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State/Territory Name: **New York**

State Plan Amendment (SPA) #: **16-0024**

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

APR 11 2017

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) TN 16-0024

Dear Mr. Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State Plan submitted under transmittal number (TN) 16-0024. Effective April 1, 2016 this amendment proposes to continue a pay for performance quality incentive payment program for non-specialty nursing facilities and a related 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. This letter is to inform you that New York 16-0024 is approved effective April 1, 2016. The CMS-179 and approved plan pages are enclosed.

If you have any questions, please contact Betsy Pinho at 518-396-3810.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

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: **16-0024**	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 **April 1, 2016**	

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: **§1902(r)(5) of the Social Security Act, and 42 CFR 447**	7. FEDERAL BUDGET IMPACT: **(in thousands)** **a. FFY 04/01/16-09/30/16 $ 0** **b. FFY 10/01/16-09/30/17 $ 0**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D: Pages 110(d)(21), 110(d)(22), 110(d)(22.1), 110(d)(22.2), 110(d)(22.3), 110(d)(23), 110(d)(24), 110(d)(25), 110(d)(25.1), 110(d)(26), 110(d)(27), 110(d)(28)**	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D: Pages 110(d)(21), 110(d)(22), 110(d)(22.1), 110(d)(22.2), 110(d)(22.3), 110(d)(23), 110(d)(24), 110(d)(25), 110(d)(25.1), 110(d)(26), 110(d)(27), 110(d)(28)**

10. SUBJECT OF AMENDMENT:
NH Quality Care Incentive Changes
(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: [redacted]	16. RETURN TO: **New York State Department of Health** **Bureau of Federal Relations & Provider Assessments** **99 Washington Ave – One Commerce Plaza** **Suite 1432** **Albany, NY 12210**
13. TYPED NAME: **Jason A. Helgerson**	
14. TITLE: **Medicaid Director** **Department of Health**	
15. DATE SUBMITTED: JUN 2 7 2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: APR 11 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 01 2016	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

New York
110(d)(21)

The New York State Nursing Home Quality Pool (NHQP) is an annual budget-neutral pool of $50 million dollars, or an amount as determined by the Commissioner. 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 guide the distribution of the funds in the NHQP.

[p)] For the calendar year [2015] 2016, the Commissioner will calculate a [quality] score and quintile ranking[,] based on [quality] data from the [2014] 2015 calendar year (January 1, [2014] 2015 through December 31, [2014] 2015), for each non-specialty facility. [For purposes of calculating a 2015 quality score, non-specialty facilities will exclude non-Medicaid facilities, and CMS Special Focus Facilities.] 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 shall 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, and facilities or discrete units within facilities that provide services solely to children. The [quality] score for each such non-specialty facility will be calculated using the following Quality, Compliance, and Efficiency Measures.

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

New York
110(d)(22)

8	Percent of Long Stay Antipsychotic Use in Persons with Dementia	Pharmacy Quality Alliance (PQA)
9	Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain (As Risk Adjusted by the Commissioner)	CMS
10	Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased	CMS
11	Percent of Long Stay Residents with a Urinary Tract Infection	CMS
12	Percent of Employees Vaccinated for Influenza	NYS DOH
13	Percent of Contract/Agency Staff Used	NYS DOH
14	Rate of Staffing Hours per Day [CMS Five-Star Quality Rating for Staffing as of April 1, 2015]	NYS DOH [CMS]
	Compliance Measures	
15	CMS Five-Star Quality Rating for Health Inspections as of April 1, [2015] 2016 (By Region)	CMS
16	Timely Submission and Certification of Complete [2014] 2015 New York State Nursing Home Cost Report to the Commissioner	NYS DOH
17	Timely Submission of Employee Influenza Immunization Data for the September 1, [2014] 2015 - March 31, [2015] 2016 Influenza Season by the deadline of May 1, [2015] 2016	NYS DOH
	Efficiency Measure	
18	Rate of Potentially Avoidable Hospitalizations for Long Stay Residents January 1, [2014] 2015– December 31, [2014] 2015 (As Risk Adjusted by the Commissioner)	NYS DOH

The maximum points a facility may receive for the Quality Component is 70. The applicable percentages or ratings for each of the 14 measures will be determined for each facility. Two measures will be awarded points based on threshold values. The remaining 12 measures will be ranked and grouped by quintile with points awarded as follows:

Scoring for 12 Quality Measures	
Quintile	**Points**
1st Quintile	5
2nd Quintile	3
3rd Quintile	1
4th Quintile	0
5th Quintile	0

Note: The following quality measures will not be ranked into quintiles and points will be awarded based on threshold values:

- Percent of employees vaccinated for influenza: facilities will be awarded five points if the rate is 85% or higher, and zero points if the rate is less than 85%.
- 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.

New York
110(d)(22.1)

Addition of New Measure to Quality Component

[Percent of Long Stay Antipsychotic Use in Persons with Dementia]

[This measure will replace the current CMS measure, Percent of Long Stay Residents Who Received an Antipsychotic Medication. NYS DOH will follow the measure specifications developed and endorsed by the Pharmacy Quality Alliance Quality Metrics Expert Panel. The measure specifications can be found at http://pqaalliance.org/measures as of June 30, 2015.]

