor attributable to the 2010 calendar year period will be zero.
- (n) For rates of payment effective for inpatient services provided by residential health care facilities on or after April 1, 2010, except for residential health care facilities that provide extensive nursing, medical, psychological, and counseling support services to children, the otherwise applicable trend factors attributable to:
 - i. the 2010 through 2012 calendar year periods will be no greater than zero.
 - ii. the 2013 and 2014 calendar year periods will be no greater than zero.
 - iii. the 2015 calendar year period will be no greater than zero for rates effective for the period January 1, 2015, through March 31, 2015, and April 23, 2015, through December 31, 2015.
 - iv. the 2016 calendar year period will be no greater than zero.
 - v. the 2017 calendar year period will be no greater than zero for rates effective for the period January 1, 2017, through March 31, 2017, and April 1, 2017 through December 31, 2019.
 - vi. the 2019 - 2021 calendar year periods will be no greater than zero for rates effective for the period April 1, 2019, through March 31, 2021.
 - vii. the 2021 - 2025 calendar year periods will be no greater than zero for rates effective for the period April 1, 2021, through March 31, 2025.

Effective July 1, 1994, payment rates for the 1994 rate setting cycle will be calculated using the proxy data described in this section that is available through the third quarter of 1993. Proxy data, which becomes available subsequent to the third quarter of 1993, will not be considered in setting or adjusting 1994 payment rates.

TN #23-0099 _____

Approval Date January 24, 2024

Supersedes TN #21-0039 _____

Effective Date October 1, 2023

New York
51(b)

TREND AND ROLL FACTORS:

The authorization of an independent Panel of Health Economists to develop trend factors used in the residential health care facility reimbursement methodology is contained in statute. The following [are] is a summary of the major components of the trend factors methodology as adopted by the Panel of Health Economists.

The actual proxies used in the calculation of the trend factors are listed in p.51(c) (d) (e) and (f). The proxies adopted by the Panel as listed in p.51 (c) (d) (e) and (f) may change back to the beginning of the year when data upon which a proxy is based becomes unavailable or by recommendation of the Panel of Health Economists who statutorily are authorized to determine the trend factor methodology.

Projection Methodologies

Labor – In order to quantify the labor price movement component of the trend factor, national proxies are used, adjusted by a Regional Adjustment Factor (RAF) to estimate New York State experience. These proxies are weighted to produce a composite labor price movement. In calculating the initial and revised trend factors for a given year, a projection methodology for the labor price movements is used since actual data for the year are not yet available. The projections are based on the compounding of quarterly increases in the proxies for the four latest available quarters of data. The final trend factor calculations are based on actual proxy data for the trend factor year compared to the preceding year.

All but one of the [some] labor proxies measure increases in compensation and therefore reflect changes in both salaries and fringe benefits. The labor (proxies) proxy which measures only changes in wages and salaries [are] is adjusted by a Compensation Factor (the ration of the percent change in the Employment Cost Index-Compensation to the Employment Cost Index-Wages and Salaries) [for the appropriate series] to incorporate fringe benefits changes.

Non-Labor – A number of different proxies are used to measure price movements in non-labor (related) expenses incurred by facilities. In calculating the initial and revised trend factors, an estimate of the non-labor price movement is made based upon the projection of the GDP [GNP] Implicit Price Deflator. The final trend factor calculations are made using the actual changes in the non-labor proxies.

New York
51(c)

1995 Proxies and Sources
Residential Health Care Facilities

ITEM	PROXY
Labor	
Executive, Administrative and Managerial Personnel	ECI-Civilian-Compensation-Health Services – Executive, Administrative and Managerial 1/
Professional and Technical Personnel	ECI-Civilian-Compensation-Service Producing Industries-Service Occupation 41.1% 1/ Professional and Technical 1/
All Other Personnel	1. ECI-Civilian-Compensation-Service Producing Industries- Service Occupation 41.1% 1/ 2. ECI-Civilian-Compensation-Service Producing Industries-Clerical 45.0% 1/ 3. ECI-Civilian-Compensation-Service Producing Industries-Blue Collar 8.9% 1/ 4. ECI-Compensation-Private Industry-Workers-Union-Service Producing Industries 5.0% 1/ Collective bargaining Agreements Service Producing Industries 5.0% 2/ a. ECI Compensation-Private Industry-Service-Producing Industries 3% b. ECI Wages and Salaries-Private Industry-Service-Producing Industries 3%
Regional Adjustment Factor	Average hourly earnings industry composite-New York and U.S. -50% CPI-U-New York City Area, Buffalo Area, Northeast Size b, Northeast Size C. U.S.-50%
Non-Labor	
Telephone	Telephone rate index
Insurance – Malpractice, general liability, umbrella & other	Weighted average percent change in insurance cost

TN #98-04

Supersedes TN #94-04

Approval Date August 3, 1999

Effective Date January 1, 1998

New York
51(d)

**1995 Proxies and Sources
Residential Health Care Facilities**

ITEM	PROXY
Legal Services	ECI-Compensation-Private Industry Workers-Professional Specialty & Technical 1/
Auditing Services	ECI-Compensation-Civilian Private Industry Workers –Executive, Administrative and Managerial 1/
Office Supplies	<ol style="list-style-type: none"> 1. Office Supplies & Accessories (PPI) – (15%) 40% 2. Unwatermarked Bond, #4 (PPI) 35% 3. Form Bond, 15 lb. (PPI) 30% 4. ECI Compensation-Private Industry Workers-Executive, Administrative and Managerial 20% 1/ 2. Office Machines NEC – 12.5% (PPI) 3. Writing and Printing Papers – 20% (PPI) 4. Pens, Pencils and Marking Devices – 12.5% (PPI) 5. Classified Advertising – 7.5% (PPI) 6. Periodicals, Circulation – 7.5% (PPI)
Management Consulting Fees	<p>Average hourly earnings – Management and Public Relation Services 2/</p> <ol style="list-style-type: none"> a. ECI Private Industry Workers – Compensation – Executive, Administrative and Managerial 3/ b. ECI – Private Industry Workers – Wages and Salaries – Executive, Administrative and Managerial 3/
Interest Expense – Working Capital	Predominant prime time
Real Estate Taxes	<ol style="list-style-type: none"> 1. NYC tax rates 2. Upstate overall tax rate
Dietary	<ol style="list-style-type: none"> 1. All Foods (PPI) – 40% 2a. Food at Home, U.S. City average (CPI) or 2b. Food at Home, NY-NENJ (CPI) – 40% 3. Cups and Liquid – Tight Containers (PPI) – 3% 4. Tableware, Service Pieces, and Nonelectric Kitchenware (CPI) – 7% 5a. Food Away From Home, (CPI) U.S. City average or 5b. Food Away From Home, NY-NENJ (CPI) – 10%¹
Maintenance & Repairs	Maintenance & Repairs (CPI)

TN #98-04

Supersedes TN #94-04

Approval Date August 3, 1999

Effective Date January 1, 1998

New York
51(e)

1995 Proxies and Sources
Residential Health Care Facilities

ITEM	PROXY
• #2 Fuel oil	Price, Tank Car Reseller, NYC & Albany
• #6 Fuel oil	Price, Tank Car Reseller, NYC & Albany
• Natural Gas	NYSDPS data for Brooklyn Union, Central Hudson, Columbia Gas, Con-Ed, L.I. Lighting, National Fuel Dist., Niagara Mohawk, NYS Electric & Gas, Orange & Rockland, Rochester Gas & Electric
• Electric Power	NYSDPS price index for Con-Ed, L.I. Lighting, Orange & Rockland, Central Hudson, NYS Electric & Gas, Niagara Mohawk, Rochester Gas & Electric
• Water and Sewer	Water and Sewerage Maintenance (CPI)
• Disposable Linen	Disposable Diapers (PPI)
• Linen and Bedding	Textile House furnishings (CPI)
• Housekeeping	Housekeeping Supplies (CPI)
• Maintenance and Repairs Other Utilities	Maintenance and Repairs (CPI)

TN #98-04

Supersedes TN #94-04

Approval Date August 3, 1999

Effective Date January 1, 1998

New York
51(f)

1995 Proxies and Sources
Residential Health Care Facilities

ITEM	PROXY
• Drugs	1. Preparations, Ethical (Prescription) (PPI) – 72.0% 2. Preparation, Prop. (Over the Counter) (PPI) – 5.0% 3. Prescription Drugs (CPI) – 23.0%
• Medical Supplies	1. Medical Instruments and Apparatus – (PPI)
• Physicians Fees	Physicians' Services (CPI) 4/
• Other Health Personnel Fees	ECI – Compensation – Private Industry Workers – Professional Specialty and Technical 1/

1/Includes Regional Adjustment Factor
2/Includes Regional Adjustment Factor and Compensation Factor
3/Excludes Regional Adjustment Factor
4/Includes Regional Adjustment Factor and Excludes Compensation Factor

TN #98-04

Supersedes TN #94-04

Approval Date August 3, 1999

Effective Date January 1, 1998

New York
52

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 exist 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 of errors made by the Department of Health.

TN <u> #86-4 </u>	Approval Date <u> July 29, 1987 </u>
Supersedes TN <u> #82-30 </u>	Effective Date <u> January 1, 1986 </u>

New York
53

86-2.14 Revision 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 [six-month] 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;
- [(2)](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;

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Supersedes TN <u>#86-4</u>	Effective Date <u>April 1, 1993</u>

New York
53(a)

- [(3)][4] significant increases in 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;
- [(4)][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;
- [(5)][6] request for waivers of any provisions of this Subpart for which waivers may be granted by the commissioner as prescribed in specific sections; [and]
- [(6)][7] alternative means of allocating costs in the cost-finding process which have been submitted with the annual cost report (RHCF-4c) and approved [in accordance with Section 456.2(b) and (c)]; and
- [(7)][8] requests for relief from the provisions 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 requests must contain sufficient documentation to demonstrate

TN #93-04

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New York
53(b)

that the services rendered are necessary and are reasonably related to the efficient production of such services.

TN #93-04
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Effective Date April 1, 1993

New York
54

- (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.

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Supersedes TN <u> #86-4 </u>	Effective Date <u> April 1, 1993 </u>

New York
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appeal submitted pursuant to paragraphs (1) and (3) – (7) of subdivision (a) of this Subpart within one year 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 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. 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 the Public Health Law section 12-a and the State Administrative Procedure Act.

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- (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 paragraph (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.

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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.
- (f) Reserved.

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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) The rates certified for such residential health care facilities as set forth in subdivision (a) of this section, shall be determined in accordance with the following:
 - (1) Except as identified in paragraph (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 [base] 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

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58(a)

month thereafter until the end of the [six-month] twelve-month cost report period referred to in section 86-2.2(e) of this Subpart or if applicable, the six-month cost report 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 paragraph (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 [base] mean price for the applicable affiliation group as identified in subdivision (d) of section 86-2.10 of this Subpart. The blended [base] 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 [base] mean price determined using the facility's PRI's and adjusted by the RIIPAF.

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- (3) the non-comparable component of the rate shall be determined on the basis of generally applicable factors, including but not limited to the following:
 - (i) satisfactory cost projections;
 - (ii) allowable actual expenditures;
 - (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.

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59(a)

(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 [base] mean [price] 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 [base] mean price for the first three months of operation shall be determined 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 as a non-comparable cost.

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59(b)

- (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 the 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.

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59(c)

Withdrawn

TN #93-04

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59(d)

- (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[, but for a period not to exceed 18 months from the effective date of such rate, or April 1, 1991 whichever is later. If a rate pursuant to subdivision (e) of section 86-2.2 of this Subpart cannot be established within this 18 month period, a facility shall have the operational component of its rate determined pursuant to subparagraphs (i), (ii), and (iii) of this paragraph which will be effective on the first day of the month following the 18 month period referenced in this subclause].

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59(e)

- (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. However, for a facility that did not or does not achieve 90 percent or greater overall average utilization for any year within 5 calendar years from the date of commencing operation, the rates will be recalculated utilizing the facility's most recently available reported allowable costs divided by patient days imputed at 90 percent. Such recalculated rates shall be effective January 1 of the 6th calendar year following the date the facility commenced operations, or April 1, 2006, whichever is later.
- (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 [96] 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 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.

TN #06-18

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59(f)

(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 for TBI patients 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 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

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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 RIPAF 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 the Department to operate a TBI unit 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, the noncomparable component of the rate shall be determined in accordance with paragraph (3) of this subdivision.

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59(h)

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

~~[(iv) The provisions of this paragraph will expire on December 31, 1994.]~~

(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~~ Appendix 2 of this State Plan 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 section 86-2.10(c)(3)(iii) of this Subpart increased by a factor of 2.89 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 this Subpart based on the facility's case

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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 direct 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 RIPAF 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 care 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 the Department to operate a ventilator-dependent unit that would be reported in the functional cost centers identified in subdivision (f) of section 86-2.10.

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59(j)

- (b) For a new facility without a residential health care 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 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 section 86-2.10(c)(1) of this Subpart shall be considered a noncomparable cost reimbursed pursuant to section 86-2.10(f) of this Subpart.
- (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 ~~subdivision (f) of this~~ section 86-2.10(f) of this Subpart.
- (iv) Rates established pursuant to this paragraph shall also include an adjustment pursuant to 86-2.10(u) of this Subpart.
- ~~[(v) The provisions of this paragraph will expire on December 31, 1994.]~~

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59(k)

- (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 by the Department 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 of this Subpart increased by a factor of 2.65 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 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 section (c) of this Subpart based on the facility's case mix. The case mix index which is used to establish the facility's specific mean direct price per day for each patient classification group pursuant to

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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 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 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 96-2.10 plus required approved budgeted costs for personnel 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.

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59(m)

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

~~[(v) The provisions of this paragraph will expire on December 3, 1994.]~~

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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 service or use of facilities or services which could have served effective alternatives or substitutes for the whole or any part of such service.

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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) costs 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.

TN #90-44

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- (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 costs as determined by the commissioner to have been created by the sale of a residential health care facility.

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- (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.
- (o) For services provided on and after January 1, 2006, allowable costs shall not include an amount for prescription drugs for residents eligible for both Medicaid and for Part D of Title XVIII of the Social Security Act (Medicare) contingent upon implementation of such provision of the Federal Social Security Care Act in this State.
- (p) For rate periods on or after October 1, 2010, residential health care facility Medicaid rates of payment will not include reimbursement for the cost of prescription drugs.

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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 can 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.

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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 of 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 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

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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 prepayment 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 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 prior initial utilization of similarly situated facilities, and information that may have been submitted to the department by the facility as to the anticipated demand for the service.

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- (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 for 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 under the RHCF Certificate of Need process. 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

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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.

~~[(4) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, the incurred rental specified in the agreement is includable in allowable costs if the following conditions are met:~~

~~(i) the rental charges are reasonable based on consideration of rental charges of comparable equipment and market conditions in the area; the type, expected life, condition and value of the equipment rented and other provisions of the rental agreements;~~

~~(ii) adequate alternate equipment which would serve the purpose are not or were not available at a lower cost; and~~

~~(iii) the leasing was based on economic and technical considerations;~~

~~(iv) if all these conditions were not met, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs had it retained legal title to the equipment, such as interest, taxes, depreciation, insurance, and maintenance costs.~~

~~(v) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving land, the incurred rental cost for the land shall not be includable in allowable costs.]~~

(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

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

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- (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 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 on equity in the following manner:

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(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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[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 needs, 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, trustee 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

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- (d) interest on current indebtedness shall be treated and reported as an operating, administrative expense. Effective April 1, 2006 and thereafter, rates of payment shall not include a payment factor for interest on current indebtedness if the cost report utilized to determine such payment factor also shows a withdrawal of equity, a transfer of assets, or a positive net income.
- (e) interest on capital indebtedness, as defined in paragraph 86-2.21(a)(1) of this Subpart, except as provided for in section 86-2.2(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

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- (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, investment income reported for the same year year used to compute capital cost reimbursement for a facility's rate shall reduce the interest expense allowed for reimbursement, as provided in sub-paragraph (c)(2)(i)-(iii) of this section.
- (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. Effective April 1, 2006 and thereafter, rates of payment shall not include a payment factor for interest on current indebtedness if the cost report utilized to determine such payment factor also shows a withdrawal of equity, a transfer of assets, or a positive net income.
- (2) (a) 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 prime lending rate as published in the first issue of the Wall Street Journal for the calendar year plus 200 basis points (200 points equals 2%) 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.
 - * For example, for a home with 100 beds (i.e., less than 120) the threshold would be prime rate +2% applied to \$270,000. For a home having 150 beds, the threshold will be the prime rate + 2% applied to \$270,000 + \$2,250 (30 beds) or \$337,500.
- (b) 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

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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.

- (c) 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 86-2.2(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] to 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.

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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.

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(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 reevaluation 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

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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, [as said rate is determined by the United States Department of Health, Education and Welfare as an element of reasonable cost for purposes of payments to or reimbursement of proprietary providers under title XVIII of the Federal Social Security Act.] 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.

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(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 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

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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 cost 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

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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 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

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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, under the hospital certificate of need process. 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.
- ~~(6) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment, the incurred rental specified in the agreement shall be included in allowable costs if the following conditions are met:~~
 - ~~(i) the rental charges are reasonable based on consideration of rental charges of comparable equipment and market conditions in the area;~~

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- (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] section in [Subpart 86-1] Attachment 4.19-D Part I [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 for 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.

Effective April 23, 2015, for purposes of effectuating a shared saving program, facilities that elect to refinance existing approved debt service, on or after April 23, 2015, medical assistance payments for real property costs will include 50% of the savings attributable to the refinancing. Such refinancing must be approved by the Department. Savings will be calculated each year based upon expenses that correspond only to the refinance portion of the new encumbrance relative to what it would have been absent the refinancing.

(3) Amortization.

- (i) Subject to the limitations of paragraph (5) of this subdivision, the capital cost component shall, in each year of useful facility

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life, include a payment factor sufficient to reimburse the amortization component of capital indebtedness pursuant to the terms of the mortgage note or bond.

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- (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;

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- (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.

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(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 a cumulative 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.

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- (ii) This limitation may be waived by the commissioner where a facility applies to the commissioner for approval to finance 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

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factor for any facility for which he determines that continued capital cost reimbursement is appropriate; provided, however, that such payment factor [shall] will not exceed one half of the capital cost reimbursement received by such facility in the final year of useful facility life.

Effective on April 2, 2020, and thereafter, the capital cost component of the rate for corporation and partnership-based residential health care facilities will be adjusted to reflect the removal of residual equity reimbursement. Effective on June 4, 2020, and thereafter, the capital cost component of the rate for all other residential health care facilities will be adjusted to reflect the removal of residual equity reimbursement.

(8) Capital improvement cost reimbursement.

