DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services (CMCS)

JUN 21 2012

Jason A. Helgerson
State Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs
NYS Department of Health
Corning Tower (OCP - 1211)
Albany, NY 12237

RE: TN 11-23-A

Dear Mr. Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-23-A. Effective January 1, 2012, this SPA will establish a new payment methodology for nursing facility (NF) services furnished by non-specialty NFs. The new system will better align Medicaid payments with the cost of NF care provided to meet the needs Medicaid residents.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. New York State plan amendment 11-23-A is approved effective January 1, 2012. We have enclosed the HCFA-179 and the approved plan pages.

If you have any questions, please contact Tom Brady at 518-396-3810 or Rob Weaver at 410-786-5914.

Sincerely,

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: **#11-23-A**	2. STATE **New York**
	3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 1, 2012**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: **Section 1902(a) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **a. FFY 01/1/12-9/30/12 $ 0** **b. FFY 10/1/12-9/30/13 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D: Pages 50(g)(1), 110(d)(3), 110(d)(4), 110(d)(5), 110(d)(6), 110(d)(7), 110(d)(8), 110(d)(9), 110(d)(10), 110(d)(11), 110(d)(12), 110(d)(13), 110(d)(14), 110(d)(15), 110(d)(16), 110(d)(17), 110(d)(18), 110(d)(19), 110(d)(20), 110(d)(21), 110(d)(22)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Revisions to Transition to Statewide Pricing Methodology for NHs (FMAP = 50% 7/1/11 forward)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: **Jason A. Helgerson**	**New York State Department of Health** **Corning Tower** **Empire State Plaza** **Albany, New York 12237**
14. TITLE: **Medicaid Director & Deputy Commissioner Department of Health**	
15. DATE SUBMITTED: **June 15, 2012**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: **JUN 21 2012**
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **JAN - 1 2012**	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

Attachment 4.19-D
(01/12)

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.

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 (RHCFs) shall be a price and shall consist of the sum of the following components:

1) ((50% of the statewide direct price for all non-specialty facilities + 50% of the peer group direct price) X (direct WEF adjustment) X (case mix adjustment))+((50% of the statewide indirect price for all non-specialty facilities + 50% of the peer group indirect price) X (indirect WEF adjustment)) + non comparable component + 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.

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

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)

Attachment 4.19-D
(01/12)

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
January 1, 2017	$119.02	$59.51	$132.17	$66.09	$125.60

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
January 1, 2017	$117.39	$58.70	$130.43	$65.22	$123.91

TN #11-23-A **Approval Date** JUN 21 2012

Supersedes TN NEW **Effective Date** JAN - 1 2012

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
January 1, 2017	$119.02	$59.51	$111.71	$55.86	$115.37

Direct Component of the Price Medicare Part B Eligible Price, Medicare Part B and Part D Eligible Price (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
January 1, 2017	$117.39	$58.70	$110.14	$55.07	$113.77

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.

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);
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).

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/((Facility-Specific Wage Ratio/ Wage Index) + (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.

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

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

1/((Regional Wage Ratio/ Regional Wage Index) + (Regional Non-Wage Ratio))

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.

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.

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) Subsequent case mix adjustments to the direct component of the price for rate periods effective after January 1, 2012, shall be made in July and January of each calendar year and shall use Medicaid-only case mix data applicable to the previous case mix period (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).

5) Case mix adjustments to the direct component of the price for facilities for which facility-specific case mix data is unavailable or insufficient shall be equal to the base year case mix of the peer group applicable to such facility.

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

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

1) For NSHB/NS300+ the indirect component of the price shall consist of a blended rate equal to:

i) 50% of the Statewide indirect NSF price which shall 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 shall 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 shall consist of a blended rate equal to:

i) 50% of the Statewide indirect NSF price which shall 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 shall 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.

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

Indirect Component of the Price (NSHB/NS300+) Peer Group					
Effective Date of Prices	**Indirect NSF Price (a)**	**50% of Indirect NSF Price (b)**	**Indirect NSHB/NS300+ Price (c)**	**50% of Indirect NSHB/NS300 + Price (d)**	**Total Indirect Component of Price for NSHB/NS300+ Peer Group (b)+(d)**
January 1, 2012	$53.15	$26.58	$61.54	$30.77	$57.35
January 1, 2013	$56.18	$28.09	$65.04	$32.52	$60.61
January 1, 2014	$58.57	$29.29	$67.82	$33.91	$63.20
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
Indirect Component of the Price (NS300-)Peer Group					
Effective Date of Prices	**Indirect NSF Price (a)**	**50% of Indirect NSF Price (b)**	**Indirect NS300- Price (c)**	**50% of Indirect NS300- Price (d)**	**Total Indirect Component of Price for NS300- Peer Group (b)+(d)**
January 1, 2012	$53.15	$26.58	$48.49	$24.25	$50.82
January 1, 2013	$56.18	$28.09	$51.25	$25.63	$53.72
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

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).

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/((Facility-Specific Wage Ratio/ Wage Index) + (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.

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

1/((Regional Wage Ratio/ Regional Wage Index) + (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.

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.

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.

p) For the calendar year 2012, the operating component of the price of each non-specialty facility that fails to submit to the Commissioner data or reports on quality measures shall be subject to a per diem reduction. The per diem reduction shall be calculated as follows:

(Number of Medicaid Days of the non-specialty facility that fails to report/ total Medicaid days of all non-specialty facilities) * $50 million

q) Per Diem Transition Adjustments: Over the five-year period beginning January 1, 2012, and ending December 31, 2016, non-specialty facilities shall be eligible for per diem transition rate adjustments, calculated as follows:

1) In each year for each non-specialty facility computations shall be made by the Department pursuant to subparagraphs (i) and (ii) below and per diem rate adjustments shall be made for each year such that the difference between such computations for each year is no greater than the percentage as identified in subparagraph (iii) below, of the total Medicaid revenue received from the non-specialty facility's July 7, 2011, rate (as transmitted in the Department's Dear Administrator Letter (DAL) dated November 9, 2011, and not subject to reconciliation or adjustment, provided, however, that those facilities which are, subsequent to November 9, 2011, issued a revised non-capital rate for rate periods including July 7, 2011, reflecting a new base year that is subsequent to 2002, shall have such revised non-capital rate as in effect on July 7, 2011 utilized for the purpose of computing transition adjustments pursuant to this subdivision.

i) A non-specialty facility's Medicaid revenue, calculated by summing the direct component, indirect component, non-comparable components of the price in effect for each non-specialty facility on January 1, 2012, and multiplying such total by the non-specialty facility's 2010 Medicaid days or the most recently available Medicaid days as of October 24, 2011.

A non-specialty facility's Medicaid revenue calculated by multiplying the non-specialty facility's July 7, 2011, rate (as communicated to facilities by Department letter dated November 9, 2011) by the non-specialty facility's 2010 Medicaid days or the most recently available Medicaid days as of October 24, 2011, and deemed not subject to subsequent reconciliation or adjustment.

The Medicaid days used in the calculation provided for in (i) and (ii) above shall be identical.

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

(iv) Non-specialty facilities which do not have a July 7, 2011, rate as described above shall not be eligible for the per diem transition adjustment described herein.

r) Other Provisions:

1) The appointment of a receiver, the establishment of a new operator, or the replacement or renovation of an existing facility on or after January 1, 2012, shall not result in a revision to the operating component of the price.

2) For rate computation purposes, "patient days" shall include "reserved bed days," defined as the unit of measure denoting an overnight stay away from the facility for which the patient or the patient's third-party payor provides per diem reimbursement when the patient's absence is due to hospitalization or therapeutic leave.