SUMMARY OF EXPRESS TERMS

The New York State Nursing Home Quality Pool (NHQP) is a $50 million budget-neutral pool that was established in the 2010-2011 final State budget. The pool was created to improve the quality of care for residents in Medicaid-certified nursing facilities across the state, and to reward facilities for quality based on their performance. The New York State Department of Health (NYS DOH) worked in consultation with a workgroup of industry experts, comprised of representatives from five nursing home advocacy groups, as well as nursing home patient advocates to assist in the development of the quality pool.

The 2013 NHQP contains three measurement components comprised of 14 quality measures, three compliance measures, and one efficiency measure. All measures are shown below with the measure steward in parentheses. The measures included in the quality pool were decided upon with input and advice from the workgroup based on expert opinions, industry standards, and quality measure outcomes being assessed at the national level.

Quality Measures

- Annual level of temporary contract/agency staff used (NYS DOH)
- Centers for Medicare and Medicaid Services (CMS) five-star quality rating for staffing (CMS)
- Percent of employees vaccinated for the flu (NYS DOH)
- Percent of long stay high risk residents with pressure ulcers (CMS)

- Percent of long stay residents assessed and given, appropriately, the pneumococcal vaccine (CMS)
- Percent of long stay residents assessed and given, appropriately, the seasonal influenza vaccine (CMS)
- Percent of long stay residents experiencing one or more falls with major injury (CMS)
- Percent of long stay residents who have depressive symptoms (CMS)
- Percent of long stay low risk residents who lose control of their bowel or bladder (CMS)
- Percent of long stay residents who lose too much weight (CMS)
- Percent of long stay residents who received an antipsychotic medication (CMS)
- Percent of long stay residents who self-report moderate to severe pain (CMS)
- Percent of long stay residents whose need for help with daily activities has increased (CMS)
- Percent of long stay residents with a urinary tract infection (CMS)

Compliance Measures

- CMS Five-Star Quality Rating for Health Inspections (CMS)
- Timely submission of complete nursing home certified cost reports (NYS DOH)
- Timely submission of employee flu immunization data (NYS DOH)

Efficiency Measure

- Number of potentially avoidable hospitalizations per 10,000 long stay episode days (CMS with NYS DOH modifications)

The NYS DOH assesses the nursing homes on their performance in all components of the NHQP, as compared to their peers. Nursing homes are categorized into quintiles based on the distribution of their overall scores. Under the payment methodology of the 2013 NHQP, eligible nursing homes contribute to the funding of the $50 million pool. The amount of a nursing home's contribution is proportional to the nursing home's Medicaid rate and total number of Medicaid patient days. The pool money is redistributed to the nursing homes based on their quintile placement. Nursing homes in the top three quintiles receive distributions, with nursing homes in the first quintile receiving a proportion larger than nursing homes in the second and third quintiles, and nursing homes in the second quintile receiving a proportion larger than nursing homes in the third quintile. The nursing homes in the fourth and fifth quintiles do not receive a redistribution.

Pursuant to the authority vested in the Commissioner of Health by Section 2808(2-c)(d) of the Public Health Law as enacted by Section 95 of Part H of Chapter 59 of the Laws of 2011, Subpart 86-2 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulation of the State of New York, is hereby amended, to be effective upon publication of a Notice of Adoption in the New York State Register, by adding a new section 86-2.42 to read as follows:

86-2.42. Residential health care facility quality pool.

(a) For the calendar year 2013 and thereafter, the Commissioner shall establish a residential health care facility quality pool for the purpose of making quality incentive payments to facilities meeting the criteria set forth in this section. In furtherance of such payments the Commissioner shall calculate a quality score for each non-specialty residential health care facility. For the purposes of calculating such score, the Commissioner shall exclude non-Medicaid facilities, CMS Special Focus facilities, Continuing Care Retirement facilities, Transitional Care Units, and other specialty facilities and specialty units within facilities. Specialty facility shall mean: AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and

counseling support services solely to children. The quality score for each non-specialty facility shall be calculated using the following measurements as defined in this section:

(1) quality;

(2) compliance;

(3) potentially avoidable hospitalizations;

(4) rate adjustments to fund quality pool;

(5) facilities not eligible for 2013 payments;

(6) per diem transition adjustments;

(7) per diem reduction;

(8)other provisions.