- (i) The capital improvement cost [shall] will 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] will 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

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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;

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- (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] the Limitation subsection of the Capital Cost Reimbursement for Proprietary Residential Health Care Facilities section of this Attachment 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 the [section 86-2.21(e)(4) of this Subpart,] Return of Equity subsection of the Capital Cost Reimbursement for Proprietary Residential Health Care Facilities section of this Attachment, a return of equity, for the funds invested in the improvement.
- [(e) Effective April 1, 2009, any proprietary facility entitled to residual reimbursement, will have the capital cost component of its rate recalculated by the Department to take into account any capital improvements and/or renovations made to the facility's existing infrastructure for the purpose of converting beds to alternative long-term care uses or protecting the health and safety of patients, subject to the approval of the Commissioner and all applicable certificate of need requirements. Capital improvements and/or renovation costs that are not related to the provision of nursing facility services are not eligible to be reimbursed in the capital cost component of the nursing home rate.]
- (e) Effective April 1, 2011, through March 31, 2012, the capital cost component of the Medicaid rate shall reflect:
 - (1) The elimination of the payment factor for return on equity on real property, moveable equipment and operating assets, and
 - (2) A reduction in the payment factor for return of equity on real property which is calculated as follows:

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- a) If the balance of useful life is currently five years or less, such useful life will be increased by 100 percent.
- b) If the balance of useful life is currently six years or more, such useful life will be increased by five years.

The provisions of this paragraph will not apply to facilities which are entitled to residual reimbursement.

Effective for periods June 1, 2012 through December 31, 2012, the capital cost component of the Medicaid rate will reflect:

- (1) The elimination of the payment factor for return on equity on real property, moveable equipment and operating assets, and
- (2) A reduction in the payment factor for return of equity on real property which is calculated as follows:
 - a) the balance of useful life on January 1, 2012, will be increased by four years.

The provisions of this paragraph will not apply to facilities which are entitled to residual reimbursement.

Effective for annual periods beginning January 1, 2013, the capital cost component of the Medicaid rate will reflect:

- (1) The elimination of the payment factor for return on equity on real property, moveable equipment and operating assets, and
- (2) A reduction in the payment factor for return of equity on real property which is calculated as follows:
 - a) the balance of useful life on January first of the prior year will be reduced by one year.

The provisions of this paragraph will not apply to facilities which are entitled to residual reimbursement.

- (f) (1) With respect to facilities granted operating certificates prior to March 10, 1975, the Commissioner will modify or

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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:

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- (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, all of the following conditions must be met:

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- (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.

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- (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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- (i) (1) The Commissioner shall timely develop and implement a standardized process for assessing the feasibility of capital mortgage refinancing, including a standard formula for determining the net cost benefit of refinancing, inclusive of all transaction and closing costs. On or before September 1, 2003, each residential health care facility established under Section 2808 of the Public Health Law and certified as a provider pursuant to Title XIX of the federal Social Security Act (Medicaid), except for those facilities established under the Nursing Home Companies Law or the Hospital Loan Construction Law, shall review its existing capital debt structure using the standard formula to evaluate whether or not a material cost benefit could be derived by refinancing its capital mortgage or mortgages, and shall forward the results of such review to the Commissioner. The Commissioner may request and such facility shall submit descriptions of existing mortgage arrangements and debt service reserve funds as needed to implement paragraph (2) of this subdivision. Facilities established under the Nursing Home Companies Law or the Hospital Loan Construction Law shall submit to the Dormitory Authority, the Housing Finance Agency and/or the State of New York Mortgage Agency such information as is required by such agency to evaluate potential refinancing of such capital mortgages.
- (2) The Commissioner shall review each facility's submission and make a written determination as to whether or not the facility should refinance its capital mortgage or mortgages, and if so, for what amount, within sixty days of the date of the facility's submission based on the following parameters:
- (a) the mortgage refinancing must result in a present value cost benefit that "materially exceeds", as such term is defined by the Commissioner, the amount of all transaction and closing costs associated with the refinancing, including any pre-payment penalties associated with the current mortgage or mortgages. The Commissioner shall do such calculations in a manner consistent with comparable calculations in the State Finance Law;
- (b) mortgages may be refinanced for a term greater than the remaining term of the existing debt within certain limits, if doing so would result in the present value cost benefit specified in subparagraph (a) of this paragraph;
- (c) mortgages may be refinanced utilizing variable rate mortgage loans, if doing so would result in the present value cost benefit specified in subparagraph (a) of this paragraph. In such cases, for purposes of determining the reimbursable capital interest expense included in the capital cost component of rates of payment determined pursuant to this section, the average interest rate over the life of the refinanced mortgage shall not exceed the interest rate in effect on the previous mortgage debt immediately prior to the refinancing;

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88(b)

- (d) not-for-profit and governmental residential health care facilities may utilize taxable mortgage loans to refinance their existing debts, if doing so would result in the present value cost benefit specified in subparagraph (a) of this paragraph;
 - (e) moneys contained in facility debt service reserve funds may be considered in the evaluation of amounts necessary to be refinanced, but only to the extent such moneys total more than the debt service reserves needed to establish the successor capital mortgage financing;
 - (f) in no event shall funded depreciation accounts, or building funds accumulated through donor-restricted contributions or unrestricted contributions, gifts, bequests or legacies, be considered in the evaluation of amounts necessary to be refinanced; and
 - (g) notwithstanding any inconsistent provision of law or regulation to the contrary, the principal amount, including all transaction and closing costs and any pre-payment penalties associated with the previous mortgage or mortgages, that is thereby deemed necessary to be refinanced by the Commissioner, as approved by the Public Authorities Control Board and the United States Department of Housing and Urban Development where appropriate, shall be considered the final, approved mortgage amount for capital cost reimbursement under the relevant provisions of this section.
- (3) Notwithstanding any inconsistent provision of law or regulation to the contrary, the capital cost component of rates of payment for services provided for the period beginning October 1, 2003 through March 31, 2004 for residential health care facilities that have been identified by the commissioner as refinancing candidates pursuant to paragraph (2) of this subdivision shall reflect capital interest costs equivalent to the lower of the prevailing market borrowing rates available on or about July 1, 2003, for refinancing capital mortgages for their remaining term plus two hundred basis points, or the existing rate being paid by the facility on its capital mortgage or mortgages as of that date. The Commissioner shall determine, in consultation with mortgage financing experts, the prevailing market borrowing rates available

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88(c)

to not-for-profit and governmental residential health care facilities to refinance capital mortgages on a tax-exempt fixed rate basis, and to proprietary residential health care facilities to refinance capital mortgages on a taxable fixed rate basis, for this purpose. Exceptions to this policy shall be provided by the Commissioner to each such facility that demonstrates, prior to December 1, 2003, or thirty days after receipt of the Commissioner's written determination specified in paragraph (2) of this subdivision, whichever occurs later, that:

- (a) it has initiated or completed the process of refinancing the mortgage or mortgages in question, in which case the capital cost component of rates of payment shall be timely revised to reflect capital interest costs associated with a refinanced mortgage that conforms to the standards in paragraph (2) of this subdivision. For this purpose, a facility that has applied for approval by the Commissioner, the State Hospital Review and Planning Council and/or Public Health Council to refinance its existing mortgage debt as part of a larger project involving facility replacement, expansion, renovation or change of ownership is considered to have initiated the process of refinancing; or
- (b) it can not refinance its capital mortgage or mortgages to achieve the relevant present value cost benefit specified in subparagraphs (a) and (b) of paragraph (2) of this subdivision due to a "lock out" or similar provision in its current mortgage agreement that prevents re-financing; due to some other type of genuine refinancing obstacle, such as an inability of the facility to obtain credit approval from a lender or mortgage insurer, or due to an intervening change in credit market conditions or other relevant circumstances, in which case the capital cost component of rates of payment shall continue to reflect capital interest costs associated with the existing mortgage or mortgages, together with reasonable costs incurred in connections with the facility's attempt to refinance its existing mortgage debt.

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88(d)

- (4) Each residential health care facility established under the New York State Nursing Home Companies Law and designated as an acquired immune deficiency syndrome (AIDS) facility or having a discrete AIDS unit approved by the Commissioner of Health shall refinance its capital mortgage on or before August 1, 2004 or 120 days immediately after the effective date of the authorizing legislation, whichever is later, and shall forward the results of such refinancing to the Commissioner of Health; provided however, no such residential health care facility shall be required to refinance its capital mortgage if the Department of Health, in consultation with the Dormitory Authority of the State of New York, determines that such refinancing could not be accomplished on an economic basis or is otherwise not feasible. Notwithstanding any inconsistent provision of law or regulation to the contrary, in the event that any such residential health care facility does not refinance its capital mortgage and the Department of Health has not made a determination that a refinancing was not economic or feasible, then the capital cost component of rates of payment determined pursuant to Article 28 of the New York State Public Health Law for such facilities beginning August 1, 2004 or 120 days immediately after the effective date of the authorizing legislation, whichever is later, shall reflect the capital interest cost equivalent to the lower of: (i) the prevailing market borrowing rates available for refinancing capital mortgages for their remaining term on or about August 1, 2004 or 120 days immediately after the effective date of the authorizing legislation, whichever is later; or (ii) the existing rate being paid by the facility on its capital mortgage or mortgages as of such date. The Commissioner of Health shall determine, in consultation with the Dormitory Authority of the State of New York, the prevailing market borrowing rates available to residential health care facilities to refinance capital mortgages.

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(k) Effective July 1, 2012, the capital cost component of the rate for eligible residential health care facilities will be adjusted 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 the federal regulations set forth in 42 CFR 483.70(a)(8). Facilities that submit a request to the Commissioner and meet at least three of the following criteria, using financial information obtained from the facility's latest cost report and more recent financial information provided by the facility, shall be eligible for such capital rate adjustment:

- (i) Operating losses;
- (ii) Negative unrestricted fund balances;
- (iii) Documentation demonstrating the inability of the facility to obtain credit, at current market rates, without the reimbursement treatment accorded pursuant to this section ;
- (iv) Negative working capital;
- (v) Less than 30 days of cash expense on hand;
- (vi) More than 30 days of revenue in accounts receivable;
- (vii) Cash flow statements and budget projections demonstrating material deterioration in fiscal stability of facility.

Eligible facilities will also be required to:

- 1) File the required certificate of need information with the Department of Health and obtain any required certificate of need approvals.
- 2) Provide information documenting the costs of the sprinkler project and that such costs are necessary to achieve compliance with the federal regulations set forth in 42 CFR 483.70(a)(8).

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- 3) Submit to the Commissioner, for review and approval, a schedule setting forth by month the estimated debt service payable over the life of the financing. Such schedule will be provided to the Commissioner at least 60 days prior to the due date of the first debt service payment (or such shorter timeframe as the Commissioner may authorize).
- 4) Deposit into a separate account maintained by the facility. Medicaid revenues attributable to the capital rate adjustments for such sprinklers and any other additional facility revenues needed to cover the scheduled debt service payments attributable to such sprinklers. All such deposits in such account may only be used solely for the purpose of satisfying such debt service payments.

TN	<u>#12-20</u>	Approval Date	<u>September 26, 2012</u>
Supersedes TN	<u>NEW</u>	Effective Date	<u>July 1, 2012</u>

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86-2.22 Movable equipment.

- (a) Necessary and reasonable expenses related to movable equipment (depreciation computed on a straight-line method or accelerated under a double declining balance [on] 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.

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Supersedes TN	<u>#86-4</u>	Effective Date	<u>October 23, 1993</u>

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- (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 cost 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.

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86-2.23 Research.

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

TN #86-4

Approval Date July 29, 1987

Supersedes TN #82-30

Effective Date January 1, 1986

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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.

TN #86-4

Supersedes TN #82-30

Approval Date July 29, 1987

Effective Date January 1, 1986

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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.

TN #86-4
Supersedes TN #82-30

Approval Date July 29, 1987
Effective Date January 1, 1986

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86-2.26 COST OF 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 or material interest exists in an entity which supplies goods and/or services to the residential health care facility, 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 in 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

TN #92-4

Approval Date December 30, 1994

Supersedes TN #86-4

Effective Date March 11, 1992

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- (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.

TN <u>#92-4</u>	Approval Date <u>December 30, 1994</u>
Supersedes TN <u>NEW</u>	Effective Date <u>March 11, 1992</u>

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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 86-2.7 of this Subpart.

TN #86-4
Supersedes TN #82-30

Approval Date July 29, 1987
Effective Date January 1, 1986

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86-2.28 Return on investment.

- (a) [In] 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 [excluding capital invested in land, plant, fixed equipment and capital improvements thereto.] invested for necessary and proper operation for patient care activities of 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

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rate year 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 [that percentage determined annually by the commissioner and 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.

TN	<u>#94-04</u>	Approval Date	<u>September 8, 1998</u>
Supersedes TN	<u>#93-04</u>	Effective Date	<u>January 1, 1994</u>

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86-2.29 Payments to receivers.

- Section deleted from State Plan.

TN <u>#86-4</u>	Approval Date <u>July 29, 1987</u>
Supersedes TN <u>#82-30</u>	Effective Date <u>January 1, 1986</u>

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TN #86-4

Approval Date July 29, 1987

Supersedes TN #82-30

Effective Date January 1, 1986

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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 appendix 7 infra.
- (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 facilities establishes, by documentary evidence, that the patient review forms cannot be submitted by the due date for reasons beyond the control of the facility.

TN #86-4 Approval Date July 29, 1987
Supersedes TN #85-6 Effective Date January 1, 1986

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- (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 scheduled established pursuant to this subdivision, shall subject the residential health care facility to a rate reduction set forth in section 86-2.2 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

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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) notwithstanding paragraph (2) of this subdivision, an operator of a free-standing health- related facility may substitute no more than two licensed practical nurses who are qualified by experience and demonstrated competence in long-term care and who have successfully completed a training program in patient case mix assessment for the purposes of establishing a facility's case mix financial reimbursement for meeting the required number of assessors pursuant to subdivision (d) of this section. Such substitution may occur only in the instance that a free-standing health-related facility does not employ a sufficient number of staff registered nurses to meet the required number of assessors pursuant to subdivision (d) of this section; and
- (4)] (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.)

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- (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 for residential health care facility is as follows:

<u>Bed Size of Facility</u>	<u>Number of Responsible Assessors</u>
<u>Under 100</u>	<u>Two</u>
<u>101 to 200</u>	<u>Three</u>
<u>201 to 300</u>	<u>Four</u>
<u>301 to 400</u>	<u>Five</u>
<u>401+</u>	<u>Five plus one additional assessor for each additional 100 beds or part thereof</u>

- (e) (1) The Department shall monitor and review each residential health care facility's performance and 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

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- (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:
- (i) 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 for (PRI) or submit any additional information for the assessment period.

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- (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 2.14 of this Subpart, the residential health care facility may not correct or amend the patient 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.

TN	<u>#86-4</u>	Approval Date	<u>July 29, 1987</u>
Supersedes TN	<u>#85-6</u>	Effective Date	<u>January 1, 1986</u>

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- (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; and
- (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.
- (iii) Any patient case mix assessment performed pursuant to subparagraph (ii) of the 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.

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- (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 non-residential health care facility person or entity shall have such form certified by such person or entity in lieu of a facility registered professional nurse as required by paragraph (2) of subdivision (c) 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 (1) of subdivision (f) 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

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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 receives 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) The provisions of this section shall expire on April 30, 1989.]

TN	<u>#89-24</u>	Approval Date	<u>May 16, 1996</u>
Supersedes TN	<u>#88-4</u>	Effective Date	<u>April 19, 1989</u>

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- (j) Residential health care facilities [with 80 or more beds] 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.
- [(i)] (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.
- [(ii)] (2) Facilities [required or those electing to submit PRI data in this format] shall have an additional ten days from the time specified pursuant to subdivision (b) of this section to file the required information.
- [(iii)] (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 [subdivision (e) of section 86-2.30 of] this [Subpart] 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 [subdivision (e) of section 86-2.30 of] this [Subpart] section.

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2.31 Recalibration.

- (a) For rate periods commencing on or after January 1, 1987, notwithstanding any other provisions of this Subpart, the Direct Component of facility rates, determined in accordance with sections 86-2.10 and 86-2.11 of this Subpart, shall be reduced by 3.035 percent to reflect a recalibration adjustment based on the change in the aggregate statewide case mix index attributable to factors other than changes in patient population or condition.
- (b) The reduction in the Direct Component of facility rates as defined in subdivision (a) of this section shall be implemented on or about July 1, 1987 and shall be applied retroactive to January 1, 1987.

TN #87-6 Approval Date January 18, 1989
Supersedes TN ----- Effective Date January 1, 1987

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- (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

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- (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
- (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

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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

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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.

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- (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.

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- (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.

* The three-year effect of improved coding was annualized by taking the cube root of the three year accumulation factor.

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- (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 when conditions set forth in section 86-2.31(c)(1) are met. Additionally, a facility shall submit a modification request as an appeal application within the time limit set forth in section 86-2.13(a) of this Subpart.

TN #92-07 Approval Date August 21, 1996
Supersedes TN NEW Effective Date January 1, 1992

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- (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. **

* This means that the increase in reported case mix from 1985 to 1988, after subtracting out the recalibration adjustment for the facility, must be at least ten percent for the facility to qualify to possibly get a reduction in its recalibration adjustment.

** This refers to the allocation of the accumulated facility costs as reported via the RHCF cost reports into other cost centers that utilize their services. The purpose of the step-down process is to finally consolidate reimbursable costs into the four components of the RHCF reimbursement rate for rate setting purposes. For example, costs reported under patient-specific services such as transportation, nursing administration and therapies, among others, are finally allocated to the costs contained in the direct portion of the rate.

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108(p)

- (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.
- (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

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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%.

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APPLICATION OF 1992 RECALIBRATION APPEAL CRITERIA
EXAMPLE

ASSUMPTIONS

1.	Reported CMI Change, 1985-1988	24.44%
2.	Recalibration % (Annualized)	7.40%
3.	Real CMI Change, 1985-1988	17.04% (1-2)
4.	Direct Cost-Over-Trend, 1985-1988	8.71%
5.	Indirect Cost-Over-Trend, 1985-1988	10.50%
6.	% Facility Above Direct Ceiling	20.9%

APPLICATION OF CRITERIA

- Real CMI Change (17.04%) meets 10% requirement
- Direct Cost-Over-Trend (8.71%) does not meet the 10% requirement.

However, since this facility is above ceiling on direct costs, a credit amount is determined, to be added to the direct cost growth of 8.71%.

CALCULATION OF CREDIT

- Excess of indirect Cost-Over-Trend compared to direct cost:
 $10.50\% - 8.71\% = 1.79\%$
- Credit Amount: $20.9\% - 1.79\% = 19.11\%$
- Direct Cost-Over-Trend: $8.71\% + 19.11\% = 27.82\%$
with credit

CALCULATION OF MODIFIED RECALIBRATION

Since the revised value of direct cost growth with the credit (27.82%) exceeds the 10% requirement, facility qualifies for a modification, subject to appropriate documentation showing that direct care cost increases were due to increases in staffing levels or range/types of services.

Modification Value = $27.82\% - 17.04\% = 10.78\%$
(Dir. cost) - (real CMI change)
This is then annualized, giving 3.47%

Modified Recalibration Adjustment = $7.40\% - 3.47\% = 3.93\%$

TN #92-07 Approval Date August 21, 1996
Supersedes TN NEW Effective Date January 1, 1992

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Nursing facilities (NF) shall receive prospective 1994 rate enhancements to their rates of payment, effective November 3, 1994 through December 31, 1994. An amount not to exceed \$111 million shall be distributed to all eligible nursing facilities through 1994 prospective rate enhancements to their rates of payment. Eligible facilities shall be those facilities that sought timely relief for such rate enhancements. Such amount shall be allocated to each eligible NF based upon its reported change in patient case mix as determined by the total number of patients properly assessed and reported by the facility pursuant to 86-2.30, in excess of that reimbursed for the same base period, 1989-1991. The facility's allocated share of the prospective payment enhancement shall be converted to a per diem adjustment by dividing this amount by its volume of Medicaid days for the period November 3, 1994 through December 31, 1994.

