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**State/Territory Name:** **New York**

**State Plan Amendment (SPA) #:** **12-029**

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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


**Financial Management Group**

OCT 08 2014

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: State Plan Amendment (SPA) 12-029

Dear Commissioner Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-029. Effective January 1, 2013 this amendment proposes to implement a pay for performance quality incentive payment program for non-specialty nursing facilities and also provides for a proportional rate reduction.

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 implementing Federal regulations at 42 CFR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of January 1, 2013. We are enclosing the CMS-179 and the amended approved plan pages.

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

Sincerely,

Timothy Hill
Director

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<br><br>FOR: HEALTH CARE FINANCING ADMINISTRATION | 1. TRANSMITTAL NUMBER: **12-29** | 2. STATE **New York** |
|---|---|---|
| | 3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)** | |
| TO: REGIONAL ADMINISTRATOR<br>HEALTH CARE FINANCING ADMINISTRATION<br>DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE<br>**January 1, 2013** | |

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:<br>**Section 1902(a) of the Social Security Act, and 42 CFR 447** | 7. FEDERAL BUDGET IMPACT:<br>**a. FFY 01/01/13-09/30/13 $ 0**<br>**b. FFY 10/01/13-09/30/14 $ 0** |
|---|---|
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:<br><br>**Attachment 4.19-D: Pages 110(d)(21), 110(d)(22), 110(d)(22.1), 110(d)(23), 110(d)(23.1), 110(d)(24), 110(d)(25), 110(d)(26), 110(d)(27), 110(d)(28)** | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:<br><br>**Attachment 4.19-D: Pages 110(d)(21), 110(d)(22), 110(d)(23)** |

10. SUBJECT OF AMENDMENT:
**Nursing Home Quality Incentive**
**(FMAP = 50%)**

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:<br>**New York State Department of Health**<br>**Bureau of Federal Relations & Provider Assessments**<br>**99 Washington Ave – One Commerce Plaza**<br>**Suite 1460**<br>**Albany, NY 12210** |
|---|---|
| 13. TYPED NAME: **Jason A. Helgerson** | |
| 14. TITLE: **Medicaid Director**<br>**Department of Health** | |
| 15. DATE SUBMITTED: SEP 4 2014 | |

**FOR REGIONAL OFFICE USE ONLY**

| 17. DATE RECEIVED: | 18. DATE APPROVED: OCT 08 2014 |
|---|---|
| PLAN APPROVED – ONE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2013 | 20. SIGNATURE OF REGIONAL OFFICIAL: |
| 21. TYPED NAME: Kristin Fan | 22. TITLE: Deputy Director |

23. REMARKS:

FORM HCFA-179 (07-92)

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

p) For the calendar year 2012, the operating component of the price of each non-specialty facility that fails to submit to the Commissioner a timely and properly certified 2011 nursing home cost report and nursing home employee influenza immunization data [or reports on quality measures] for September 1, 2011 through March 31, 2012 [shall] will be subject to a per diem reduction. The per diem reduction [shall] will 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

For the calendar year 2013, the Commissioner will calculate a quality score, based on quality data from the 2012 calendar year (January 1, 2012 through December 31, 2012), for each non-specialty facility. For purposes of calculating a 2013 quality score, non-specialty facilities will exclude non-Medicaid facilities and CMS Special Focus Facilities. The quality score for each such non-specialty facility will be calculated using the following Quality, Compliance, and Potentially Avoidable Hospitalizations Measures.

| Quality Measures | |
|---|---|
| 1 | Percent of Long Stay High Risk Residents With Pressure Ulcers (As Risk Adjusted by the Commissioner) |
| 2 | Percent of Long Stay Residents Assessed and Given, Appropriately, the Pneumococcal Vaccine |
| 3 | Percent of Long Stay Residents Assessed and Given, Appropriately, the Seasonal Influenza Vaccine |
| 4 | Percent of Long Stay Residents Experiencing One or More Falls with Major Injury |
| 5 | Percent of Long Stay Residents Who have Depressive Symptoms |
| 6 | Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder |
| 7 | Percent of Long Stay Residents Who Lose Too Much Weight (As Risk Adjusted by the Commissioner) |
| 8 | Percent of Long Stay Residents Who Received an Antipsychotic Medication |
| 9 | Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain (As Risk Adjusted by the Commissioner) |
| 10 | Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased |
| 11 | Percent of Long Stay Residents with a Urinary Tract Infection |
| 12 | Percent of Employees Vaccinated for Influenza |