(b) Quality. (1) The maximum points a facility may be awarded pursuant to this component is 60 points. For each facility each quality measure assigned to the first quintile shall be awarded 4.29 points; each quality measure assigned to the second quintile shall be awarded 2.57 points; each quality measure assigned to the third quintile shall be awarded 0.86 points; and zero points shall be awarded to each quality measure assigned to the fourth and fifth quintiles. All non-specialty facilities subject to this section shall be evaluated and comparatively ranked and grouped into quintiles with regard to each of the following 14 quality measures:

(i) Percent of long stay high risk residents with pressure ulcers, subject to risk adjustments as determined by the Commissioner;

(ii) Percent of long stay residents assessed and appropriately given the pneumococcal vaccine, provided that for the purposes of a facility's quality score,

maximum (4.29) points shall be awarded if the rate of appropriate vaccination is 85% or greater and zero points if the rate is less than 85% rather than assignment to a quintile;

(iii) Percent of long stay residents assessed and appropriately given the seasonal flu vaccine, provided that for the purposes of a facility's quality score, maximum (4.29) points shall be awarded if the rate of appropriate vaccination is 85% or greater and zero points if the rate is less than 85% rather than assignment to a quintile;

(iv) Percent of long stay residents experiencing one or more falls with major injury;

(v) Percent of long stay residents who have depressive symptoms;

(vi) Percent of low risk long stay residents who lose control of their bowels or bladder;

(vii) Percent of long stay residents who lose too much weight, subject to risk adjustments as determined by the Commissioner;

(viii) Percent of long stay residents who received an antipsychotic medication, subject to risk adjustments as determined by the Commissioner;

(ix) Percent of long stay residents who self-report moderate to severe pain, subject to risk adjustments as determined by the Commissioner;

(x) Percent of long stay residents whose need for help with daily activities has increased;

(xi) Percent of long stay residents with a urinary tract infection;

(xii) Percent of employees vaccinated for influenza;

(xiii) Annual percent level of temporary contract staff;

(xiv) CMS five-star rating for staffing.

(2) When a facility's rate is risk adjusted, the expected rate is the rate the facility would have had if the facility's patient mix was identical to the patient mix of the state. The expected rate is determined through the risk-adjusted model. The facility-specific, risk-adjusted rate is the ratio of observed to expected measure rates multiplied by the overall statewide measure rate. For the Percent of long stay residents who self-report moderate to severe pain, DOH follows the CMS risk adjustment methodology found in the Minimum Data Set (MDS) 3.0 Quality Measures User's Manual, Appendix A-1. The remaining two risk adjusted quality measures follow a methodology developed by DOH.

(3) Redistribution of Quality Points: Due to limitations of the nursing home cost reports, DOH cannot accurately calculate the Annual Percent Level of Temporary Contract Staff for certain facilities. In these cases, this measure will be suppressed and the quality points will be redistributed to the remaining quality measures.

(4) Superstorm Sandy had an impact on some facilities' ability to immunize their healthcare workers. For these facilities, the Percent of Employees Vaccinated for Influenza measure will be suppressed if the suppression results in a higher overall score for the facility affected. In this case, the quality points will be redistributed across the remaining quality measures.

(5) For quality measures with a denominator of less than 30, the measure will be suppressed and the quality points will be redistributed to the remaining quality measures.

(6) Facilities with a missing CMS Five-Star Rating for Staffing will have this measure suppressed and the quality points redistributed to the remaining quality measures.

(c) Compliance. (1) The maximum points a facility may receive for the compliance component is twenty points. Points shall be awarded as follows:

(i) For the CMS Five-Star Ratings for Health Inspections, facilities that receive five stars shall be awarded ten points; facilities that receive four stars shall be awarded seven points; facilities that receive three stars shall be awarded four points; facilities that receive two stars shall be awarded two points; facilities that receive one star shall be awarded zero points;

(ii) Facilities that timely submit a certified and complete cost report shall receive five points, provided that facilities that fail to timely submit a cost report will receive zero points;

(iii) Facilities that timely submit employee influenza immunization data shall receive five points, provided that facilities that fail to timely submit flu immunization data will receive zero points.

(2) Superstorm Sandy had an impact on some facilities' ability to submit their employee immunization data by the designated deadline. Facilities that do not submit timely employee flu immunization data due to Superstorm Sandy will not be penalized. In these cases, the points will be redistributed to the timely submission of nursing home certified cost reports measure. This measure will be worth 10 points instead of five.

(3) Facilities with a missing CMS Five-Star Rating for Health Inspections will have compliance points redistributed to the remaining timely submission measures. In these cases each measure will be worth 10 points.

(d) Potentially avoidable hospitalizations component. (1) The maximum points a facility may receive for the potentially avoidable hospitalizations component is twenty

points. The rates of potentially avoidable hospitalizations shall be determined for each facility and facilities shall be ranked and grouped into quintiles with twenty points awarded to facilities in the first quintile; sixteen points awarded to facilities in the second quintile; twelve points awarded to facilities in the third quintile; four points awarded to facilities in the fourth quintile; and zero points awarded to facilities in the fifth quintile.