TN	<u>#94-45</u>	Approval Date	<u>November 28, 2000</u>
Supersedes TN	<u>#91-24</u>	Effective Date	<u>November 3, 1994</u>

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Reserved

TN	<u>#91-24</u>	Approval Date	<u>October 23, 1992</u>
Supersedes TN	<u>#87-7</u>	Effective Date	<u>April 1, 1991</u>

New York
110(a)

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 of care 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 (RHCs) applying for and receiving the approval of the commissioner for participation in such projects. Acceptable uses of such adjustment 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 decision-making on the part of dementia patients.
- (c) Individual facilities or groups of facilities may participate in pilot demonstration projects pursuant to this subdivision.

TN #88-34 Approval Date March 30, 1990
Supersedes TN ----- Effective Date January 1, 1989

New York
110(a)(1)

EXPLANATION OF DEMENTIA PILOT PROJECT RATE ADJUSTMENT

The per diem for dementia care pilot demonstration projects is calculated by dividing the total award for each facility by the duration (i.e., years) of the project to determine the annual expenditure. This annual expenditure is then divided by the annualized Medicaid patient days reported by the facility to arrive at the per diem add-on.

TN #88-34 Approval Date March 30, 1990
Supersedes TN ----- Effective Date January 1, 1989

New York
110(a)(2)

Effective January 1, 2000, enhancements to the Medicaid reimbursement rates of hospice-operated nursing homes will be provided to enable them to study and analyze several issues pertaining to operations of such a nursing home. This demonstration will provide additional knowledge and experience and will collect information concerning alternative methodologies for reimbursement, delivery of medical services or eligibility of medical assistance in such facilities.

The hospice-operated nursing home will conduct a demonstration to address several patient care related issues including:

- 1) insuring appropriate placement and use of resources for residents in hospice-operated nursing homes;
- 2) training staff to promote effective care of terminally ill residents; and
- 3) maintaining and promoting autonomy and decision making on the part of the residents in hospice-operated nursing facilities.

TN #00-04 Approval Date June 6, 2001
Supersedes TN NEW Effective Date January 1, 2000 & April 1, 2000

New York
110(a)(3)

Effective for dates of service beginning on April 1, 2002 and ending on December 31, 2004, Medicaid rates of payment to non-public nursing homes shall be adjusted pursuant to a competitive process to fund projects intended to improve the quality of care for nursing home residents. This competitive process will follow the Request for Proposal procurement process, as mandated by the NYS Office of the State Comptroller.

Such eligible projects may include:

- (a) an increase in direct care staff, either facility wide or targeted at a particular area of care or shift;
- (b) increased training and education of direct care staff, including allowing direct care staff to increase their level of licensure relevant to nursing home care;
- (c) efforts to decrease staff turn-over; and
- (d) other efforts related to the recruitment and retention of direct care staff that will effect the quality of care at such facility.

The evaluation of each submitted proposal will be based on the following criteria:

- (1) proposal demonstrates that the project will improve the quality of care in a cost effective manner;
- (2) proposal provides evidence that the project can be successfully implemented;
- (3) proposal provides evidence that the quality of care will be improved by improving or increasing the training, education and retention of direct care staff;
- (4) proposal provides a detailed budget with a cost effective approach;
- (5) proposal demonstrates financial need; and
- (6) proposal provides a written labor union concurrence from the relevant bargaining agent for the projects where a collective bargaining agreement exists covering occupations in which training is proposed.

A proposal may be rejected if the submitting facility has significant non-compliance in areas that affect resident health and safety.

Submitted proposals will be ranked based on the results of the review and evaluation process. Proposals achieving a predetermined minimum score will receive an initial award determined by multiplying the score, expressed as percentage, by the project amount requested. Available funds will be distributed as follows:

TN	<u>#02-23</u>	Approval Date	<u>September 16, 2002</u>
Supersedes TN	<u>NEW</u>	Effective Date	<u>April 1, 2002</u>

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110(a)(4)

- (a) If the total amount initially awarded for all nursing homes equals the total funding available, each nursing home will receive its initial award.
- (b) If the total amount initially awarded for all nursing homes exceeds the total funding available, each initial award will be reduced on a proportional basis such that the sum of all final awards does not exceed the total funds available.
- (c) If the total amount initially awarded for all nursing homes is less than the total funding available, each nursing home will receive its initial award. Remaining funds will be distributed proportionally based on each nursing home's initial award to the total of all initial awards.

Nursing homes receiving awards shall submit an annual progress report that describes and evaluates the quality improvements achieved through this project. Significant changes from the approved project or budget may result in a revision to the nursing home's award. Funding may be discontinued if it is determined that the goal of the project is not being met. The Department of Health shall have the right to audit the nursing home's financial records to determine that the funds granted for this project have been used for the specific purposes defined in the approved proposal and shall recoup any funds determined to have been used for purposes other than specified in the approved proposal.

The Department of Health will not issue any new requests for proposals after December 31, 2004, and all awards for subsequent annual periods will be distributed on the same proportional basis as the most recent available distribution. Funds may be utilized for any of uses listed in this Section and the Department of Health shall have the right to audit to determine that the funds have been used accordingly, and recoup any funds determined to have been used otherwise.

Resultant adjustments to Medicaid rates of payment shall not, in aggregate, exceed 62.5 million dollars for the rate period beginning April 1, 2002 and ending December 31, 2002, and for each annual period thereafter beginning January 1, 2003 and ending December 31, 2004, and shall not exceed, in aggregate, 46.875 million dollars for the period July 1, 2005 through December 31, 2005, and [31.25] 78.125 million dollars [on an annualized basis,] for the period January 1, 2006 through [June 30, 2007] December 31, 2006, and 62.5 million dollars for the period January 1, 2007 through June 30, 2007. Award amounts shall be included as a reimbursable

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Supersedes TN	<u>#05-36</u>	Effective Date	<u>April 1, 2006</u>

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110(a)(4)(i)**

cost add-on to medical assistance fee-for-service rates of payment established pursuant to this section, based on Medicaid utilization data in each facility's annual cost report submitted two years prior to the rate year or projected Medicaid utilization data for those facilities that have not submitted an annual cost report for the period two years prior to the rate year. These adjustments shall not be subject to subsequent adjustment or reconciliation to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

TN	<u>#06-17</u>	Approval Date	<u>October 10, 2006</u>
Supersedes TN	<u>NEW</u>	Effective Date	<u>April 1, 2006</u>

New York
110-b

Section 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 freestanding 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 freestanding 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 freestanding 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 freestanding 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 freestanding 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 freestanding 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 freestanding under circumstances described in subdivision (a) of this section and has applied for a three year phase in of the freestanding 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 freestanding 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.

TN #88-47 Approval Date February 27, 1990
Supersedes TN ----- Effective Date October 1, 1988

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110-c

Such facilities shall be designated freestanding, 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.

TN	<u>#88-47</u>	Approval Date	<u>February 27, 1990</u>
Supersedes TN	<u>-----</u>	Effective Date	<u>October 1, 1988</u>

New York
110(d)

86-2.36 Scheduled short term care.

- (a) Residential health care facilities which provide scheduled short term care for residents 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 (PRI) and the submission of case mix information to the Department shall not apply to scheduled short term care.

Clarifying Information:

- 1. Scheduled short term care is care provided to individuals who are determined to need nursing facility care but are being cared for by someone in the community, and who do not participate in a Home and Community Based Waiver program.
- 2. All federal nursing facility statutory and regulatory requirements, including those related to admission, discharge and transfer, continue to apply to scheduled short term care services.
- 3. Individuals may receive no more than 30 days of scheduled short term care for a given admission, and no more than a total of 42 days of scheduled short term care during a given year.
- 4. If an individual receives services in the nursing facility for a time period exceeding the maximum limits specified in (3), the admission will be considered as a normal nursing facility admission for state and federal regulatory purposes, and the reimbursement for such services will be according to the standard state nursing facility rate-setting methodology contained in this Part of the plan.

New York
110(d)(1)

Pay for Performance Incentive

(a) The commissioner shall make rate adjustments, effective May 1, 2008, and thereafter, 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:

An award shall be made for the best performers for the evaluation period. Best performers are those facilities ranked in the top four percentile of all eligible residential health care facilities according to the four quarters average score for the period January 1, 2007 through December 31, 2007.

An award shall be made to residential health care facilities with the best improvement in pressure ulcer care between a base and evaluation period. Best improvers are those facilities ranked in the top four percentile of all eligible residential health care facilities according to the base and the evaluation periods four quarters average score. The base period score shall be based on the period July 1, 2006 through June 30, 2007; the evaluation score shall be based on the period July 1, 2007 through June 30, 2008. 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

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

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

The quality measure of pressure ulcer 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);

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New York
110(d)(2)

Pressure ulcer rates shall be considered only for chronic care residential health care facility residents;

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 paragraph (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

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 proportionately based on each eligible facility's percent of Medicaid patient days to the total Medicaid patient days for all eligible facilities. Such days of care are as reported in the latest RHCF-4 cost reports for patients eligible for medical assistance.

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.

- (g) A total of \$3,000,000 will be paid as rate adjustments.

**New York
110(d)(3)**

Computation of a Price for the Operating Component of the Rate for Non-specialty Facilities and the Non-capital Component of the Rate for Specialty Facilities

- a) Effective January 1, 2012, the operating component of rates of payment for non-specialty residential health care facilities (RHCs) shall be a price and shall consist of the sum of the following components:
- 1) $((50\% \text{ of the statewide direct price for all non-specialty facilities} + 50\% \text{ of the peer group direct price}) \times (\text{direct WEF adjustment}) \times (\text{case mix adjustment})) + ((50\% \text{ of the statewide indirect price for all non-specialty facilities} + 50\% \text{ of the peer group indirect price}) \times (\text{indirect WEF adjustment})) + \text{non comparable component} + \text{applicable rate add-ons}$
- b) For purposes of calculating the direct and indirect price component of the rates, peer group shall mean:
- 1) all non-specialty facilities (NSF)
 - 2) all non-specialty hospital-based facilities and non-specialty freestanding facilities with certified bed capacities of 300 beds or more (NSHB/NS300+)
 - 3) non-specialty freestanding facilities with certified bed capacities of less than 300 beds (NS300-)
- c) Specialty facilities shall mean:
- 1) AIDS facilities or discrete AIDS units within facilities;
 - 2) discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons;
 - 3) discrete units providing specialized programs for residents requiring behavioral interventions;
 - 4) discrete units for long-term ventilator dependent residents; and
 - 5) facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children.
 - 6) discrete units for residents with Neurodegenerative diseases; Amyotrophic Lateral Sclerosis and Huntington as is defined in Attachment 4.19-D Part I Huntington's disease.

TN #16-0009Approval Date January 30, 2017Supersedes TN #11-0023-AEffective Date November 1, 2016

New York
110(d)(4)

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

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Supersedes TN NEW Effective Date January 1, 2012

New York
110(d)(5)

- 1) For NSHB/NS300+ the direct component of the price shall consist of a blended rate equal to:
 - i) 50% of the statewide direct NSF price, which shall be the allowable operating costs and statistical data for the direct component of the price as reported by all non-specialty facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days, and
 - ii) 50% of the direct NSHB/NS300+ price, which shall be the allowable operating costs and statistical data for the direct component of the price as reported by all non-specialty hospital-based facilities and all non-specialty freestanding facilities with certified bed capacities of 300 beds or more in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.
- 2) For NS300- the direct component of the price shall consist of a blended rate equal to:
 - i) 50% of the statewide direct NSF price, which shall be the allowable operating costs and statistical data for the direct component of the price as reported by all non-specialty facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days, and
 - ii) 50% of the direct NS300- price, which shall be the allowable operating costs and statistical data for the direct component of the price as reported by all non-specialty facilities with certified bed capacities of less than 300 beds in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.
- 3) Pursuant to the methodology described above, the direct component of the price for each peer group shall be as follows:

**New York
110(d)(6)**

Direct Component of the Price Medicare Ineligible Price, Medicare Part D Eligible Price (NSHB/NS300+ Peer Group)					
Effective Date of Prices	Direct NSF Price (a)	50% of Direct NSF Price (b)	Direct NSHB/NS300+ Price (c)	50% of Direct NSHB/NS300 + Price (d)	Total Direct Component of Price for NSHB/NS300+ Peer Group (b) + (d)
January 1, 2012	\$105.79	\$52.90	\$117.48	\$58.74	\$111.64
January 1, 2013	\$111.82	\$55.91	\$124.17	\$62.09	\$118.00
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
April 1, 2016	\$117.92	\$58.96	\$131.01	\$65.51	\$124.47
January 1, 2017	\$119.02	\$59.51	\$132.17	\$66.09	\$125.60
April 1, 2018	\$118.80	\$59.40	\$131.95	\$65.98	\$125.38
<u>May 17, 2018</u>	<u>\$118.84</u>	<u>\$59.42</u>	<u>\$131.99</u>	<u>\$66.00</u>	<u>\$125.42</u>
Direct Component of the Price Medicare Part B Eligible Price, Medicare Part B and Part D Eligible Price (NSHB/NS300 + Peer Group)					
Effective Date of Prices	Direct NSF Price (a)	50% of Direct NSF Price (b)	Direct NSHB/NS300+ Price (c)	50% of Direct NSHB/NS300 + Price (d)	Total Direct Component of Price for NSHB/NS300+ 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
April 1, 2016	\$116.30	\$58.15	\$129.28	\$64.64	\$122.79
January 1, 2017	\$117.39	\$58.70	\$130.43	\$65.22	\$123.91
April 1, 2018	\$117.17	\$58.59	\$130.21	\$65.11	\$123.69
<u>May 17, 2018</u>	<u>\$117.21</u>	<u>\$58.61</u>	<u>\$130.25</u>	<u>\$65.13</u>	<u>\$123.73</u>

TN #18-0049Approval Date September 04, 2018Supersedes TN #18-0044Effective Date May 17, 2018

**New York
110(d)(7)**

Direct Component of the Price Medicare Ineligible Price, Medicare Part D Eligible Price (NS300- Peer Group)					
Effective Date of Prices	Direct NSF Price (a)	50% of Direct NSF Price (b)	Direct NS300-Price (c)	50% of Direct NS300-Price (d)	Total Direct Component of Price for NS300- Peer Group (b) + (d)
January 1, 2012	\$105.79	\$52.90	\$99.30	\$49.65	\$102.55
January 1, 2013	\$111.82	\$55.91	\$104.95	\$52.48	\$108.39
January 1, 2014	\$116.58	\$58.29	\$109.43	\$54.72	\$113.01
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
April 1, 2016	\$118.04	\$59.02	\$110.77	\$55.39	\$114.41
January 1, 2017	\$119.02	\$59.51	\$111.71	\$55.86	\$115.37
April 1, 2018	\$118.93	\$59.46	\$111.62	\$55.81	\$115.27
<u>May 17, 2018</u>	<u>\$118.94</u>	<u>\$59.47</u>	<u>\$111.63</u>	<u>\$55.62</u>	<u>\$115.29</u>
Direct Component of the Price Medicare Part B Eligible Price, Medicare Part B and Part D Eligible Price (NS300- Peer Group)					
Effective Date of Prices	Direct NSF Price (a)	50% of Direct NSF Price (b)	Direct NS300-Price (c)	50% of Direct NS300-Price (d)	Total Direct Component of Price for NS300- 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	\$112.74
January 1, 2016	\$116.86	\$58.43	\$109.64	\$54.82	\$113.25
April 1, 2016	\$116.42	\$58.21	\$109.20	\$54.60	\$112.81
January 1, 2017	\$117.39	\$58.70	\$110.14	\$55.07	\$113.77
April 1, 2018	\$117.28	\$58.64	\$110.04	\$55.02	\$113.66
<u>May 17, 2018</u>	<u>\$117.31</u>	<u>\$58.66</u>	<u>\$110.06</u>	<u>\$55.03</u>	<u>\$113.68</u>

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.

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Effective Date May 17, 2018

**New York
110(d)(8)**

- 4) 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%

- e) Allowable costs for the direct price component shall be the 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, as extracted by the Commissioner on December 21, 2010, or from the most recent cost report available on that day, after first deducting costs attributable to specialty units and the hospital and capital costs.
- 1) For the purposes of calculating the Medicare Ineligible Price and the Medicare Part D Eligible Price the costs identified shall be reduced by the costs of prescription drugs as reported on the facility's 2007 cost report.
 - 2) For the purposes of calculating the Medicare Part B Eligible Price and the Medicare Part B Eligible Price and Medicare Part D Eligible Price the costs identified shall be reduced by the costs of prescription drugs as reported on the facility's 2007 cost report and the revenue offsets associated with Medicare Part B Eligible Patients as reported by Medicare.
 - i) Nursing administration (013);
 - ii) Activities (014);
 - iii) Social services (021);
 - iv) Transportation (022); - non-medical transportation only effective April 1, 2016
 - v) Physical therapy (039) (including associated overhead);
 - vi) Occupational therapy (040) (including associated overhead);
 - vii) Speech/hearing therapy (041) (including associated overhead);
 - viii) Central service supply (043);
 - ix) Residential health care facility (051); and
 - x) Pharmacy (042) (excluding the costs allocated to non comparables).

New York
110(d)(9)

- f) 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 certified cost report ((RHCF-4), or extracted from a hospital-based facility's 2009 certified cost report (RHCF-2) and the institutional cost report of its related hospital as applicable) as extracted by the Commissioner on October 31, 2011, after first deducting costs attributable to specialty units and the hospital, for the 2009 calendar year. The WEF adjustment shall consist of 50% of a facility-specific direct WEF and 50% of a regional direct WEF.
- 1) The facility-specific direct WEF shall be calculated as follows:
- $1/((\text{Facility-Specific Wage Ratio} / \text{Wage Index}) + (\text{Facility-Specific Non-Wage Ratio}))$
- i) 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.
- ii) 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).
- iii) The Facility-Specific Non-Wage Ratio shall be calculated by subtracting from 1 the Facility-Specific Wage Ratio.
- 2) A regional direct WEF shall be calculated for each of the following 16 regions. The county geographic boundaries shall be the sole factor considered for determining in which WEF region a facility is located.

New York
110(d)(10)

<u>Region</u>	<u>Consisting of the counties of:</u>
<u>Albany Region</u>	<u>Albany, Columbia, Fulton, Green, Montgomery, Rensselaer, Saratoga, Schenectady and Schoharie</u>
<u>Binghamton Region</u>	<u>Broome and Tioga</u>
<u>Central Rural Region</u>	<u>Cayuga, Cortland, Seneca, Tompkins and Yates</u>
<u>Elmira Region</u>	<u>Chemung, Schuyler and Steuben</u>
<u>Erie Region</u>	<u>Cattaraugus, Chautauqua, Erie, Niagara and Orleans</u>
<u>Glens Falls Region</u>	<u>Essex, Warren and Washington</u>
<u>Long Island Region</u>	<u>Nassau and Suffolk</u>
<u>New York City Region</u>	<u>Bronx, Kings, New York, Queens and Richmond</u>
<u>Northern Rural Region</u>	<u>Clinton, Franklin, Hamilton and St. Lawrence</u>
<u>Orange Region</u>	<u>Chenango, Delaware, Orange, Otsego, Sullivan and Ulster</u>
<u>Poughkeepsie Region</u>	<u>Dutchess and Putnam</u>
<u>Rochester Region</u>	<u>Livingston, Monroe, Ontario and Wayne</u>
<u>Syracuse Region</u>	<u>Madison and Onondaga</u>
<u>Utica Region</u>	<u>Herkimer, Jefferson, Lewis, Oneida and Oswego</u>
<u>Westchester Region</u>	<u>Rockland and Westchester</u>
<u>Western Rural Region</u>	<u>Allegany, Genesee, and Wyoming</u>

3) The regional direct WEF shall be calculated for each of the 16 regions as follows:

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

New York
110(d)(11)

- i) 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 (042), central service supply (043), and residential health care facility (051) by total direct operating expenses in the region from such cost centers.
- ii) 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).
- iii) The Regional Non-Wage Ratio shall be calculated by subtracting from 1 the Regional Wage Ratio.
- 4) The regional 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 above will be equal to 100% of the applicable regional WEF.
- g) 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.