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

| | |
|---|---|
| 13 | Annual Percent Level of Temporary Contract Staff |
| 14 | CMS Five-Star Rating for Staffing |
| | **Compliance Measures** |
| 15 | CMS Five-Star Rating for Health Inspections as of April 1, 2013 |
| 16 | Timely Submission and Certification of Complete 2012 New York State Nursing Home Cost Report to the Commissioner |
| 17 | Timely Submission of Employee Influenza Data for September 1, 2012 - March 31, 2013 |
| | **Potentially Avoidable Hospitalizations Measure** |
| 18 | Rate of Potentially Avoidable Hospitalizations for Long Stay Episodes January 1, 2012 – December 31, 2012 (As Risk Adjusted by the Commissioner) |

The maximum points a facility may receive for the Quality Component is 60 points. The applicable percentages for each of the 14 measures will be determined for each facility and will be ranked and grouped by quintile with points awarded as follows:

| **Scoring for 14 Quality Measures** | |
|---|---|
| **Quintile** | **Points** |
| 1st Quintile | 4.29 |
| 2nd Quintile | 2.57 |
| 3rd Quintile | 0.86 |
| 4th Quintile | 0 |
| 5th Quintile | 0 |

**Note:** The long stay resident seasonal influenza and pneumococcal vaccine quality measures, and the annual percent level of temporary contract staff quality measure will not be ranked into quintiles. For the long stay resident seasonal influenza and pneumococcal measures, the facilities will be awarded maximum points (4.29) if the rate is 85% or greater, and zero points if the rate is less than 85%. For the annual percent level of temporary contract staff measure, the facilities will be awarded maximum points if the rate is less than 10%, and zero points if the rate is 10% or greater.

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 Residents Who Self-Report Moderate to Severe Pain: The covariate includes cognitive skills for daily decision making on the prior assessment.

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

- Percent of Long Stay High Risk Residents with Pressure Ulcers: The covariates include gender, age, healed pressure ulcer since the prior assessment, BMI, prognosis of less than six months of life expected, diabetes, heart failure, deep vein thrombosis, anemia, renal failure, hip fracture, bowel incontinence, paraplegia, and quadriplegia.

- 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 three 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, Appendix A-1.

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

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.

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 it results in a higher overall score for the facility affected. In this case, the quality points will be redistributed across the remaining quality measures.

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.

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.

# New York
# 110(d)(23)

The maximum points a facility may receive for the Compliance Component is 20 points. Points will be awarded as follows:

| Scoring for Compliance Measures | |
|---|---|
| **CMS Five-Star Rating for Health Inspections** | **Points** |
| 5 Stars | 10 |
| 4 Stars | 7 |
| 3 Stars | 4 |
| 2 Stars | 2 |
| 1 Star | 0 |
| **Submission of Timely Filed, Certified, and Complete Cost Report** | 5 (Facilities that fail to submit a timely, certified, and complete cost report will receive zero points) |
| **Timely Submission of Employee Influenza Data** | 5 (Facilities that fail to submit timely influenza data will receive zero points) |

Redistribution of Compliance Points:

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.

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.

The maximum points a facility may receive for the Potentially Avoidable Hospitalizations Component is 20 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 Potentially Avoidable Hospitalizations Measure | |
|---|---|
| **Quintile** | **Points** |
| 1st Quintile | 20 |
| 2nd Quintile | 16 |
| 3rd Quintile | 12 |
| 4th Quintile | 4 |
| 5th Quintile | 0 |

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

The Potentially Avoidable Hospitalizations measure 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: gender, age, race/ethnicity, payor, prior hospitalization (hospitalization less than or equal to 90 days before the long stay episode began), pneumonia, urinary tract infection, pressure ulcer, feeding tube, septicemia, parenteral nutrition, indwelling catheter, antibiotic-resistant infection, and Charlson Index*.