(2) The Potentially Avoidable Hospitalizations measure is subject to risk adjustments as determined by the Commissioner;

(3) A potentially avoidable hospitalization is found by matching a discharge assessment in the MDS 3.0 data to its hospital record in the Statewide Planning and Research Cooperative System (SPARCS). The following admitting six conditions on the SPARCS hospital record are potentially avoidable: sepsis, urinary tract infection, respiratory infection, congestive heart failure, anemia, and electrolyte imbalance.

(e) The following rate adjustments, which shall be applicable to the 2013 calendar year, shall be made to fund the quality pool and to make quality payments based upon the scores calculated as described above.

(1) Specialty facilities are excluded from the Quality Pool. Specialty facility shall mean: AIDS facilities or discrete AIDS units within facilities; discrete units for residents receiving care in a long-term inpatient rehabilitation program for traumatic brain injured persons; discrete units providing specialized programs for residents requiring behavioral interventions; discrete units for long-term ventilator dependent residents; and facilities or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children.

(2) Each non-specialty facility shall be subject to a negative per diem adjustment to fund the quality pool. Non-specialty shall mean all other facilities not defined as a specialty facility. The negative per diem adjustment shall be calculated as follows:

(i) For each such facility, Medicaid revenues, calculated by multiplying each facility's promulgated rate in effect for such period by reported Medicaid days, as reported in a facility's 2012 cost report, will be divided by total Medicaid revenues of all non-specialty facilities. The result will be multiplied by the $50 million dollars, and divided by each facility's most recently reported Medicaid days. If a facility fails to submit a timely filed 2012 cost report, the previous year's cost report will be used.

(ii) The total quality scores as calculated above for each such facility shall be ranked and grouped by quintile. Each of the top three quintiles shall be allocated a share of the $50 million quality pool and each such facility within such top three quintiles shall receive a quality payment. Such quality payment shall be paid as a per diem adjustment for the 2013 calendar year. Such shares and payments shall be calculated as follows:

Distribution of Quality Pool and Quality Payments			
Facilities Grouped by Quintile	A Facility's Medicaid Revenue Multiplied by Award Factor	B Share of $50 Million Quality Pool Allocated to Facility	C Facility Per Diem Quality Payment

1st Quintile	Each facility's 2012 Medicaid days multiplied by 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by an award factor of 3	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's 2012 Medicaid days
2nd Quintile	Each facility's 2012 Medicaid days multiplied by 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by an	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's 2012 Medicaid days

	award factor of 2.25		
3rd Quintile	Each facility's 2012 Medicaid days multiplied by 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by an award factor of 1.5	Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million	Each facility's column B divided by the facility's 2012 Medicaid days
Total	Sum of Total Medicaid Revenue for all facilities	Sum of quality pool funds: $50 million	--

(f) The following facilities shall not be eligible for 2013 quality payments and the scores of such facilities shall not be included in determining the share of the quality pool or facility quality payments:

(i) A facility with health inspection survey deficiency data showing a level J/K/L deficiency during the measurement year (2012) or the payment year (2013) up until and including June 30, 2013. Deficiencies will be reassessed on October 1, 2013 to allow a three-month window (after the June 30, 2013 cutoff date) for potential Informal Dispute Resolutions (IDR) to process. The deficiency data will be updated to reflect IDRs occurring between July 1, 2013 and September 30, 2013. Any new J/K/L deficiencies between July 1, 2013 and September 30, 2013 will not be included in the 2013 quality pool.

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

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

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

(iii) A non-specialty facility's Medicaid revenue calculated by multiplying the non-specialty facility's July 7, 2011, rate (as communicated to facilities by Department letter dated November 9, 2011) by the non-specialty facility's 2010 Medicaid days or the most recently available Medicaid days as of October 24, 2011, and deemed not subject to subsequent reconciliation or adjustment. The Medicaid days used in the calculation provided for in subparagraphs (ii) and (iii) of this paragraph shall be identical.

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

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

(h) Qualified facilities shall be subject to a per diem reduction in accordance with this subdivision. Qualified facilities are residential health care facilities other than those facilities or units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children.

(1) Effective January 1, 2013, all qualified residential health care facilities will be subject to a per diem adjustment that is calculated to reduce Medicaid payments by $24 million for the period January 1, 2013 through March 31, 2013.

(2) Effective April 1, 2013, all qualified residential health care facilities will be subject to a per diem adjustment that is calculated to reduce Medicaid payments by $19 million for each state fiscal year beginning April 1, 2013.

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

(i) For each such facility, Medicaid revenues, calculated by multiplying each facility's promulgated rate in effect for such period by reported Medicaid days as reported in a facility's most recently available cost report, will be divided by total Medicaid revenues of all qualified facilities. The result will be multiplied by the amount of savings identified above for each such fiscal year, and divided by each facility's most recently reported Medicaid days.