New York
110(d)(12)

- 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 RNs, LPNs, aides, therapists, and therapy aides and the 1995-97 federal time study. The minutes from the federal time study are multiplied by the NY 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 as follows:
- i) For NSHB/NS300+ the case mix adjustment shall be calculated by dividing the Medicaid-only case mix derived from data for January 2011 for each such facility by the all-payer case mix for the base year 2007. The all-payer case mix for base year 2007 shall be a blend of:
 - (a) 50% of the case mix for all non-specialty facilities, and
 - (b) 50% of the case mix for all non-specialty hospital-based facilities and non-specialty freestanding facilities with certified bed capacities of 300 beds or more; or
 - ii) For NS300- the case mix adjustment shall be calculated by dividing the Medicaid-only case mix derived from data for January 2011 for each such facility by the all-payer case mix for the base year 2007. The all-payer case mix for base year 2007 shall be a blend of:
 - (a) 50% of the case mix for all non-specialty facilities, and
 - (b) 50% of the case mix for non-specialty freestanding facilities with certified bed capacities of less than 300 beds.

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**New York
110(d)(13)**

1905(a)(4)(A) Nursing Facility Services

Calculation of 2007 All Payer Base Year Case Mix			
Peer Group	Case Mix Total (Count x Weight)*	Total Patient Days	Weighted Average Case Mix (Case Mix Total/ Patient Days)
NSHB/NS300+	12,385,293	13,623,548	0.9091
NS300-	22,137,438	24,403,182	0.9072
Statewide/All Non-Specialty Facilities	34,522,731	38,026,730	0.9079
2007 Base Year Case Mix = NSHB/NS300+ (50% NSHB/NS300+/ 50% Statewide)			0.9085
2007 Base Year Case Mix = NS300- (50% NS300- / 50% Statewide)			0.9075

*Count is defined as the number of patients in each Resource Utilization Group and Weight is calculated and defined as described above in paragraph g(1) and g(2).

- 4) (a) Subsequent case mix adjustments to the direct component of the price for rate periods effective after January 1, 2012, will be made in July and January of each calendar year and will use Medicaid-only case mix data applicable to the previous case mix period (e.g., July 1, 2012, case mix adjustment will use January 2012 case mix data, and January 1, 2013, case mix adjustment will use July 2012 case mix data).
- 4) (b) The case mix adjustment to the direct component of the price for rate periods effective July 1, 2021, and thereafter, will be made in January and July of each calendar year and will use all Medicaid-only case mix data submitted to CMS applicable to the previous six-month period (e.g., April – September for the January case mix adjustment; October – March for the July case mix adjustment).
- (c) The case mix adjustment established for the July 1, 2023, rate period will remain in effect until such time as the case mix adjustment methodology can be revised in statute, regulation, and the State Plan, to leverage acuity data from the Patient Driven Acuity Model (PDPM). No case mix changes will be calculated in 2024, per statutory requirements.

TN **#24-0043**

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Effective Date **April 1, 2024**

**New York
110(d)(14)**

1905(4)(a) Nursing Facility Services

- 5) Case mix adjustments to the direct component of the price for facilities for which facility-specific case mix data is unavailable or insufficient will be equal to the previous case mix of the peer group applicable to such facility.
- 6) The adjustments and related patient classifications for each facility will be subject to audit review by the Office of Medicaid Inspector General, and/or other agents as authorized by the Department.
- h) The indirect component of the price will consist of a blended rate to be determined as follows:
 - 1) For NSHB/NS300+ the indirect component of the price will consist of a blended rate equal to:
 - i) 50% of the Statewide indirect NSF price which will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and
 - ii) 50% of the indirect NSHB/NS300+ price which will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty hospital-based facilities and all non-specialty freestanding facilities with certified bed capacity of 300 beds or more in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; or
 - 2) For NS300- the indirect component of the price will consist of a blended rate equal to:
 - i) 50% of the Statewide indirect NSF price which will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days; and
 - ii) 50 % of the indirect NS300- prices which will be the allowable operating costs and statistical data for the indirect component of the price as reported by all non-specialty facilities with certified bed capacity of less than 300 beds in its cost reports for the 2007 calendar year, reduced by the allowable costs percent reduction, and divided by total 2007 patient days.

New York
110(d)(15)

- 3) Pursuant to the methodology described above, the indirect component of the price for each peer group shall be as follows:

<u>Indirect Component of the Price (NSHB/NS300+) Peer Group</u>					
<u>Effective Date of Prices</u>	<u>Indirect NSF Price (a)</u>	<u>50% of Indirect NSF Price (b)</u>	<u>Indirect NSHB/NS300+ Price (c)</u>	<u>50% of Indirect NSHB/NS300+ Price (d)</u>	<u>Total Indirect Component of Price for NSHB/NS300+ Peer Group (b) + (d)</u>
January 1, 2012	\$53.15	\$26.58	\$61.54	\$30.77	\$57.35
January 1, 2013	\$56.18	\$28.09	\$65.04	\$32.52	\$60.61
January 1, 2014	\$58.57	\$29.29	\$67.82	\$33.91	\$63.20
January 1, 2015	\$59.26	\$29.63	\$68.61	\$34.31	\$63.94
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
<u>Indirect Component of the Price (NS300-)Peer Group</u>					
<u>Effective Date of Prices</u>	<u>Indirect NSF Price (a)</u>	<u>50% of Indirect NSF Price (b)</u>	<u>Indirect NS300- Price (c)</u>	<u>50% of Indirect NS300- Price (d)</u>	<u>Total Indirect Component of Price for NS300- Peer Group (b)+(d)</u>
January 1, 2012	\$53.15	\$26.58	\$48.49	\$24.25	\$50.82
January 1, 2013	\$56.18	\$28.09	\$51.25	\$25.63	\$53.72
January 1, 2014	\$58.57	\$29.29	\$53.44	\$26.72	\$56.01
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

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Supersedes TN NEW Effective Date January 1, 2012

New York
110(d)(16)

- 4) The allowable costs percent reduction for the indirect component shall be the same as the allowable cost reduction used for the direct component and shown in paragraph C of the subdivision 4) of this section
- i) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's 2007 certified cost report (RHCF-4), or extracted from a hospital-based facility's 2007 certified cost report (RHCF-2) and the institutional cost report of its related hospital, as extracted by the Commissioner on December 21, 2010, after first deducting costs attributable to specialty units, and the hospital; 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 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).

New York
110(d)(17)

- j) 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 by each facility's 2009 certified cost report ((RHCF-4), or extracted from a hospital-based facility's 2009 certified cost report (RHCF-2) and the institutional cost report of its related hospital as applicable) as extracted by the Commissioner on October 31, 2011 after first deducting costs attributable to specialty units and the hospital. The WEF adjustment shall consist of 50% of a facility-specific indirect WEF and 50% of a regional indirect WEF.
- 1) The facility-specific indirect WEF shall be calculated as follows:
- $1/((\text{Facility-Specific Wage Ratio} / \text{Wage Index}) + (\text{Facility-Specific Non-Wage Ratio}))$
- i) 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 from such cost centers.
- ii) 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).
- iii) The Facility-Specific Non-Wage Ratio shall be calculated by subtracting from 1 the Facility-Specific Wage Ratio.
- 2) A regional indirect WEF shall be calculated using the 16 regions as defined for the regional WEF in paragraph e) subsection 2 of this section. The county geographic boundaries shall be the sole factor considered in determining which WEF region a facility is located.

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110(d)(18)

- 3) The regional indirect WEF shall be calculated for each of the 16 regions as follows:
- $1/((\text{Regional Wage Ratio}/ \text{Regional Wage Index}) + (\text{Regional Non-Wage Ratio}))$
- i) The Regional Indirect Wage Ratio shall be calculated by dividing total salaries and fringes related to indirect costs centers in the region 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 from such cost centers.
- ii) The 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).
- iii) The Regional Non-Wage Ratio shall be calculated by subtracting from 1 the Regional Wage Ratio.
- 4) The regional 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.
- k) The non-comparable component of the price shall be calculated using allowable operating costs and statistical data as reported in each non-specialty facility's certified cost report for the 2007 calendar year, as extracted by the Commissioner on December 21, 2010, divided by total 2007 patient days.

New York
110(d)(19)

- l) 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 certified cost report (RHCF-4), or extracted from a hospital-based facility's annual certified cost report (RHCF-2) and the institutional cost report of its related hospital, as extracted by the Commissioner on December 21, 2010, after first deducting costs attributable to specialty units, and the hospital; 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 – (Hearing Therapy Only including associated overhead) (041);
 - 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.

New York
110(d)(20)

- m) 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 above shall initially receive a non-comparable rate which is calculated using the most recently available certified cost report which is most proximate to 2007 and the total patient days which relate to such report and if no such report is available, the regional average non comparable price shall be utilized until such time as a certified cost report is available.
- n) Per Diem Adjustments for Dementia, Bariatric, or Traumatic Brain-Injured Patients. If applicable, and as updated pursuant to the case mix adjustments described above, the operating component of the price shall be adjusted to reflect:
- 1) A per diem add-on in the amount of \$8 for each dementia patient, defined as one who A) qualifies under both the RUG-III impaired cognition and the behavioral problems categories, or (B) 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 bariatric patient, defined as one whose body mass index is greater than thirty-five.
 - 3) A per diem add-on in the amount of \$36 for each traumatic brain-injured patient, defined as one requiring extended care as a result of that injury.
- o) [Reserved.] Effective for services provided on and after June 20, 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, will receive a per diem adjustment. The adjustment is equal to the difference between (1) such facility's allowable operating cost, as described previously in this section, for 2010 extracted by the Commissioner on January 10, 2012 divided by 2010 total resident days, and (2) the daily weighted average non-capital component of the rate, calculated using 2010 Medicaid days, 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 previously in this section. Such per diem adjustment shall not result in a total operating rate that exceeds allowable total operating costs per day.

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110(d)(20.1)

- p) Effective May 10, 2018 and thereafter, the fee-for-service rate of reimbursement for inpatient services for a residential health care facility located in a county with a population of more than seventy-two thousand but less than seventy-five thousand persons, based on the 2010 federal census, and operating between one hundred and one hundred thirty beds, will be increased by 17% of the base operating and capital components of the inpatient services rate calculated for that facility. Residential health care facility fee-for-services rates can be found on the Department of Health website at:

https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/

TN #18-0046

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Supersedes TN #NEW

Effective Date 05/10/2018

New York
110(d)(20.2)

Effective on or after May 17, 2018, the Department of Health shall adjust Medicaid service payments in response to a New York State Supreme Court decision in the Matter of The Bronx-Lebanon Highbridge Woodycrest Center. The adjustment shall be a lump sum payment of \$4,314,009. This payment is intended to satisfy the judgment in the aforementioned court decision. This payment will be made in SFY 2019.

TN #18-0050

Approval Date August 6, 2018

Supersedes TN #NEW

Effective Date May 17, 2018

**New York
110(d)(21)**

1905(a)(4)(A) Nursing Facility Services

The New York State Nursing Home Quality Pool (NHQP) is an annual budget-neutral pool of \$50 million dollars. The intent of the NHQP is to incentivize Medicaid-certified nursing facilities across New York State to improve the quality of care for their residents, and to reward facilities for quality based on their performance. The set of measures used to evaluate nursing homes are part of the Nursing Home Quality Initiative (NHQI). The performances of facilities in the NHQI determine the distribution of the funds in the NHQP.

NHQI is described below using MDS (Minimum Data Set) year and NHQI (Nursing Home Quality Initiative) year. MDS year refers to the year the assessment data is collected. NHQI year refers to the year when the nursing home performance is evaluated. For example, if the NHQI year is 2023, then the MDS year is 2022. For NHQI 2023, the Commissioner will calculate a score and quintile ranking based on data from the MDS year 2022 (January 1 of the MDS year through December 31 of the MDS year), for each non-specialty facility. The score will be calculated based on measurement components comprised of Quality, Compliance, and Efficiency Measures. These measurement components and their resulting score and quintile ranking will be referred to as the Nursing Home Quality Initiative. From the NHQI, the Commissioner will exclude specialty facilities consisting of non-Medicaid facilities, Special Focus Facilities as designated by the Centers for Medicare and Medicaid Services (CMS), Continuing Care Retirement Communities, Transitional Care Units, specialty facilities, and specialty units within facilities. Specialty facilities and specialty units will include AIDS facilities or discrete AIDS units within facilities, facilities or discrete units within facilities for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons, facilities or discrete units within facilities that provide specialized programs for residents requiring behavioral interventions, facilities or discrete units within facilities for long-term ventilator dependent residents, facilities or discrete units within facilities that provide services solely to children, and neurodegenerative facilities or discrete neurodegenerative units within facilities. The score for each such non-specialty facility will be calculated using the following Quality, Compliance, and Efficiency Measures. The measures in this NHQI are listed below:

Quality Measures		Measure Steward
1	Percent of Long Stay Residents Who Received the Pneumococcal Vaccine	CMS
2	Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine	CMS
3	Percent of Long Stay Residents Experiencing One or More Falls with Major Injury	CMS
4	Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder	CMS
5	Percent of Long Stay High Risk Residents with Pressure Ulcers (As Risk Adjusted by the Commissioner)	CMS
6	Percent of Long Stay Residents Who have Depressive Symptoms	CMS
7	Percent of Long Stay Residents Who Lose Too Much Weight (As Risk Adjusted by the Commissioner)	CMS

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**New York
110(d)(22)**

1905(a)(4)(A) Nursing Facility Services

8.	Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased	CMS
9.	Percent of Long Stay Residents with a Urinary Tract Infection	CMS
10.	Percent of Employees Vaccinated for Influenza	NYS DOH
11.	Percent of Contract/Agency Staff Used	NYS DOH
12.	Rate of Staffing Hours per Resident per Day	NYS DOH
13.	Total Nursing Staff Turnover (By Region)	CMS
14.	Percentage of Current Residents Up to Date with COVID-19 Vaccines	CMS
15.	Percentage of Current Healthcare Personnel Up to Date with COVID-19 Vaccines	CMS
Compliance Measures		
16.	CMS Five-Star Quality Rating for Health Inspections as of April 1 of the NHQI year (By Region)	CMS
17.	Timely Submission of Employee Influenza Immunization Data for the September 1 of the MDS year - March 31 of the NHQI year Influenza Season by the deadline	NYS DOH
Efficiency Measure		
18.	Rate of Potentially Avoidable Hospitalizations for Long Stay Residents January 1 of the MDS year – December 31 of the MDS year (As Risk Adjusted by the Commissioner)	NYS DOH

Quality Component:

The maximum points a facility will receive for the Quality Component is 75. The applicable percentages or ratings for each of the 15 quality measures will be determined for each facility. The quality measures will be awarded points based on quintile values or threshold values. For quintile-based measures, the measures will be ranked and grouped by quintile with points awarded as follows:

Scoring for quintile-based Quality Measures	
Quintile	Points
1 st Quintile	5
2 nd Quintile	3
3 rd Quintile	1
4 th Quintile	0
5 th Quintile	0

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110(d)(22.1)**

1905(a)(4)(A) Nursing Facility Services

For threshold-based measures, the points will be awarded based on threshold values. The threshold-based measures are:

- Percent of Contract/Agency Staff Used: facilities will be awarded five points if the rate is less than 10%, and zero points if the rate is 10% or higher.
- Percent of Long Stay Residents Experiencing One or More Falls with Major Injury: facilities will be awarded five points if the rate is equal to or less than 5%, and zero points if the rate is greater than 5%.
- Percent of Long Stay Residents with a Urinary Tract Infection: facilities will be awarded five points if the rate is equal to or less than 5%, and zero points if the rate is greater than 5%.

Rate of Staffing Hours per Resident per Day

NYS DOH will calculate an annualized adjusted rate of staffing hours per resident per day using staffing information downloaded from the Centers for Medicare & Medicaid Services (CMS) appropriate for that year. The staffing information is based on Payroll Based Journal Public Use Files (PBJ PUFs). PBJ PUFs are public data sets prepared by the CMS. For this measure, staffs are defined as RNs, LPNs, and Aides. The rate of reported staffing hours and the rate of case-mix staffing hours will be taken from the staffing information and the adjusted rate of staffing hours will be calculated using the formula below.

Rate Adjusted = (Rate Reported/Rate Case-Mix) * Statewide average

Total Nursing Staff Turnover (by region)

Total nursing staff turnover is defined as the percentage of nursing staff that left the nursing home over a twelve-month period.

The turnover measure is derived based on data from the CMS Payroll-Based Journal (PBJ) System. Using data submitted through PBJ, annual turnover measure for total nurses (RNs, licensed practical/licensed vocational nurses (LPNs), and nurse aides) are constructed by CMS. The PBJ job codes included in the total nursing staff turnover measure are as follows: RN director of nursing (job code 5), RNs with administrative duties (job code 6), RNs (job code 7), LPNs with administrative duties (job code 8), LPNs (job code 9), certified nurse aides (job code 10), aides in training (job code 11), and medication aides/technicians (job code 12). Please refer to Nursing Home Five-Star Quality Rating System: Technical Users' Guide for additional measure specification details.

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**New York
110(d)(22.1)(a)**

1905(a)(4)(A) Nursing Facility Services

Total Nursing Staff Turnover (by region) continued

The annual turnover percentages for all the NHQI facilities are downloaded from CMS for the MDS year. These percentages are used to calculate quintile cut points for Metropolitan (MARO) and Non-Metropolitan (Non-MARO) regions in the New York state. Non-Metropolitan region include Western New York, Capital District, and Central New York. Nursing homes will be given points for this measure based on their performance in that region.

Metropolitan Area Regional Offices (MARO): Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester.

Non-Metropolitan Area Regional Offices (Non-MARO):

Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Rensselaer, Saint Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Tioga, Tompkins, Warren, Washington, Wayne, Wyoming, and Yates.

Percentage of Current Residents Up to Date with COVID-19 Vaccines

The vaccination rate for this measure is calculated as follows: (Number of Residents Staying in this Facility for At Least 1 Day This Week Up to Date with COVID-19 Vaccines / (Number of Residents Staying in this Facility for At Least 1 Day This Week) * 100.

The weekly vaccination rates for this measure are downloaded from the CMS's COVID-19 Nursing Home data website. The Nursing Home COVID-19 Public File includes data reported by nursing homes to the CDC's National Healthcare Safety Network (NHSN) Long Term Care Facility (LTCF) COVID-19 Module: Surveillance Reporting Pathways and COVID-19 Vaccinations. One of the weekly vaccination rates during October to December 2023 will be used. The rates will be used to calculate quintile cut points. Nursing homes will be given points for this measure based on their performance.