*The Charlson Index is a score based on several comorbidities following CMS specifications. In the statistical model, the Charlson Index is separated into the following three groups: Low (a score of less than or equal to 1), Mid (2-4), and High (5 and greater).The comorbidities were determined using (1) any MDS assessment during the resident's long stay episode, or (2) a hospitalization record up to 12 months before the resident's long stay episode began, or (3) a hospitalization record up to three days after the resident's long stay episode ended. The comorbidities used to create the Charlson Index include the following: myocardial infarction, congestive heart failure, peripheral vascular disease, cerbrovascular disease, dementia, chronic pulmonary disease, rheumatolic disease, peptic ulcer disease, mild liver disease, diabetes with complications, diabetes without complications, paraplegia and hemiplegia, renal disease, cancer/leukemia, moderate or severe liver disease, metastatic carcinoma, and AIDS/HIV

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

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 admitting diagnoses on the SPARCS hospital record are potentially avoidable:

| |
|---|
| **Respiratory Infections** |
| 466 Acute bronchitis |
| 480.0-487.8 Pneumonia |
| 507 Pneumonia |
| **Sepsis** |
| 038.0-038.9 Septicemia |
| **UTI** |
| 590.00-590.9 Infections of kidney |
| 595.0-595.4 Cystitis |
| 595.9 Cystitis |
| 595.89 Other type of cystitis |
| 597 Urethral abscess |
| 598 Urethral stricture due to infection<br>598.01 Urethral stricture due to infection |
| 599 Urinary tract infection |
| 601.0-604 Inflammation of prostate |
| **Electrolyte Imbalance** |
| 276.0-276.9 Disorders of fluid, electrolyte and acid-base balance |
| **CHF** |
| 428.0-428.9 Heart Failure |
| 398.91 Rheumatic heart failure |
| **Anemia** |
| 280-280.9 Iron deficiency anemias |
| 281.0-281.9 Other deficiency anemias |
| 285.1 Acute posthemorrhagic anemia |
| 285.29 Anemia of chronic illness |

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

- Specialty facilities, such as AIDS and pediatrics are excluded from the Quality Pool. Each such non-specialty facility, as defined by this paragraph, will be subject to a negative per diem adjustment to fund the quality pool. Specialty facility will 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

**New York**
**110(d)(25)**

or discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children. Non-specialty will mean all other facilities not defined as a specialty facility. The negative per diem adjustment will be calculated as follows:

- 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.

- The total quality 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 quality pool and each such facility within such top three quintiles will receive a quality payment. Such quality payment will be paid as a per diem adjustment for the 2013 calendar year. Such shares and payments will be calculated as follows:

| Distribution of Quality Pool and Quality Payments | | | |
|---|---|---|---|
| **Facilities Grouped by Quintile** | **A Facility's Medicaid Revenue Multiplied by Award Factor** | **B Share of $50 Million Quality Pool Allocated to Facility** | **C Facility Per Diem Quality Payment** |
| **1st Quintile** | Each facility's 2012 Medicaid days multiplied by 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by an award factor of 3 | Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million | Each facility's column B divided by the facility's 2012 Medicaid days |
| **2nd Quintile** | Each facility's 2012 Medicaid days multiplied by 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by an award factor of 2.25 | Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million | Each facility's column B divided by the facility's 2012 Medicaid days |
| **3rd Quintile** | Each facility's 2012 Medicaid days multiplied by 2013 Medicaid Rate as of January 1, 2013 = Total Medicaid Revenue multiplied by an award factor of 1.5 | Each facility's column A Divided by Sum of Total Medicaid Revenue for all facilities, Multiplied by $50 million | Each facility's column B divided by the facility's 2012 Medicaid days |
| **Total** | Sum of Total Medicaid Revenue for all facilities | Sum of quality pool funds: $50 million | = |

Payments made pursuant to this program will be subject to this rate adjustment and will be reconciled using actual Medicaid claims data.

**TN** #12-29 **Approval Date** OCT 08 2014

**Supersedes TN** NEW **Effective Date** JAN 01 2013

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

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

- 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 Nursing Home Quality Pool (NHQP).

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

1) In each year for each non-specialty facility computations [shall] will be made by the Department pursuant to subparagraphs (i) and (ii) below and per diem rate adjustments [shall] will 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 June 7, 2011, reflecting a new base year that is subsequent to 2002, [shall] will 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.

ii) 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 (i) and (ii) [above shall] will be identical.

iii) In year one the percentage will be 1.75%, in year two it [shall] will be 2.5%, in year three it [shall] will be 5.0%, in year four it [shall] will l be 7.5% and in year five it will be 10.0%. In year six, the prices calculated in this section [shall] will 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] will 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] will not result in a revision to the operating component of the price.

2) For rate computation purposes, "patient days" [shall] will 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.

**New York**
**110(d)(28)**

**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, 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.

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.

(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, 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.