(ii) Following the close of each fiscal year, the interim per diem adjustment effective January 1, 2013 through March 31, 2013, and April 1, 2013 through March 31, 2014 and in each state fiscal year thereafter will be reconciled using actual Medicaid claims data to determine the actual combined savings from the per diem adjustment and from the reduction in the payment for reserve bed days for hospitalizations from 95% to 50% of the Medicaid rate for such fiscal year. To the extent that such interim savings is greater than or less than $40 million, the per diem adjustment for each eligible provider in effect during such prior fiscal year will be adjusted proportionately such that $40 million in savings is achieved.

(i) Other provisions.

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

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

REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authority for this regulation is contained in Section 2808(2-c) of the Public Health Law (PHL) as enacted by Section 95 of Chapter 59 of the Laws of 2011, which authorizes the Commissioner to promulgate regulations, including emergency regulations, with regard to Medicaid reimbursement rates for residential health care facilities. Such rate regulations are set forth in Subpart 86-2 of Title 10 (Health) of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

Legislative Objectives:

Subpart 86-2 of Title 10 will be amended by adding a new section 86-2.42 to provide for the creation of a quality incentive pool intended to improve the quality of care among nursing home residents in Medicaid-certified facilities, and to reward facilities based on their performance compared to their peers.

The proposed regulation permits the Commissioner to establish benchmarks and measures toward achievement of raising overall quality. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals, as determined by the Commissioner, shall be a basis for declining to award quality incentive dollars to a facility.

Needs and Benefits:

The quality pool is needed to incentivize nursing facilities to maintain and improve the quality of care for their residents. The benefits of the quality pool include improving quality of care and, in turn, reducing overall health care costs. Specific benefits that fall under the umbrella of improving quality of care include reducing the

percent of residents with pressure ulcers, reducing antipsychotic medication use, reducing urinary tract infections, reducing depression, reducing pain, reducing unnecessary weight loss, and reducing avoidable hospitalizations. These quality of care improvements are associated with reductions in health care costs and improved quality of life for nursing home residents. The additional reimbursement provided by this adjustment will support the intent of the quality pool. Facilities can use the additional funds to facilitate quality improvements through activities including, but not limited to, increasing direct care staffing levels, providing training and education for staff, and utilizing technology.

Costs:

Costs to Private Regulated Parties:

There will be no additional costs to private regulated parties. The only additional data requested from providers are standard periodic report which are already being completed by providers.

Costs to State Government:

There is no additional aggregate increase in Medicaid expenditures anticipated as a result of these regulations, as the cost of the temporary rate adjustment will be offset by the overall reduction in Medicaid.

Costs to Local Government:

Local districts' share of Medicaid costs is statutorily capped; therefore, there will be no additional costs to local governments as a result of this proposed regulation.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of this proposed regulation.

Local Government Mandates:

The proposed regulation does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

The proposed regulation does not have any paperwork requirements for nursing facilities.

Duplication:

This is an amendment to an existing State regulation and does not duplicate any existing federal, state or local regulations.

Alternatives:

The authorizing statute, PHL Section 2808(2-c), specifically provides for facilitating quality improvements through the establishment of a nursing home quality pool. Therefore no alternatives were considered. The Department of Health worked in consultation with a workgroup of industry experts, comprised of representatives from five nursing home advocacy groups, as well as nursing home patient advocates to assist in the development of the quality pool. The quality measures included in the quality pool were decided upon with input and advice from the workgroup based on expert opinions, industry standards, available data, and quality measure outcomes being assessed at the national level. During development, the workgroup also provided input on the scoring methods of such quality measure outcomes.

Federal Standards:

The proposed regulation does not exceed any minimum standards of the federal government for the same or similar subject area.

Compliance Schedule:

This rule does not create new compliance or reporting requirements for nursing facilities in New York State.

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STATEMENT IN LIEU OF

REGULATORY FLEXIBILITY ANALYSIS

No regulatory flexibility analysis is required pursuant to section 202-(b)(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping or other compliance requirements on small businesses or local governments.

STATEMENT IN LIEU OF

RURAL AREA FLEXIBILITY ANALYSIS

No rural area flexibility analysis is required pursuant to section 202-bb(4)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse impact on facilities in rural areas, and it does not impose reporting, record keeping or other compliance requirements on facilities in rural areas. The New York State Nursing Home Quality Pool places no additional reporting requirements on any nursing facility or locality. The data used in the calculation of the quality pool resulting and per diem adjustments are culled from existing data sources including the nursing home cost report (RHCF-4, RHCF-2), data from the DOH Bureau of Immunization, Statewide Planning and Research Cooperative System data, and data from the Centers for Medicare and Medicaid Services.

JOB IMPACT STATEMENT

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature and purpose of the proposed rule, that it will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulation has no implications for job opportunities.