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**New York
110(d)(22.1)(b)**

1905(a)(4)(A) Nursing Facility Services

Percentage of Current Healthcare Personnel Up to Date with COVID-19 Vaccines

The vaccination rate for this measure is calculated as follows: Number of Healthcare Personnel Eligible to Work in this Facility for At Least 1 Day This Week Up to Date with COVID-19 Vaccines / Number of All Healthcare Personnel Eligible to Work in this Facility for At Least 1 Day This Week) * 100

The weekly vaccination rates for this measure are downloaded from the CMS's COVID-19 Nursing Home data website. The Nursing Home COVID-19 Public File includes data reported by nursing homes to the CDC's National Healthcare Safety Network (NHSN) Long Term Care Facility (LTCF) COVID-19 Module: Surveillance Reporting Pathways and COVID-19 Vaccinations. One of the weekly vaccination rates during October to December 2023 will be used. The rates will be used to calculate quintile cut points. Nursing homes will be given points for this measure based on their performance.

Awarding for Improvement

Nursing homes will be awarded improvement points from previous years' performance in selected measures in the Quality Component only. One improvement point will be awarded for a nursing home that improves in its quintile for a specific quality measure, compared to its quintile in the previous year for that quality measure. Nursing homes that obtain the top quintile in a quality measure will not receive an improvement point because maximum points per measure cannot exceed five. The threshold-based quality measures below will not be eligible to receive improvement points:

- Percent of Long Stay Residents Experiencing One or More Falls with Major Injury
- Percent of Long Stay Residents with a Urinary Tract Infection
- Percent of Contract/Agency Staff Used

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**New York
110(d)(22.2)**

1905(a)(4)(A) Nursing Facility Services

The quintile-based quality measures that are eligible for improvement points are listed below:

- Percent of Employees Vaccinated for Influenza
- Percent of Long Stay High-Risk Residents with Pressure Ulcers
- Percent of Long Stay Low-Risk Residents Who Lose Control of Their Bowel or Bladder
- Percent of Long Stay Residents Who Have Depressive Symptoms
- Percent of Long Stay Residents Who Lose Too Much Weight
- Percent of Long Stay Residents Who Received the Pneumococcal Vaccine
- Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine
- Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased
- Rate of Staffing Hours Per Resident Per Day
- Total Nursing Staff Turnover

The grid below illustrates the method of awarding improvement points.

MDS year Performance						
NHQI year Performance	Quintiles	1 (best)	2	3	4	5
	1 (best)	5	5	5	5	5
	2	3	3	4	4	4
	3	1	1	1	2	2
	4	0	0	0	0	1
	5	0	0	0	0	0

For example, if MDS year performance is in the third quintile, and NHQI year performance is in the second quintile, the facility will receive four points for the measure. This is three points for attaining the second quintile and one point for improvement from the previous year's third quintile.

Risk Adjustment of Quality Measures

The following quality measures will be risk adjusted using the following covariates as reported in the MDS 3.0 data to account for the impact of individual risk factors:

Percent of Long Stay High Risk Residents with Pressure Ulcers: The covariates include gender, age, BMI, prognosis of less than six months of life expected, diabetes, anemia, renal failure, bowel incontinence, paraplegia, and quadriplegia.

**New York
110(d)(22.3)**

1905(a)(4)(A) Nursing Facility Services

- Percent of Long Stay Residents Who Lose Too Much Weight: The covariates include age, hospice care, cancer, renal failure, prognosis of less than six months of life expected.

For these two measures the risk adjusted methodology includes the calculation of the observed rate; that is the facility's numerator-compliant population divided by the facility's denominator.

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 and follows the CMS methodology found in the MDS 3.0 Quality Measures User's Manual.

The facility-specific, risk-adjusted rate is the ratio of observed to expected measure rates multiplied by the overall statewide measure rate.

Reduction of Points Base: When a quality measure is not available for a nursing home, the number of points the measure is worth will be reduced from the NHQI maximum base points. The nursing home's total score will be the sum of its points divided by the base. For example, this reduction can happen in the following scenario: when a quality measure has a denominator of less than 30.

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110(d)(23)**

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Compliance Component: The maximum points a facility will receive for the Compliance Component is 15 points. Points will be awarded as follows:

Scoring for Compliance Measures	
CMS Five-Star Quality Rating for Health Inspections (By Region)	Points
5 Stars	10
4 Stars	7
3 Stars	4
2 Stars	2
1 Star	0
Timely Submission of Employee Influenza Immunization Data	5 (Facilities that fail to submit timely influenza data by the deadline will receive zero points)

CMS Five-Star Quality Rating for Health Inspections

The CMS Five-Star Quality Rating for Health Inspections as of April 1 of the NHQI year will be adjusted by region. This is not a risk adjustment. For eligible New York State nursing homes, the health inspection scores from CMS will be stratified by region. Cut points for health inspection scores within each region will be calculated using the CMS 10-70-20% distribution method. Per CMS' methodology, the top 10% of nursing homes receive five stars. The middle 70% receive four, three, or two stars, with an equal percentage (~23.33%) receiving four, three, or two stars. The bottom 20% receive one star. Each nursing home will be awarded a star rating based on the health inspection score cut points specific to its region. Regions include the Metropolitan Area (MARO), Western New York (WRO), Capital District (CDRO), and Central New York (CNYRO). Regions are defined by the New York State Health Facilities Information System (NYS HFIS). The counties within each region are shown below.

Metropolitan Area Regional Offices (MARO): Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester.

Central New York Regional Offices (CNYRO): Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Saint Lawrence, Tioga, and Tompkins.

Capital District Regional Offices (CDRO): Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington.

TN #23-0016

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**New York
110(d)(23.1)**

1905(a)(4)(A) Nursing Facility Services

Western New York Regional Offices (WRO): Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, and Yates.

Reduction of Points Base: When a compliance measure is not available for a nursing home, the number of points the measure is worth will be reduced from the NHQI maximum base points. The nursing home's total score will be the sum of its points divided by the base. This reduction can happen when a facility does not have a CMS Five-Star Quality Rating for Health Inspections.

Efficiency Component:

The maximum points a facility may receive for the Efficiency Component is 10 points. The rates of potentially avoidable hospitalizations will be determined for each facility and each such rate will be ranked and grouped by quintile with points awarded as follows:

Scoring for Efficiency Measure	
Quintile	Points
1 st Quintile	10
2 nd Quintile	8
3 rd Quintile	6
4 th Quintile	2
5 th Quintile	0

The Efficiency Measure will be risk adjusted for certain conditions chosen from a pool of covariates as reported in the MDS 3.0 data to account for the impact of individual risk factors: gender, age, shortness of breath, falls with injury, pressure ulcer, activities of daily living, renal disease, cognitive impairment, dementia, diabetes, parenteral nutrition, rheumatologic disease, gastrointestinal disease, multi-drug-resistant infection, indwelling catheter, wound infection, deep vein thrombosis, cancer, feeding tube, coronary artery disease, liver disease, paralysis, peripheral vascular disease, and malnutrition.

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**New York
110(d)(24)**

1905(a)(4)(A) Nursing Facility Services

A potentially avoidable hospitalization is found by matching a discharge assessment in the MDS 3.0 data to its hospital record in SPARCS. The following primary ICD-10 diagnoses on the SPARCS hospital record are potentially avoidable:

Potentially Avoidable Hospitalization Condition	Source of ICD-10-CM Codes
Respiratory infection	Default CCSR CATEGORY DESCRIPTION IP * <ul style="list-style-type: none"> • "Acute and chronic tonsillitis" • "Acute bronchitis" • "Influenza" • "Other specified upper respiratory infections" • "Pneumonia (except that caused by tuberculosis)" • "Sinusitis"
Sepsis	CCSR CATEGORY 1 DESCRIPTION "Septicemia" *
Urinary tract infection	CCSR CATEGORY 1 DESCRIPTION "Urinary tract infections" *
Electrolyte imbalance	CCSR CATEGORY 1 DESCRIPTION "Fluid and Electrolyte Disorders" *
Heart failure	PQI 08 Heart Failure Admission Rate †
Anemia	CCSR CATEGORY 1 DESCRIPTION containing the text string "anemia" *

* From Healthcare Cost and Utilization Project (HCUP) Clinical Classifications Software Refined (CCSR) files found at https://www.hcup-us.ahrq.gov/tools_software.jsp (CCSR for ICD-10-CM Diagnoses Tool, v2022.1 released 10/28/21).

ICD 10 codes with 'Default CCSR CATEGORY DESCRIPTION IP' as Unacceptable PDX are excluded.

† Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) [PQI_08_Heart_Failure_Admission_Rate.pdf](#) (ahrq.gov)/ [AHRQ QI: PQI Technical Specifications Updates](#)

Reduction of Points Base: When the number of long stay residents that contribute to the denominator of the potentially avoidable hospitalization measure is less than 30, the number of points the measure is worth will be reduced from the base of 100 maximum NHQI points. The nursing home's total score will be the sum of its points divided by the base.

**New York
110(d)(25)****1905(a)(4)(A) Nursing Facility Services**

The following payments, which will be applicable to the NHQI Year, will be made to fund the NHQP and to make payments based upon the scores calculated from the NHQI as described above.

- Each non-specialty facility will be subject to a Medicaid rate reduction to fund the NHQI, which will be calculated as follows:
- For each such facility, Medicaid revenues, calculated by multiplying each facility's NHQI Year promulgated rate in effect for such period by reported Medicaid days, as reported in a facility's MDS Year 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 as reported in a facility's cost report of the MDS Year. If a facility fails to submit a timely filed cost report in the MDS Year, the most recent cost report will be used.

The total scores as calculated above for each such facility will be ranked and grouped by quintile. Each of the top three quintiles will be allocated a share of the \$50 million NHQI and each such facility within such top three quintiles will receive a payment. Such payments will be paid as a lump sum payment outside of the Nursing Home rate for the NHQI Year. Such shares and payments will be calculated as follows:

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**New York
110(d)(25.1)**

Distribution of NHQP Payments			
Facilities Grouped by Quintile	A Facility's Medicaid Revenue Multiplied by Award Factor	B Share of \$50 Million [NHQI] NHQP Payments Allocated to Facility	[C Facility Per Diem Quality Payment]
1st Quintile	Each facility's [2017] <u>MDS Year</u> Medicaid days multiplied by [2018] Medicaid Rate as of January 1[, 2018] of the <u>NHQI Year</u> = 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] <u>Column A</u> , Multiplied by \$50 million	[Each facility's column B divided by the facility's 2017 Medicaid days]
2nd Quintile	Each facility's [2017] <u>MDS Year</u> Medicaid days multiplied by [2018] Medicaid Rate as of January 1[, 2018] of the <u>NHQI Year</u> = 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] <u>Column A</u> , Multiplied by \$50 million	[Each facility's column B divided by the facility's [2017] Medicaid days]
3rd Quintile	Each facility's [2017] <u>MDS Year</u> Medicaid days multiplied by [2018] Medicaid Rate as of January 1[, 2018] of the <u>NHQI Year</u> = 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] <u>Column A</u> , Multiplied by \$50 million	[Each facility's column B divided by the facility's 2017 Medicaid days]
Total	Sum of [Total Medicaid Revenue for all facilities] <u>Column A</u>	Sum of quality pool funds: \$50 million	--

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**New York
110(d)(26)**

1905(a)(4)(A) Nursing Facility Services

The following facilities will not be eligible for NHQP payments and the scores of such facilities will not be included in determining the share of the NHQP payments:

- A facility with health inspection survey deficiency data showing a level J/K/L deficiency during the time period of July 1 of the MDS year through June 30 of the NHQI year. Deficiencies will be reassessed on October 1 of the NHQI year to allow a three-month window (after the June 30 of the NHQI year cutoff date) for potential Informal Dispute Resolutions (IDR) to process. The deficiency data will be updated to reflect IDRs occurring between July 1 of the NHQI year and September 30 of the NHQI year. Any *new* J/K/L deficiencies between July 1 of the NHQI year and September 30 of the NHQI year will *not* be included in the NHQI. If a JKL citation is found to be expunged or lowered based upon an IDR panel review, the Department reserves the right to make the adjustments.

TN 22-0008

Approval Date November 18, 2022

Supersedes TN 20-0007

Effective Date January 1, 2022

New York
110(d)(26.1)

Effective May 17, 2018, and every January 1 thereafter, low quality performing residential health care facilities will have their rates reduced as described in this section based on the most recent two years of Nursing Home Quality Initiative (NHQI) data. A low quality performing facility is one that was ranked in the lowest two quintiles for the second most recent year, and ranked in the lowest quintile for the most recent year. In the rate year immediately following the two-year measurement period, a low quality performing facility's computed Medicaid rate will be reduced by 2 percent. Financially distressed providers will be excluded from this penalty.

TN #18-0049
Supersedes TN NEW

Approval Date September 04, 2018
Effective Date May 17, 2018

**New York
110(d)(27)**

1905(a)(4)(A) Nursing Facility Services

Adjustment for Minimum Wage Increases. Effective January 1, 2017, and every January 1, thereafter until the minimum wage reaches the state statutorily described per hour wage as shown below, a minimum wage add-on will be developed and applied to the specialty and non-specialty Nursing Home rate.

Minimum Wage (MW) Region	12/31/2016	12/31/2017	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022
New York City	\$11.00	\$13.00	\$15.00	\$15.00	\$15.00	\$15.00	\$15.00
Nassau, Suffolk, & Westchester counties	\$10.00	\$11.00	\$12.00	\$13.00	\$14.00	\$15.00	\$15.00
Remainder of the State	\$9.70	\$10.40	\$11.10	\$11.80	\$12.50	\$13.20	\$14.20*

*Effective January 1, 2023, the minimum wage value for the Remainder of the State will be \$14.20.

The minimum wage adjustment will be developed and implemented as follows:

1. Minimum wage costs will mean the additional costs incurred beginning January 1, 2017, and thereafter, as a result of New York State statutory increases to minimum wages until all regions of the state reach \$15.00 per hour.
2. The 2017 facility specific minimum wage add-on will be developed based on collected survey data received and attested to by nursing facility providers. If a facility does not submit a survey, the minimum wage add-on will be calculated based on the facility's Residential Health Care Facility (RHCF) cost report wage data from two years prior to the period being calculated. If a facility fails to submit both the attested survey and the cost report, the facility's minimum wage add-on will not be calculated.
 - i. Minimum wage cost development based on survey data collected.
 - a. Survey data will be collected for facility specific wage data.
 - b. Facilities will report by wage bands, the total count of FTEs and total hours paid to all employees (contracted and non-contracted staff) earning less than the statutory minimum wage applicable for each region.
 - c. Facilities will report an average fringe benefit percentage for the employees directly affected by the minimum wage increase.
 - d. The minimum wage costs are calculated by multiplying the total hours paid by the difference between the statutory minimum wage and the midpoint of each wage band where the facility has reported total hours paid. To this result, the facility's average fringe benefit percentage is applied and added to the costs.

TN #23-0025

Approval Date September 5, 2024

Supersedes TN #22-0025

Effective Date January 1, 2023

New York
110(d)(27.1)

1905(a)(4)(A) Nursing Facility Services

Adjustment for Minimum Wage Increases (continued)

- ii. Minimum wage cost development based on the RHCF cost report data.
 - a. The average hourly wages of employees where the reported average hourly wage is below the regional statutory minimum wage are identified.
 - b. The total payroll hours of the employees identified are then multiplied by the regional statutory minimum wage resulting in a projected payroll. The actual payroll as reported in the cost report is then subtracted from the projected payroll resulting in the expected wage costs increase.
 - c. The facility's fringe benefit costs directly affected by the wage increase are identified, and the average fringe benefit percentage is calculated.
 - d. The fringe benefit percentage is applied to the increased wage costs and added resulting in the minimum wage costs.

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110(d)(28)

3. The facility specific cost amount will be adjusted by a factor calculated by dividing the facility's average dollar per hour under minimum wage by the regional average. The resulting amount will be divided by patient days to arrive at a rate per diem add on, which will be applied to only Medicaid days for purposes of Medicaid reimbursement.
4. In subsequent years until the minimum wage is completely implemented statewide, the Department will survey facilities utilizing the methodology employed in year one. If a facility fails to submit the minimum wage survey, the calculation for minimum wage costs will default to the personnel wage data reported on the Facility's latest available RHCF cost report. If a facility fails to submit both the survey and the RHCF cost report, its minimum wage add-on will not be calculated. Once the minimum wage costs are included in the development of the nursing home rate, the minimum wage add-on will be excluded from the rate.
5. **Minimum Wage Reconciliation** - After the end of each calendar year, the Department of Health will survey providers to obtain the following information for the purpose of reconciling annual minimum wage reimbursement. The state will release the reconciliation survey by the end of March and providers will have two weeks to complete the survey or request an extension if a provider determines it is unable to complete the survey within that time. Approval of extensions, and the time of the extension, is at the discretion of the state. If the reconciliation survey is not submitted within the two weeks or within the extension time frame, should one be granted, the provider's minimum wage add-on for the calendar year covered by the survey will be recouped.
 - i. Total annual minimum wage funding paid to the provider (as determined from the minimum wage add-on to claims paid for services rendered in the prior calendar year) for the Medicaid share of the minimum wage law increase requirement. (This information will be supplied by the Department of Health.) Medicaid's share is the percentage of minimum wage costs that are attributable to Medicaid services based on the proportion of Medicaid services to a provider's total services.
 - ii. Medicaid's share of the total amount the provider was obligated to pay to bring salaries up to the minimum wage for the calendar year. (This information will be completed by the provider.)
 - iii. Minimum wage funds to be recouped or additional funds to be received by the provider. (This information will be completed by the provider.) This will be the difference between the amount paid to the provider for the Medicaid share of the minimum wage law increase requirement and the corresponding amount the provider determined it was actually obligated to pay.
 - iv. The State agency will review providers' submissions for accuracy and reasonableness, following which it will process associated payments and recoupments via retroactive per unit rate adjustments as quickly as practical thereafter.

The agency's Chief Executive Officer or Chief Financial Officer must sign an Attestation verifying the data that is supplied in the survey.

TN #17-0007

Approval Date January 10, 2018

Supersedes TN #16-0024

Effective Date January 1, 2017

**New York
110(d)(29)**

Nursing Home Advanced Training Incentive Payments

Advanced Training Incentive Payments to Eligible Facilities. Effective June 1, 2015, the state will annually distribute \$46 million to eligible nursing facilities in State Fiscal Years 2016, [and in] 2017, 2020 and thereafter. The purpose of these incentive payments is to reduce avoidable hospital admissions for nursing home residents. New York will incentivize and encourage facilities to develop training programs aimed at early detection of patient decline. Such programs will allow frontline caregivers to provide staff with the training/tools needed to identify resident characteristics that may signify clinical complications. A comprehensive training program will lead to consistent staff assignment to ensure that families and residents can rely on highly trained caregivers to provide effective, high quality, individualized care.

Patient decline detection programs will assist caregivers with identifying residents who are exhibiting warning signs for worsening clinical conditions and allow for rapid intervention to avoid the decline and possible hospitalization. The goal of such training programs will be to reign in the high costs of avoidable hospitalizations, improving the quality of life for New York's nursing home residents. This initiative will reward eligible nursing home providers who are those that have shown a commitment to giving direct care staff the tools to help lower resident hospitalization rates.

The annual amount will be distributed proportionally to each eligible facility based on its relative share of Medicaid bed days to total Medicaid bed days of all such eligible facilities. Incentive payments will be paid in two lump sum adjustments to supplement nursing facility rates. 75% will be paid in the October - December quarter and the 25% will be paid in the January - March quarter.

To be eligible for this incentive payment, in each state fiscal year a facility must:

- 1) Provide a training program to direct care staff that has been reviewed and approved by the Department to assist direct care staff identify changes in a resident's physical, mental, or functional status that could lead to hospitalization. The training program will be subject to Department of Health oversight; and
- 2) Have a direct care staff retention rate above the statewide median; and
- 3) Not be excluded from participating in this program.

**New York
110(d)(29.1)**

1905(a)(4)(A) Nursing Facility Services

Nursing Home Advanced Training Incentive Payments (cont'd)

Excluded Facilities are:

- Hospital based nursing facilities; and
- Nursing Facilities that have been approved to receive Vital Access Provider (VAP) payments during the same state fiscal year the incentive payment is available.
 - However, facilities that are receiving VAP funds only through Attachment 4.19-D, "Temporary Adjustments for Mergers, Acquisitions, Consolidations, Restructurings, and Closures – Nursing Homes Workforce" would be eligible for the Nursing Home Advanced Training Incentive payments.

Calculation Statewide Median and Staff Retention Percentage: Data from Schedule P (Staff Turnover) of the most recently filed Cost Report will be used to measure staff turnover and retention rates for direct care staff. The cost report two years prior to the payment year, will be used for this calculation. The staff retention percentage will be equal to the number of employees retained as of December 31, who were employed on January 1 of the same year by the number of staff as of January 1 of that year.

$$(\# \text{ of Employees Retained as of December 31, 20XX, who were Employed on January 1, 20XX}) = \text{Staff Retention \% divided by } (\# \text{ of Staff as of January 1, 20XX})$$

XX =cost report two years prior to the payment year.

A statewide staff retention median was derived by sorting the provider percentages from high to low and selecting the percentage in the middle of the range.

Restorative (Intensive) Care in a Nursing Home

Effective December 1, 2016 NYSDOH will implement a Restorative Care Unit Program to reduce hospital admissions and readmissions from residential health care facilities through the establishment of restorative care units. These restorative care units will provide higher-intensity treatment services to residents who are at risk of hospitalization upon an acute change in condition and seeks to improve the capacity of nursing facilities to identify and treat higher acuity patients with multiple co-morbidities as effectively as possible in place, rather than through admission to an acute care facility. Eligible facilities are required to institute new programs through which residents normally transported to hospital will be cared for in the nursing facility through the use of more intensive nursing home units.

The targeted population receiving restorative care unit services are participating in the restorative care program, post hospital admission and have an overall goal of discharging to the community.

Rate payments will be provided, semi-annually, to eligible residential health care facilities which meet the criteria of providing intensive treatments to nursing home residents in the facility and thereby avoid hospitalization. The rate adjustment is intended to:

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Effective Date **October 1, 2022**

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110(d)(29.2)

- Enhance quality of care
- Provide immediate intensive care in a nursing home setting
- Improve the cost effectiveness through the avoidance of hospital admission

Eligible residential health care providers, the amount of the semi-annual payment, and the duration of each rate adjustment period shall be listed in the table which follows. The total adjustment amount for each period shown below will be paid semi-annually during each period in equal installments. The temporary payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the six months To remain eligible, providers must submit benchmarks and goals acceptable to the Commissioner and must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals may result in termination of the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's payment period adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology.

Additional payments have been approved for the following providers in the amounts and for the effective periods listed.

Nursing Homes:

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Golden Hill Nursing Center</u>	<u>\$3,000,000</u>	<u>12/01/2016 – 03/31/2017</u>
	<u>\$1,500,000</u>	<u>04/01/2017 – 09/30/2017</u>
	<u>\$1,500,000</u>	<u>10/01/2017 – 03/31/2018</u>
	<u>\$1,500,000</u>	<u>04/01/2018 – 09/30/2018</u>
	<u>\$1,500,000</u>	<u>10/01/2018 – 03/31/2019</u>

New York
110(d)(30)

Per Diem Reduction to all qualified facilities.

(a) 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.

(b) Effective January 1, 2015, 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, 2015 through March 31, 2015.

Effective January 1, 2015, 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, 2015.

(c) An interim per diem adjustment for each facility will be calculated as follows:

(1) For each such facility, 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.

(2) Following the close of each fiscal year, the interim per diem adjustment effective January 1, 2015 through March 31, 2015, and April 1, 2015 through March 31, 2016 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.

TN # 15-0014 _____

Approval Date April 16, 2021

Supersedes TN NEW

Effective Date January 1, 2015

**New York
110(d)(31)**

1905(a)(4)(A) Nursing Facility Services

Young Adult Special Populations Demonstration

Effective August 17, 2021 through August 16, 2025, the State will establish a demonstration program for two eligible pediatric residential health care facilities, as defined in section 4 below, to construct a new facility or repurpose part of an existing facility to operate as a young adult residential health care facility for the purpose of improving the quality of care for young adults with medical fragility.

1. "Children with medical fragility" will mean children up to twenty-one years of age who have a chronic or conditions, are at risk of hospitalization, are technology-dependent for life or health sustaining functions, require complex medication regimens or medical interventions to maintain or to improve their health status, and/or are in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk.
2. "Young adults with medical fragility" will mean individuals who meet the definition of children with medical fragility, but for the fact such individuals are aged between eighteen and thirty-five years old.
3. "Pediatric residential health care facility" will mean a residential health care facility or discrete unit of a residential health care facility providing services to children under the age of twenty-one.
4. "Eligible pediatric residential health care facilities" will mean pediatric health care facilities that meet the following eligibility criteria for the demonstration program: (i) has over one hundred and sixty licensed pediatric beds; or (ii) is currently licensed for pediatric beds, is co-operated by a system of hospitals licensed, and such hospitals qualify for funds pursuant to a vital access provider assurance program (VAPAP) or a value based payment incentive program (VBP), as administered by the department. Eligibility requirements for VAPAP and VBP include:
 - a. a public hospital, defined as a general hospital operated by a county or municipality, but not operated by a public benefit corporation; or
 - b. a federally designated Critical Access Hospital; or
 - c. a federally designated Sole Community Hospital; or
 - d. a safety net hospital, defined as a general hospital (but not operated by a public benefit corporation); and
 - i. with at least 30 percent of its inpatient discharges made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; and
 - ii. with at least 35% of its outpatient visits made up of Medicaid eligible individuals, uninsured individuals or Medicaid dually-eligible individuals; or
 - iii. that serves at least 30 percent of the residents of a county or a multi-county area who are Medicaid eligible individuals, uninsured individuals or Medicaid dually- eligible individuals.

TN **#21-0048**

Approval Date **September 26, 2023**

Supersedes TN **NEW**

Effective Date **August 17, 2021**

**New York
110(d)(31.1)**

1905(a)(4)(A) Nursing Facility Services

Young Adult Special Populations Demonstration

- e. in severe financial distress as evidenced by:
 - i. less than 15 days cash and equivalents; and
 - ii. no assets that can be monetized other than those vital to the operation; and
 - iii. the operator has exhausted all efforts to obtain resources from corporate parents and affiliated entities to sustain operations.

Any child with medical fragility who has resided for at least thirty consecutive days in an eligible pediatric residential health care facility and who has reached the age of twenty-one while a resident, may continue residing at such eligible pediatric residential health care facility and receiving such services from the facility, provided that such young adult with medical fragility remains eligible for nursing home care, and provided further that the eligible pediatric residential health care facility has prepared, applied for, and submitted to the commissioner, a proposal for a new residential health care facility for the provision of extensive nursing, medical, psychological and counseling support services to young adults with medical fragility.

A young adult with medical fragility may remain in such eligible pediatric residential health care facility until such time that the young adult with medical fragility attains the age of thirty-five years or the young adult residential health care facility is constructed and becomes operational, whichever is sooner.

A young adult facility may admit, from the community-at-large or upon referral from an unrelated facility, young adults with medical fragility who prior to reaching age twenty-one were children with medical fragility, and who are eligible for nursing home care and in need of extensive nursing, medical, psychological and counseling support services, provided that the young adult facility, to promote continuity of care, undertakes to provide priority admission to young adults with medical fragility transitioning from the pediatric residential health care facility or unit operated by the entity that proposed the young adult facility and ensure sufficient capacity to admit such young adults as they approach or attain twenty-one years of age.

For inpatient services provided to any young adults with medical fragility eligible for medical assistance residing at any eligible pediatric residential health care facility, the operating component of rates of reimbursement will be based on the methodology used to establish the operating component of the rates pursuant to existing approved reimbursement methodology for specialty residential health care facilities. Once cost information is available, the rates will be adjusted, as appropriate, to account for any discrete expenses associated with caring for young adults with medical fragility, including addressing their distinct needs as young adults for psychological and counseling support services. Nursing Home rates are posted at https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/ and are updated to remain current.

TN **#21-0048**

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Effective Date **August 17, 2021**

New York
110(d)(32)

1905(a)(4)(A) Nursing Facility Services

Minimum Staffing Requirements for Nursing Homes

Effective for rate year April 1, 2022 through March 31, 2023, the State will distribute \$187 million to Qualified facilities for the purposes of meeting the following minimum staffing requirements.

1. Minimum Direct Resident Care Spending

Nursing homes will be required to spend a minimum of 40 percent of revenue on resident-facing staffing and 70 percent of revenue on direct resident care, provided that 15 percent of costs associated with resident-facing staffing contracted out by a facility for services provided by registered professional nurses, licensed practical nurses, or certified nurse aides who have completed certification and training approved by the department will be deducted from the calculation of the amount spent on resident-facing staffing and direct resident care.

Additionally, nursing home total operating revenues must not exceed total operating and non-operating expenses by more than five percent of total operating and non-operating expenses.

Excess revenues and deficiencies in spending on resident-facing staffing and direct resident care will be recouped by the state, effective upon commencement of compliance determinations for the calendar year 2022.

- a. "Revenue" will mean the total operating revenue from or on behalf of residents of the residential health care facility, government payers, or third-party payers, to pay for a resident's occupancy of the residential health care facility, resident care, and the operation of the residential health care facility as reported in the residential health care facility cost reports submitted to the department; provided, however, that revenue will exclude the average increase in the capital portion of the Medicaid reimbursement rate from the prior three years, the capital portion of the Medicaid reimbursement rate for all nursing homes with a CMS Overall Rating of 4 or 5, grant funds from the federal government for reimbursement of COVID-19 pandemic-related expenses, and funding received as reimbursement for residential health care facilities assessment.
- b. "Resident-facing staffing" will include all staffing expenses in the ancillary and program services categories of the residential health care cost reports.
- c. "Direct resident care" will include all expenses in the following categories of the residential health care cost reports: (i) Nonrevenue Support Services - Plant Operation & Maintenance, Laundry and Linen, Housekeeping, Patient Food Service, Nursing Administration, Activities Program, Nonphysician Education, Medical Education, Medical Director's Office, Housing, Social Service, Transportation; (ii) Ancillary Services - Laboratory Services, Electrocardiology, Electroencephalography, Radiology, Inhalation Therapy, Podiatry, Dental, Psychiatric, Physical Therapy, Occupational Therapy, Speech/Hearing Therapy, Pharmacy, Central Services Supply,

TN #22-0007

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Effective Date April 01, 2022

New York
110(d)(32.1)

1905(a)(4)(A) Nursing Facility Services

Minimum Staffing Requirements for Nursing Homes (continued)

1. Minimum Direct Resident Care Spending (continued)

- c. Medical Staff Services provided by licensed or certified professionals including and without limitation Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistant; and (iii) Program Services - Residential Health Care Facility, Pediatric, Traumatic Brain Injury (TBI), Autoimmune Deficiency Syndrome (AIDS), Long Term Ventilator, Respite, Behavioral Intervention, Neurodegenerative, Adult Care Facility, Intermediate Care Facilities, Independent Living, Outpatient Clinics, Adult Day Health Care, Home Health Care, Meals on Wheels, Barber & Beauty Shop, and Other similar program services that directly address the physical conditions of residents. Direct resident care does not include, at a minimum and without limitation, administrative costs (other than nurse administration), capital costs, debt service, taxes (other than sales taxes or payroll taxes), capital depreciation, rent and leases, and fiscal services.
- d. "Cost Report" will mean the annual financial and statistical report (RHCF IV) submitted to the department which includes the residential health care facility's revenues, expenses, assets, liabilities, and statistical information.
- e. "Hospital-Based Nursing Homes" will mean nursing homes that are required to complete a RHCF II Cost Report. Hospital-based nursing homes will be required to provide supplementary data to calculate revenue, resident-facing staffing, and direct resident care costs because their cost report data does not include this information.

2. Supplemental Payment to Qualified Facilities

Qualified facilities are those that met the requirement to spend 40 percent or more of revenue on resident-facing staffing and 70 percent or more of revenue on direct resident care and whose total operating revenues did not exceed total operating and non-operating expenses by more than five percent of total operating and non-operating expenses.

- a. The facility's percentage of revenue spent on resident-facing staffing is calculated by dividing a facility's resident-facing staffing expense by the facility's total revenue.
- b. The facility's percentage of revenue spent on direct resident care is calculated by dividing a facility's direct resident care expense by the facility's total revenue.
- c. The facility's percentage of excess revenue is calculated by subtracting a facility's total operating expenses and total nonoperating expenses from the facility's total operating revenue, and dividing this calculation by the sum of the facility's total operating and non-operating expenses.

New York
110(d)(32.2)

1905(a)(4)(A) Nursing Facility Services

Minimum Staffing Requirements for Nursing Homes (continued)

2. Supplemental Payment to Qualified Facilities (continued)

d. The data used in the calculations of section 2a. and 2b. and 2c. above is as follows:

State Fiscal Year	State Cost Report
FY23	2020

e. If the percentage calculated in section (2)(a) is equal to or greater than forty percent and the percentage calculated in section (2)(b) is equal to or greater than seventy percent and the percentage calculated in (2)(c) is less than or equal to five percent, then the facility is a Qualified Facility and eligible to receive the supplemental payment. The supplemental payment for each Qualified Facility will be calculated as follows:

- i. Divide the Qualified Facility's total Certified Bed count as reported in the Cost Report by the total Certified Beds for all Qualified Facilities.
 - ii. Multiply the value by the total funding available for Qualified Facilities.
- f. The State will withhold the Federal Financial Participation (FFP) of excess Medicaid revenues for the claiming period, and return the FFP of any recouped funds to the Centers for Medicaid and Medicare Services in accordance with federal overpayment regulations.

TN #22-0007

Supersedes TN #NEW

Approval Date March 6, 2024

Effective Date April 01, 2022

New York
110(E)

Provider Assessments.

For purposes of determining rates of payment for residential health care facilities beginning July 1, 1992 for beneficiaries eligible for medical assistance under Title XIX of the federal Social Security Act, a state assessment of 1.2% of residential health care facility gross revenues received during the period April 1, 1992 through March 31, 1994, and as may be extended by statute, shall be a reimbursable cost to be included in calculating rates of payment. The state assessment of 1.2% of RHCF gross revenues shall be in effect from April 1, 1992 through March 31, 1994, and as may be extended by statute, an additional state assessment of 3.8% of facility gross revenues shall be a reimbursable cost to be included in calculating rates of payment.

Effective for the period April 1, 1996 through April 30, 1996, the further additional assessment will be reduced from 3.8% to 1.9% of each facility's cash receipts from all patient care services and other operating income, for a total state assessment of 3.1% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment. Effective on or after May 1, 1996, rates of payment will be adjusted to allow costs associated with a total state assessment of 5.4% of facility gross revenues which shall be a reimbursable cost to be included in calculating rates of payment.

The reimbursable operating costs of facilities for purposes of calculating the reimbursement rates will be increased prospectively, beginning July 1, 1992, to reflect an estimate of the provider cost for the assessment for the period. As soon as practicable after the assessment period, an adjustment will be made to RHCF rates based on a reconciliation of actual assessment payments to estimated payments.¹

¹The extent to which a facility is reimbursed for the additional cost of the assessment is dependent upon Medicaid volume of services.

TN	<u>#96-24</u>	Approval Date	<u>June 6, 2001</u>
Supersedes TN	<u>#95-24B</u>	Effective Date	<u>April 1, 1996</u>

**New York
110(E)(1)**

Effective January 1, 1997, the rates of payment will be adjusted to allow costs associated with a total State assessment of 5% of facility gross revenues which will be a reimbursable cost to be included in calculating rates of payment. Effective March 1, 1997, the reimbursable assessment will be 3.1%. Effective April 1, 1997, the total reimbursable state assessment to be included in calculating rates of payment will be 4.8%. Effective April 1, 1999 through December 31, 1999, the total reimbursable state assessment of 2.4% of gross revenues as paid by facilities will be included in calculating rates of payment. Effective April 1, 2002 through March 31, 2003, April 1, 2003 through March 31, 2005, April 1, 2005 through March 31, 2013, April 1, 2013 through March 31, 2015, April 1, 2015 through March 31, 2017 [and] April 1, 2017 through March 31, 2019, and April 1, 2019 through March 31, 2020 and thereafter the total reimbursable state assessment on each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for hospital or health-related services, including adult day service, but excluding, effective October 1, 2002, gross receipts attributable to payments received pursuant to Title XVIII of the federal Social Security Act (Medicare), will be 6%, 5%, and 6% thereafter, respectively.

The reimbursable operating costs of facilities for purposes of calculating the reimbursement rates will be increased prospectively, beginning July 1, 1992, to reflect an estimate of the provider cost for the assessment for the period, provided, however, that effective October 1, 2002 the adjustment to rates of payment made pursuant to this paragraph [shall] will be calculated on a per diem basis and based on total reported patient days of care minus reported days attributable to Title XVIII of the federal social security act (Medicare) units of service. As soon as practicable after the assessment period, an adjustment will be made to RHCF rates of payments applicable within the assessment period, based on a reconciliation of actual assessment payments to estimated payments. The reimbursable portion of the provider's cost for the assessment will only be Medicaid's share of the assessment; which is determined by the appropriate assessment percentage multiplied by Medicaid revenues.

TN #19-0043Approval Date August 20, 2019Supersedes TN #17-0035Effective Date April 1, 2019

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**Appendix 13 – Patient Categories and Case Mix Indices Under the Resource
Utilization Group (RUG-II) Classification System**

Patient Category	Case Mix Index
Special Care A	1.51
Special Care B	1.74
Heavy Rehabilitation A	1.57
Heavy Rehabilitation B	1.79
Clinically Complex A	.70
Clinically Complex B	1.18
Clinically Complex C	1.32
Clinically Complex D	1.64
Severe Behavioral A	.69
Severe Behavioral B	1.03
Severe Behavioral C	1.25
Reduced Physical Functioning A	.55
Reduced Physical Functioning B	.83
Reduced Physical Functioning C	1.03
Reduced Physical Functioning D	1.17
Reduced Physical Functioning E	1.41

TN <u> #87-7 </u>	Approval Date <u>February 21, 1989</u>
Supersedes TN <u> #86-4 </u>	Effective Date <u>January 1, 1987</u>

New York
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Appendix 13(a) – Schedule of Allowances for Operators, Administrators, and Assistant Administrators Effective for the Base Year Ending 12/31/83

BEDS	TOTAL ALLOWANCE	INDIVIDUAL ALLOWANCE
1-40	\$20, 690	
45	23, 280	
50	25, 870	
55	28, 460	
60	31, 050	
65	33, 640	
70	36, 230	
75	38, 820	\$36, 970
80	41, 410	37, 930
85	44, 000	38, 890
90	46, 590	39, 850
95	49, 180	40, 810
100	51, 770	41, 770
110	54, 360	42, 730
120	56, 950	43, 690
130	59, 540	44, 650
140	62, 130	45, 610
150	64, 720	46, 570
160	67, 310	47, 530
170	69, 900	48, 490
180	72, 490	49, 450
190	75, 080	50, 410
200	77, 670	51, 370
210	80, 260	52, 330
220	82, 850	53, 290
230	85, 440	54, 250
240	88, 030	55, 210
250	90, 620	56, 170
260	93, 210	57, 130
270	95, 800	58, 090
280	98, 390	59, 050
290	100, 980	60, 010
300	103, 570	60, 970
310	106, 160	61, 930
320	108, 750	62, 890

To determine the salary allowance for facilities with bed capacities not listed above, use the following amounts:

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BEDS	TOTAL	BEDS	INDIVIDUAL
41-100	\$518 per bed	76-100	\$192 per bed
100 & over	259 per bed	101 & over	96 per bed
			Maximum 79, 707

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[Appendix 13(b)]

Counties and Regions

Region

Counties in region

ALBANY	Albany, Columbia, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Fulton
BINGHAMTON	Broome, Tioga
ERIE	Cattaraugus, Chautauqua, Erie, Niagara, Orleans
ELMIRA	Chemung, Steuben, Schuyler
GLENS FALLS	Essex, Warren, Washington
LONG ISLAND	Nassau, Suffolk
ORANGE	Chenango, Delaware, Orange, Otsego, Sullivan, Ulster
NEW YORK CITY	Bronx, Kings, Queens, Richmond, New York
POUGHKEEPSIE	Dutchess, Putnam
ROCHESTER	Livingston, Monroe, Ontario, Wayne
CENTRAL RURAL	Cayuga, Cortland, Seneca, Tompkins, Yates
SYRACUSE	Madison, Onondaga
UTICA	Herkimer, Jefferson, Lewis, Oneida, Oswego
WESTCHESTER	Rockland, Westchester
NORTHERN RURAL	Clinton, Franklin, Hamilton, St. Lawrence
WESTERN RURAL	Allegany, Genesee, Wyoming

TN <u>#91-4</u>	Approval Date <u>July 2, 1993</u>
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New York
PRI-1

NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

INSTRUCTIONS: PATIENT REVIEW INSTRUMENT (PRI)

GENERAL CONCEPTS

1. **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:
 - **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.
 - **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.
 - **DOCUMENTATION** – Some of the questions require specific medical record documentation to be present. Otherwise, the question cannot be answered “yes” for the patient.
 - **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.

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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 either be 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 18, 1913, you would enter: /B/R/A/0/5/0/8/1/3 on the PRI.
3. **RESIDENT IS LOCATED:** Former HRF Area of 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

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

Documentation – For a patient to be cited as level 4, documentation by a licensed clinician must exist which describes the following three components:

- A description of the patient's decubitus
- Circumstance or medical condition which led to the decubitus.
- An active treatment plan.

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Definition LEVELS:

- #0 No reddened skin or breakdown
- #1 Reddened skin, potential breakdown.
- #2 Blushed skin, dusty colored, superficial layer of broken or blistered skin.
- #3 Subcutaneous skin is broken down.
- #4 Necrotic breakdown of skin and subcutaneous tissue which may involve muscle, fascia and bone.
- #5 Patient is a level 4, but the documentation qualifier has not been met.

17. MEDICAL CONDITIONS: For a "YES" to be answered for any of these conditions, all of the following qualifiers must be met:

Time Period – Condition must have existed during the past four weeks. (The only exception is to use the past twelve weeks for question 17H, urinary tract infection.

Documentation – Written support exists that the patient has the condition.

Definitions – See chart below. (Examples are for clarification and are not intended to be all-inclusive.)

DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENT
17A. COMATOSE: Unconscious, cannot be aroused, and at most can respond only to powerful stimuli. The coma must be present for at least four days	Brain insult Hepatic encephalopathy Cerebral vascular accident	Total ADL care Intake and output Parenteral feeding
17B. DEHYDRATION: Excessive loss of body fluids requiring immediate medical treatment and ADL care.	Fever Acute Urinary tract infections Pneumonia Vomiting Unstable diabetes	Intake & output Electrolyte lab tests Parenteral hydration Nasal Feedings
17C. INTERNAL BLEEDING: Blood loss stemming from a subacute or chronic condition (e.g., gastrointestinal, respiratory or genito-urinary conditions) which may result in low blood pressure and hemoglobin, pallor, dizziness, fatigue, rapid respiration.	Use only the causes presented in the definition. Exclude external hemorrhoids and other minor blood loss which is not dangerous and requires only minor intervention	Critical monitoring of vital signs Transfusion Use of blood pressure elevators Plasma expanders Blood likely to be needed every 60 day

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DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
<p>17D. STASIS ULCER: Open lesion, usually in lower extremities, caused by decreased blood flow from chronic venous insufficiency.</p> <p>17E. TERMINALLY ILL: Professional prognosis (judgement) is that patient is rapidly deteriorating and will likely die within three months.</p> <p>17F. CONTRACTURES: Shortening and tightening of ligaments and muscles resulting in loss of joint movement. Determine whether range of motion loss is actually due to spasticity, paralysis or joint pain. It is important to observe the patient to confirm whether a contracture exists and check the chart for confirmatory documentation.</p> <p>To qualify as "YES" on the PRI the following qualifiers must be met:</p> <ol style="list-style-type: none"> 1. The contracture must be documented by a physician, physical therapist or occupational therapist. 2. The status of the contracture must be reevaluated and documented by the physician, physical therapist or occupational therapist on an annual basis. <p>There does not need to be an active treatment plan to enter "YES" to contractures.</p>	<p>Severe edema Diabetes PVD</p> <p>End stages of: Carcinoma, Renal disease, and Cardiac diseases</p>	<p>Sterile dressing Compresses Whirlpool Leg elevation</p> <p>ADL Care Social/emotional support</p>

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DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
<p>17G. DIABETES MELLITUS: A metabolic disorder in which the ability to oxidize carbohydrates is compromised due to inadequate pancreatic activity resulting in disturbance of normal insulin production. This may or may not be the primary problem (Q. 29) or primary diagnosis. It should be diagnosed by a physician. Include any degree of diabetes, stable or unstable, and any manner it is controlled.</p>	<p>Destruction/malfunction of the pancreas Exclude hypoglycemia or hyperglycemia which may be a diabetic condition, but by itself does not constitute diabetes mellitus</p>	<p>Special diet Oral agents Insulin Exercise</p>
<p>17H. URINARY TRACT INFECTION: During the past twelve weeks symptoms of a UTI have been exhibited or it has been diagnosed by lab tests. Symptoms may include frequent voiding, foul smelling urine, voiding small amounts cloudy urine, sediment and an elevated temperature. May or may not be the primary problem under Q. 29. Include as a UTI if it has not been confirmed yet by lab tests, but the symptoms are present. Include patients who appear asymptomatic, but whose lab values are positive (e.g., mentally confused or incontinent patients).</p>	<p>Exclude if symptoms are present, but the lab values are negative</p>	<p>Antibiotics Fluids</p>

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DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
<p>17I. HIV INFECTION SYMPTOMATIC: HIV (Human Immunodeficiency Virus) Infection, Symptomatic: Includes Acquired Immunodeficiency Syndrome (AIDS) and HIV related illnesses. The patient has been tested for HIV infection AND a positive finding is documented AND the patient has had symptoms, documented by a physician, <u>nurse practitioner (in conformance with a written practice agreement with a physician), or physician assistant</u> as related to the HIV infection. Symptoms include but are not limited to abnormal weight loss, respiratory abnormalities, anemia, persistent fever, fatigue and diarrhea. Symptoms need not have occurred in the past four weeks. Exclude patients who have tested positive for HIV infection and have not become symptomatic, and patients who have not received the results of the HIV test.</p> <p>17J. ACCIDENT: An event resulting in serious bodily harm, such as a fracture, a laceration which requires closure, a second or third degree burn or an injury requiring admission to a hospital.</p> <p>To qualify as "YES" on the PRI the following qualifier must be met:</p> <p>1. During the past six months serious bodily harm occurred as the result of one or more accidents.</p>		

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DEFINITION	EXAMPLES OF CAUSES	EXAMPLES OF TREATMENTS
17K. VENTILATOR DEPENDENT: A patient who has been admitted to a skilled nursing facility on a ventilator or has been ventilator dependent within five (5) days prior to admission to the skilled nursing facility. Patients who are in the process of being weaned off of ventilator support will qualify for this category for one month after extubation if they are receiving active respiratory rehabilitation services during that period. Patients in the facility who decompensate and require intubation also qualify for this category.		

All services shall be provided in accordance with Sections 416.13, 711.5 and 713.21 of Chapter V of Title 10 of the *Official Compilation of Codes Rules and Regulations* of the State of New York.

- 18. MEDICAL TREATMENTS:** For a "YES" to be answered for any of these, the following qualifiers must be met:

Time Period – Treatment must have been given during the past four weeks in conformance with the frequency requirements cited below and is still be required. For medical treatments having a daily frequency requirement, treatment must be provided every day of the four week period, except for residents newly admitted during the period. For residents newly admitted during the four week period, treatments required daily must have been provided each day from admission to the end of the four week period and documentation must support the seriousness of the condition and the probability that treatment will continue for at least four weeks.

Frequency – As specified in the chart below. (The only exception is to use the past twelve weeks for question 18L, catheter.)

Documentation – Physician order, nurse practitioner order (in conformance with a written practice agreement with a physician), or appropriately cosigned physician assistant order specifies that treatment should be given and includes frequency as cited below, where appropriate.

Exclusions – See chart on next page.

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DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
<p>18A. TRACHEOSTOMY CARE: Care for a tracheostomy, including suctioning. Exclude any self-care patients who do not need daily staff help.</p>	Daily	Self-care patients
<p>18b. SUCTIONING: Nasal or oral techniques for clearing away fluid or secretions. May be for a respiratory problem.</p>	Daily	Any tracheostomy Suctioning
<p>18C. OXYGEN THERAPY: Administration of oxygen by nasal catheter, mask (nasal or oronasal), funnel/cone, or oxygen tent for conditions resulting from oxygen deficiency (e.g., cardiopulmonary condition).</p>	Daily	Inhalators Oxygen in room, but not in use
<p>18D. RESPIRATORY CARE: Care for any portion of the respiratory tract, especially the lungs (for example COPD, pneumonia). This care may include one or more of the following: percussion or cupping, postural drainage, positive pressure machine, possibly oxygen to administer drugs, etc.</p>	Daily	Suctioning
<p>18E. NASAL GASTRIC FEEDING: Primary food intake is by a tube inserted into nasal passage; resorted to when it is the only route to the stomach.</p>	None	None Gastrostomy not applicable
<p>18F. PARENTERAL FEEDING: Intravenous or subcutaneous route for the administration of fluids used to maintain fluid, nutritional intake, electrolyte balance (e.g., comatose, damaged stomach).</p>	None	None Gastrostomy not applicable
<p>18G. WOUND CARE: Subcutaneous lesion(s) resulting from surgery, trauma, or open cancerous ulcers.</p>	Care has been provided or is professionally judged to be needed for at least 3 consecutive weeks	Decubiti Stasis ulcers Skin tears Feeding tubes

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DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
<p>18H. CHEMOTHERAPY: Treatment of carcinoma through IV and/or oral chemical agents, as ordered by a physician, <u>nurse practitioner, (in conformance with a written practice agreement with a physician), or physician assistant when the physician assistant's order is appropriately cosigned.</u> (Patient may have to go to a hospital for treatment.)</p>	None	None
<p>18I. TRANSFUSIONS: Introduction of whole blood or blood components directly into the blood stream. (Patients may have to go to a hospital for treatment.)</p>	None	None
<p>18J. DIALYSIS: The process of separating components, as in kidney dialysis (<i>e.g.</i>, renal failures, leukemia, blood dyscrasia). Patient may have to go to a hospital for treatment.</p>	None	None
<p>18K. BOWEL AND/OR BLADDER REHABILITATION: The goal of this treatment to gain or regain optimal bowel and/or bladder function and to re-establish a pattern. It is much more than just a toileting schedule or a maintenance/conditioning program. Rather it is an intense treatment which is very specific and unique for each patient and is of short term duration (<i>i.e.</i>, usually not longer than six weeks). NOT all patients at level 5 under Toileting Q.22 may be a "YES" with this question. The specific definition for bladder rehabilitation differs from bowel rehabilitation; refer below:</p>	Very specific And unique for each patient	Maintenance toileting schedule Restorative toileting program but does not meet the treatment requirements specified in the definitions

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DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
<p>Bladder rehabilitation: Will generally include these step-by-step procedures which are closely monitored, evaluated and documented: (1) mental and physical assessment of the patient to determine training capacity; (2) a 24 hour flow sheet or chart documenting voiding progress; (3) possibly increased fluid intake during the daytime; (4) careful attention to skin care; (5) prevention of constipation; (6) in the beginning may be toileted 8 to 12 times per day with decreased frequency with progress.</p> <p>Bowl rehabilitation: A program to prevent chronic constipation/impaction. The plan will generally include: (1) assessment of past bowel movements, relevant medical problems, medication use; (2) a dietary regimen of increased fluids and bulk (<i>e.g.</i>, bran, fruits); (3) regular toileting for purposes of bowel evacuation; (4) use of glycerine suppositories or laxatives; (5) documentation on a worksheet or Kardex.</p> <p>18L CATHETER: During the past twelve weeks, an indwelling or external catheter has been needed. Indwelling catheter has been used for any duration during the past twelve weeks. The external catheter was used on a continuous basis (with proper removal and replacement during this period) for one or more days during the past twelve weeks. A physician order is required for an indwelling catheter; for an external catheter a physician order is not required.</p>		<p>Exclude a bowel maintenance program which controls bowel intinence by development of a routine bowel schedule</p> <p>Exclude catheters used to empty the bladder once, secure a specimen or instill medication</p>

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DEFINITION	SPECIFIC FREQUENCY	EXCLUSIONS
<p>18M. PHYSICAL RESTRAINTS: A physical device used to restrict resident movement. Physical restraints include belts, vests, cuffs, mitts, jackets harnesses and geriatric chairs.</p> <p>To Qualify as "YES" on the PRI the following qualifiers must be met:</p> <ol style="list-style-type: none"> 1. The restraint must have been applied for at least two continuous daytime hours for at least 14 days during the past four weeks. Daytime includes the time from when the resident gets up in the morning to when the resident goes to bed at night. 2. An assessment of need for the physical restraint must be written by an M.D. or R.N. 3. The comprehensive care plan based on the assessment must include a written physician's order and specific nursing interventions regarding use of the physical restraint. <p>NEW ADMISSIONS: If a patient is a new admission and will require the use of a physical restraint for at least two continuous daytime hours for at least 14 days as specified by the physician order, then enter "YES" on the PRI.</p>	<p>At least two continuous Daytime hours for at least 14 days during the past four weeks.</p>	<p>Exclude all of following:</p> <ul style="list-style-type: none"> • Medication use for the sole purpose of modifying residents behavior • Application only at night • Application for less than two continuous daytime hours for 14 days • Devices which residents can release/remove such as, Velcro seatbelts on wheelchairs • Residents who are bed bound • Side rails, locked doors/gates, domes

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III. ACTIVITIES OF DAILY LIVING: EATING, MOBILITY, TRANSFER, TOILETING

Use the following qualifiers in answering each ADL question:

Time Period – Past four weeks.

Frequency – Assess how the patient completed each ADL 60% or more of the time performed (since ADL status may fluctuate during the day or over the past four weeks.)

CHANGED CONDITION RULE: When a patient's ADL has improved or deteriorated during the past four weeks and this course is unlikely to change, measure the ADL according to its status during the past seven days.

Definitions – **SUPERVISION** means verbal encouragement and observation, not physical hands-one care.

ASSISTANCE means physical hands-on care.

INTERMITTENT means that a staff person does not have to be present during the entire activity, nor does the help have to be on a one-to-one basis.

CONSTANT means one-to-one care that requires a staff person to be present during the entire activity. If the staff person is not present, the patient will not complete the activity.

Note how these terms are used together in the ADLs. For example there is intermittent supervision and intermittent assistance.

CLARIFICATION OF ADL RESPONSES

19. EATING:

#3 "Requires 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 "Walks with constant supervision and/or assistance..." may be required if the patient cannot

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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 a 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.

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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:

Time Period – Past four weeks.

Frequency – As stated in the responses to each behavioral question.

Documentation – To qualify a patient as LEVEL 4 or to qualify the patient as a “YES” to HALLUCINATIONS, the following conditions must be met:

- Active treatment plan for the behavioral problem must be in current use.
- Psychiatric assessment by a recognized professional with psychiatric training/education must exist to support the fact that the patient has a severe behavioral problem. The problem addressed by this assessment must still be exhibited by the patient.

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Definitions – The terms used on the PRI should be interpreted only as they are defined below:

- **PATIENT'S BEHAVIOR:** Measure it as displayed with the behavior modification and treatment plan in effect during the past four weeks.
- **DISRUPTION:** Through verbal outbursts and/or physical actions, the patient interferes with the staff and/or other patients. This interference causes the staff to stop or change what they are doing immediately to control the situation. Without this staff assistance, the disruption would persist or a problem would occur.
- **NONDISRUPTION:** Verbal outbursts and/or physical actions by the patient may be irritating, but do not create a need for immediate action by the staff.
- **UNPREDICTABLE BEHAVIOR:** The staff cannot predict when (that is, under what circumstances) the patient will exhibit the behavioral problem. There is no evident pattern.
- **PREDICTABLE BEHAVIOR:** Based on observations and experiences with the patient, the staff can discern when a patient will exhibit a behavioral problem and can plan appropriate responses in advance. The behavioral problem may occur during activities of daily living (for example, bathing), specific treatments (for example, contracture care, ambulation exercises), or when criticized, bumped into, etc.

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:
- Verbal outbursts
 - Social withdrawal
 - Hoarding
 - Paranoia

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- 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:

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

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27. *LEVEL QUESTION: **QUALIFIERS (see level 4 below)

QUALIFIERS FOR LEVEL	MAINTENANCE THERAPY= LEVEL 2	RESTORATIVE THERAPY= LEVEL 3
DOCUMENTATION QUALIFIERS: POTENTIAL FOR INCREASED FUNCTIONAL/ADL ABILITY	None. Therapy is provided to maintain and/or retard deterioration of current functional/ADL status. Therapy plan of care and progress notes should support that patient has no potential for further or any significant improvement.	There is positive potential for improved functional status within a short and predictable period of time. Therapy plan of care and progress notes should support that patient has this potential/is improving.
<u>PHYSICIAN ORDER, NURSE PRACTITIONER ORDER (IN CONFORMANCE WITH A WRITTEN PRACTICE AGREEMENT WITH A PHYSICIAN), OR APPROPRIATELY COSIGNED PHYSICIAN ASSISTANT ORDER</u>	Yes	Yes, monthly
PROGRAM DESIGN AND EVALUATION QUALIFIER	Licensed professional person with a 4 year, specialized therapy degree evaluates program on a monthly basis.	Licensed professional person with a 4 year, specialized therapy degree evaluates program on a monthly basis.
TIME PERIOD QUALIFIER	Treatments have been provided during the past four weeks.	Treatments have been provided during the past four weeks.

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27. *LEVEL QUESTION: **QUALIFIERS (see level 4 below)

QUALIFIERS FOR LEVEL	MAINTENANCE THERAPY= LEVEL 2	RESTORATIVE THERAPY= LEVEL 3
NEW ADMISSION QUALIFIER	Not Applicable	<p>New admissions of less than four weeks can be marked for restorative therapy if:</p> <ul style="list-style-type: none"> • There is a physician <u>order</u>, nurse practitioner order (in conformance with a written practice agreement with a physician), or appropriately cosigned physician assistant order for therapy and patient is receiving it. • The licensed therapist has documented in the care/plan that therapy is needed for at least 4 weeks. • A new admission includes readmission to a residential health care facility.

* After completion of the "Level" question, proceed to the separate "Days" and "Time" qualifiers on the next page.

** QUALIFIERS NOT MET = LEVEL 4
ENTER LEVEL 4 IF ANY ONE OF THE QUALIFIERS UNDER QUALIFIERS FOR LEVELS 2 OR 3 IS NOT MET.

27. DAYS AND TIME PER WEEK QUESTION: QUALIFIERS*

QUALIFIERS FOR DAYS AND TIME*	MAINTENANCE THERAPY (i.e., level 2 or 4 under "Level" question)	RESTORATIVE THERAPY (i.e., If level 3 or 4 under "Level" question)
TYPE OF THERAPY SESSION	Count only one-to-one care. Exclude group sessions (e.g., PT exercise session, OT cooking session).	Count only one-to-one care. Exclude group sessions (e.g., PT exercise session, OT cooking session).

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SPECIALIZED PROFESSIONAL ON-SITE (ON-SITE MEANS WITHIN THE FACILITY)	A certified (2 year) or licensed (4 year) specialized professional is on-site supervising or providing therapy.	A licensed (4 year) specialized professional is on-site supervising or providing care. (Do not include care provided by PT or OT aides).
--	---	--

* QUALIFIERS NOT MET: DO NOT ENTER ON THE PRI ANY DAYS AND TIME OF THERAPY WHICH DO NOT MEET BOTH THE QUALIFIERS UNDER EACH LEVEL OF THERAPY.

28. NUMBER OF PHYSICIAN VISITS: Enter "0" (zero) unless the patient needs qualifiers stated below are met. If, and ONLY if, the patient meets all the patient need qualifiers, then enter the number of physician visits, nurse practitioner visits (in conformance with a written practice agreement with a physician), or a physician assistant visits that meet the physician, nurse practitioner, or physician assistant visit qualifiers.

- **PATIENT TYPE/NEED QUALIFIERS:** The patient has a medical condition that (1) is unstable and changing or (2) is stable, but there is a high risk of instability. If this patient is not closely monitored and treated by medical staff, an acute episode or severe deterioration can result. Documentation must support that the patient is of this type (for example, terminally ill, acute episode, recent hospitalization, post-operative).
- **PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT VISIT QUALIFIER:** If, and only if, the patient meets the PATIENT TYPE/NEED QUALIFIER, then enter the number of physician visits, nurse practitioner visits (in conformance with a written practice agreement with a physician), or physician assistant visits during the past four weeks that meet the following qualifications:
 - A visit qualifies only if there is physician, nurse practitioner, or physician assistant documentation that she/he has personally examined the patient to address the pertinent medical problem. The physician, nurse practitioner, or physician assistant must make a notation or documentation in the medical record as to the result of the visit for the unstable medical condition (*e.g.*, change medications, renew treatment orders, nursing orders, order lab tests).
 - Do not include phone calls as a visit nor visits which could have been accomplished over the phone.
 - A visit qualifies whether it is on-site or off-site, as long as the patient is not an inpatient in a hospital/other facility.

29. MEDICATIONS

A. Monthly average number for 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

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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 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 "psychoactive" medication 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:

- Antidepressants – Amitriptyline (Elavil); Imipramine (Tofranil); Doxepin (Sinequan); Tranylcypromine (Parnate); Phenelzine (Nardil)
- Anticholinergics – Benztropine (Cogentin); Trihexyphenidyl (Artane)
- Antihistamines – Diphenhydramine (Benadryl); Hydroxyzine (Atarax)
- Anxiolytics – Chlordiazepoxide (Librium); Diazepam (Valium)
- Cerebral Stimulants – Methylphenidate (Ritalin); Amphetamines (Benzedrine)
- Neuroleptics – Phenothiazines; Thiothixene (Navane); Haloperidol (Haldol); Chlorpromazine (Thorazine); Thioridazine (Mellaril)
- Somnifacients – Barbituates (Nembutal); Temazepam (Restoril); Glutethimide (Doriden); Flurazepam (Dalmane)

VI. DIAGNOSIS

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

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

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- **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.
- **NO ICD-9 NUMBER:** Enter "0" (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.
- **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).

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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.

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PATIENT REVIEW INSTRUMENT (PRI)**I. ADMINISTRATIVE DATA****1 OPERATING CERTIFICATE NUMBER**

(1-8)

2 SOCIAL SECURITY NUMBER

(9-17)

3 RESIDENT IS LOCATED:

1 = Former HRF Area

(18)

2 = Former SNF Area

11 DATE OF INITIAL ADMISSION: to this facility (NF) (first admission, not most recent)

62-67

MC

DAY

YEAR

4 PATIENT NAME (PLEASE PRINT)

LAST

FI

MI

12 MEDICAID NUMBER

68-78

13 MEDICARE NUMBER

79-88

5 DATE OF PRI COMPLETION

31-36

MO

DAY

YEAR

14 PRIMARY PAYOR

1 = Medicaid

3 = Other

2 = Medicare

89

7 ROOM NUMBER

46-50

15A REASON FOR PRI COMPLETION:

1 = Biannual Full Facility Cycle

2 = Quarterly New Admission Cycle

15A

(90)

8 UNIT NUMBER (Assigned by RUG II Project)

(51-52)

15B Was a PRI submitted by your facility (NF) for this patient during a previous full facility or a new admit cycle?

1 = Yes

2 = No

15B

(91)

9 DATE OF BIRTH

53-60

MO

DAY

YEAR

10 SEX

1 = Male

2 = Female

(61)

II. MEDICAL EVENTS**16 DECUBITUS LEVEL:** ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS**17 MEDICAL CONDITIONS:** DURING THE PAST FOUR WEEKS, READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS. 1 = Yes 2 = No

A. Comatose

B. Dehydration

C. Internal Bleeding

D. Stasis Ulcer

E. Terminally Ill

F. Contractures

G. Diabetes Mellitus

H. Urinary Tract Infection

I. HIV Infection Symptomatic

J. Accident

K. Ventilator Dependent

18 MEDICAL TREATMENTS: READ THE INSTRUCTIONS FOR QUALIFIERS.

1 = Yes

2 = No

A. Tracheostomy Care/Suctioning
(Daily — Exclude self care)

B. Suctioning — General (Daily)

C. Oxygen (Daily)

D. Respiratory Care (Daily)

E. Nasal Gastric Feeding

F. Parenteral Feeding

G. Wound Care

H. Chemotherapy

I. Transfusion

J. Dialysis

K. Bowel and Bladder Rehabilitation
(SEE INSTRUCTIONS)

L. Catheter (Indwelling or External)

M. Physical Restraints (Daytime Only)

III. ACTIVITIES OF DAILY LIVING (ADLs)**19 EATING:** PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE, PLATE, CUP, TUBE).

- 1 = Feeds self without supervision or physical assistance. May use adaptive equipment.
- 2 = Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.
- 3 = Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.
- 4 = Totally fed by hand; patient does not manually participate.
- 5 = Tube or parenteral feeding for primary intake of food (Not just for supplemental nourishments)

20 MOBILITY: HOW THE PATIENT MOVES ABOUT

- 1 = Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.
- 2 = Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).
- 3 = Walks with *constant* one-to-one supervision and/or constant physical assistance.
- 4 = *Wheels* with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.
- 5 = Is *wheeled*, chairfast or bedfast. Relies on someone else to move about, if at all.

21 TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING, (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET).

- 1 = Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.
- 2 = Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.
- 3 = Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.
- 4 = Requires *two* people to provide constant supervision and/or physically lift. May need lifting equipment.
- 5 = Cannot and is not gotten out of bed.

22 TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN), TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES.

- 1 = Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.
- 2 = Requires *intermittent* supervision for safety or encouragement; or *minor* physical assistance (for example, clothes adjustment or washing hands).
- 3 = Continent of bowel and bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, *including* appliances (i.e., colostomy, ileostomy, urinary catheter).
- 4 = Incontinent of bowel and/or bladder and is not taken to a bathroom.
- 5 = Incontinent of bowel and/or bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

IV. BEHAVIORS**23 VERBAL DISRUPTION:** BY YELLING, BAITING, THREATENING, ETC

- 1 = None during the past four weeks. (May have verbal outbursts which are not disruptive.)
- 2 = Verbal disruption one to three times during the past four weeks.
- 3 = Short-lived disruption at least once per week during the past four weeks or *predictable* disruption regardless of frequency (for example, during specific care routines, such as bathing).
- 4 = Unpredictable, recurring verbal disruption *at least once per week* for no foretold reason.
- 5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

24 PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH INTENT FOR INJURY, (FOR EXAMPLE HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR).

- 1 = None during the past four weeks.
- 2 = Unpredictable aggression during the past four weeks (whether mild or extreme), *but not at least once per week*.
- 3 = Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.
- 4 = Unpredictable, recurring aggression at least once per week during the past four weeks for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).
- 5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions).

PATIENT NAME (please print) _____

25 DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: CHILDISH, REPETITIVE OR ANTISOCIAL **PHYSICAL** BEHAVIOR WHICH CREATES *DISRUPTION WITH OTHERS* (FOR EXAMPLE, CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESELF TO OTHERS). EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS.

- 1 = No infantile or socially inappropriate behavior, whether or not disruptive, during the past four weeks. 4 = Disruptive behavior at least *once per week* during the past four weeks.
- 2 = Displays this behavior, but is not disruptive to others (for example, rocking in place). 5 = Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).
- 3 = Disruptive behavior during the past four weeks, but *not* at least once per week.

26 HALLUCINATIONS: EXPERIENCED AT LEAST ONCE PER WEEK DURING THE PAST FOUR WEEKS. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY.

- 1 = Yes 2 = No 3 = Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions)

V. SPECIALIZED SERVICES**27 PHYSICAL AND OCCUPATIONAL THERAPIES:** READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) PER WEEK.

A. Physical Therapy (P.T.) _____

B. Occupational Therapy (O.T.) _____

LEVEL

- 1 = Does not receive. occupational therapy for four or more consecutive weeks.
- 2 = Maintenance Program - Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration. 4 = Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, restorative therapy given or to be given for only two weeks.)
- 3 = Restorative Therapy - Requires and is currently receiving physical and/or

DAYS AND TIME PER WEEK: ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) PER WEEK THAT EACH THERAPY IS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

28 NUMBER OF PHYSICIAN VISITS: ENTER ONLY THE NUMBER OF VISITS DURING THE PAST FOUR WEEKS THAT ADHERE TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. EXCLUDE VISITS BY PSYCHIATRISTS.**29 MEDICATIONS**

- A. Monthly average number of medications ordered.
- B. Monthly average number of psychoactive medications ordered.

DIAGNOSIS**30 PRIMARY PROBLEM:** THE MEDICAL CONDITION (ICD-9 CODE) REQUIRING THE LARGEST AMOUNT OF NURSING TIME. THIS MAY NOT BE THE ADMISSION DIAGNOSIS BY THE PHYSICIAN.

ICD-9 Code of medical problem _____

If code cannot be located, print medical name here: _____

I HEREBY CERTIFY THE INFORMATION CONTAINED HEREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORDS.

Signature of Qualified Assessor _____

Assessor Identification Number _____

31

(print name)

38 RACE/ETHNIC GROUP: ENTER THIS CODE WHICH BEST DESCRIBES THE PATIENT'S RACE OR ETHNIC GROUP

1 = White	4 = Black/Hispanic	7 = American Indian or Alaskan Native
2 = White/Hispanic	5 = Asian or Pacific Islander	8 = American Indian or Alaskan Native/Hispanic
3 = Black	6 = Asian or Pacific Islander/Hispanic	9 = Other



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Specialized programs for residents requiring behavioral interventions.

(a) General.

- (1) Specialized programs for residents requiring behavioral interventions ("the program") shall mean a discrete unit with a planned combination of services with staffing, equipment and physical facilities designed to serve individuals whose severe behavior cannot be managed in a less restrictive setting. The program shall provide goal-directed, comprehensive and interdisciplinary services directed at attaining or maintaining the individual at the highest practicable level of physical, affective, behavioral and cognitive functioning.
- (2) The program shall serve residents who are a danger to self or others and who display violent or aggressive behaviors which are typically exhibited as physical or verbal aggression such as clear threats of violence. This behavior may be unpredictable, recurrent for no apparent reason, and typically exhibited as assaultive, combative, disruptive or socially inappropriate behavior such as sexual molestation or fire setting.
- (3) The program shall be located in a nursing unit which is specifically designated for this purpose and physically separate from other facility residents. The unit shall be designed in accordance with the provisions as set forth in Subpart 713-2 of this Title.
- (4) The facility shall have a written agreement with an inpatient psychiatric facility licensed under the Mental Hygiene Law to provide for inpatient admissions and consultative services as needed.
- (5) In addition to the implementation of the quality assessment and assurance plan for this program as required by section 415.27 of this Part, the facility shall participate with the commissioner or his or her designee in a review of the program and resident outcomes. The factors to be reviewed shall include but not be limited to a review of admissions, the care and services provided, continued stays, and discharge planning. The facility shall furnish records, reports and data in a format as requested by the commissioner or his or her designee and shall make available for participation in the review, as necessary, members of the interdisciplinary resident care team.

(b) Admission.

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- (1) The facility shall develop written admission criteria which are applied to each prospective resident. As a minimum, for residents admitted to the program, there shall be documented evidence in the resident's medical record that:
 - (i) the resident's behavior is dangerous to him or herself or to others;
 - (ii) the resident's behavior has been assessed according to severity and intensity;
 - (iii) within 30 days prior to the date of application to the program, the resident has displayed:
 - (a) verbal aggression which constitutes a clear threat of violence towards others or self; or
 - (b) physical aggression which is assaultive or combative and causes or is likely to cause harm to others or self; or
 - (c) persistently regressive or socially inappropriate behavior which causes actual harm.
 - (iv) various alternative interventions have been tried and found to be unsuccessful;
 - (v) the resident cannot be managed in a less restrictive setting; and
 - (vi) the prospective resident has the ability to benefit from such a program.
- (2) Prior to admission, the facility shall fully inform the resident and the resident's designated representative both orally and in writing about the program plan and the policies and procedures governing resident care in this unit. Such policies and procedures shall at a minimum include a statement that the resident's right to leave or be discharged from the program shall be consistent with the rights of other residents in the facility.

(c) Assessment and Care Planning.

- (1) The interdisciplinary team shall have determined preliminary approaches and interventions to the severe behavior and recorded them in the resident care plan prior to admission to the unit.
- (2) Each resident's care plan shall include care and services which are therapeutically beneficial for the resident and selected by the resident

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when able and as appropriate. The care plan shall be prepared by the interdisciplinary team, as described in section 415.11 of this Part, which shall include psychiatrist, psychologist, or social worker participation as appropriate to the needs of the resident.

- (3) Based on the resident's response to therapeutic interventions, the care plan including the discharge plan shall be reviewed and modified, as needed, but at least once a month.

(d) Discharge.

- (1) A proposed discharge plan shall be developed within 30 days of admission for each resident as part of the overall care plan and shall include input from all professionals caring for the resident, the resident and his or her family, as appropriate, and any outside agency or resource that will be involved with the resident following discharge.
- (2) When the interdisciplinary team determines that discharge of a resident to another facility or community-based program is appropriate, a discharge plan shall be implemented which is designed to assist and support the resident, family and caregiver in the transition to the new setting. Program staff shall be available post-discharge to act as a continuing resource for the resident, family or caregiver.
- (3) The resident shall be discharged to a less restrictive setting when he or she no longer meets the admission criteria for this program as stated in subdivision (b) of this section.
- (4) A resident discharged to an acute care facility shall be accompanied by a member of the program's direct care staff during transfer. He or she shall be given priority readmission status to the program as his or her condition may warrant.
- (5) There shall be a written transfer agreement with any nursing home of origin which allows for priority readmission to such transferring facility when a resident is capable of a safe discharge.

(e) Resident services and staffing requirements.

- (1) The program shall consist of a variety of medical, behavioral, counseling, recreational, exercise, and other services to help the resident control or redirect his or her behavior through interventions carried out in a therapeutic environment provided on-site.
- (2) There shall be dedicated staffing in sufficient numbers to provide for the direct services in the unit and to allow for small group activities and for one-on-one care.

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- (3) The unit shall be managed by a program coordinator who is a licensed or certified health care professional with previous formal education, training and experience in the administration of a program concerned with the care and management of individuals with severe behavioral problems. The program coordinator shall be responsible for the operation and oversight of the program. Other responsibilities of the program coordinator shall include:
- (i) the planning for and coordination of direct care and services;
 - (ii) developing and implementing inservice and continuing education programs, in collaboration with the interdisciplinary team, for all staff in contact with or working with these residents;
 - (iii) participation in the facility's decisions regarding resident care and services that affect the operation of the unit; and
 - (iv) ensuring the development and implementation of a program plan and policies and procedures specific to this program.
- (4) A physician who has specialized training and experience in the care of individuals with severe behavioral or neuropsychiatric conditions shall be responsible for the medical direction and medical oversight of this program and shall assist with the development and evaluation of policies and procedures governing the provision of medical services in this unit.
- (5) A qualified specialist in psychiatry who has clinical experience in behavioral medicine and experience working with individuals who are neurologically impaired shall be available on staff or a consulting basis to the residents and to the program.
- (6) A clinical psychologist with at least one year of training in neuropsychology shall be available on staff or a consulting basis to the residents and to the program.
- (7) A social worker with experience associated with severe behavioral conditions shall be available either on staff or a consulting basis to work with the residents, staff and family as needed.
- (8) Other than the program coordinator, there shall be at least one registered professional nurse deployed on each shift in this unit who has training and experience in caring for individuals with severe behaviors.
- (9) A full-time therapeutic recreation specialist shall be responsible

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for the therapeutic recreation program.

- (10) The facility shall ensure that all staff assigned to the direct care of the residents have pertinent experience or have received training in the care and management of individuals with severe behaviors.
- (11) The facility shall ensure that educational programs are conducted for staff not providing direct care but who come in contact with these residents on a regular basis such as housekeeping and dietary aides. The programs shall familiarize staff with the program and the residents.

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