[Addition of New Measures for Benchmarking Purposes Only
The following two staffing measures will be calculated and reported to nursing homes with the results of the 2015 NHQI. The measures will be reported for benchmarking purposes only and will not factor in to the scoring for the 2015 NHQI.]

Rate of [Nursing] Staffing Hours per Day

This measure will replace the CMS Five-Star Quality Rating for Staffing. NYS DOH will calculate an annualized adjusted rate of staffing hours per resident per day. For this measure, staff are defined as RNs, LPNs, and Aides. The observed staffing hours will be taken from the [2014] 2015 nursing home cost reports. The expected staffing hours will be determined using Resource Utilization Group data on the [2014] 2015 MDS 3.0 and the CMS 1995-1997 Staff Time Measurement Study. The observed-to-expected staffing hours will be adjusted using the statewide distribution and the formula adapted from the CMS Five-Star Quality Rating for Staffing at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/usersguide.pdf . The formula below will be used [as of June 30, 2015]:

(Hours worked reported from cost reports /# of residents from MDS 3.0) / 365 days

Divided by

((RUG distribution from MDS 3.0*hours from CMS time study)/# of residents from MDS 3.0) / 365 days

[Percent of Staff Turnover

NYS DOH will calculate an annual average staff turnover rate using 2014 nursing home cost report data. For this measure, staff are defined as full time and contract RNs, LPNs, and Aides. Per diem staff are excluded. NYS DOH will use the staff turnover formula put forth by the Advancing Excellence in America's Nursing Homes Campaign. The staff turnover formula as of June 30, 2015, can be found at https://www.nhqualitycampaign.org/goaldetail.aspx?g=ss#tab2.]

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 three [five] quality measures below will not be eligible to receive improvement points:

- [Percent of Long Stay Residents Who Received the Pneumococcal Vaccine (based on threshold in 2014 NHQI)]
- Percent of Employees Vaccinated for Influenza (based on threshold)

New York
110(d)(22.2)

- Percent of Contract/Agency Staff Used (based on threshold)
- [Long Stay Antipsychotic Use in Persons with Dementia (new measure)]
- [CMS Five-Star Quality Rating for Staffing as of April 1, 2015]
- Rate of Staffing Hours per Day (new measure)

The remaining 11 [ten] quality measures that are eligible for improvement points are listed below:

- Percent of Long Stay High Risk Residents With Pressure Ulcers
- Percent of Long Stay Residents Experiencing One or More Falls with Major Injury
- Percent of Long Stay Residents Who have Depressive Symptoms
- Percent of Low Risk Long Stay Residents Who Lose Control of Their Bowels or Bladder
- Percent of Long Stay Residents Who Lose Too Much Weight
- Percent of Long Stay Residents Who Self-Report Moderate to Severe Pain
- Percent of Long Stay Residents Whose Need for Help with Daily Activities Has Increased
- Percent of Long Stay Residents with a Urinary Tract Infection
- Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine
- Percent of Long Stay Antipsychotic Use in Persons with Dementia
- Percent of Long Stay Residents Who Received the Pneumococcal Vaccine

The grid below illustrates the method of awarding improvement points.

		[2014] 2015 Performance				
	Quintiles	1 (best)	2	3	4	5
[2015] 2016 Performance	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 [2014] 2015 NHQI performance is in the third quintile, and [2015] 2016 NHQI 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 Residents Who Self-Report Moderate to Severe Pain: the covariate includes cognitive skills for daily decision making on the prior assessment.
- 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, cancer, paraplegia, and quadriplegia.

New York
110(d)(22.3)

- 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.

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 base of 100 maximum NHQI points. The nursing home's total score will be the sum of its points divided by the base. This reduction can happen in the following scenarios:

- When nursing homes do not have enough cost report data to calculate a percent of contract/agency staff used or the rate of staffing hours per day; or
- When a quality measure has a denominator of less than 30

New York
110(d)(23)

The maximum points a facility may receive for the Compliance Component is 20 points. Points shall 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 and Certification of Complete [2014] 2015 New York State Nursing Home Cost Report to the Commissioner	5 (Facilities that fail to submit a timely, certified, and complete cost report will receive zero points)
Timely Submission of Employee Influenza Immunization Data	5 for the May 1, [2015] 2016 deadline [2.5 for the May 1, 2014 deadline] (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, [2015] 2016 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.

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 primary [admitting] ICD-9 and ICD-10* 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 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]

Potentially Avoidable Hospitalization Condition	ICD-9 codes	ICD-10 codes
Respiratory infection	466, 480.0-487.8, 507	A221, A3791, A481, B250, B440, J101, J1100, J111, J112, J1181, J1189, J120, J121, J122, J1281, J1289, J129, J13, J14, J150, J151, J1520, J15211, J15212, J1529, J153, J154, J155, J156, J157, J158, J159, J160, J168, J17, J180, J181, J189, J209, J690
Sepsis	038.0-038.9	A403, A409, A4101, A4102, A411, A412, A413, A414, A4150, A4151, A4152, A4153, A4159, A4189, A419, R6520, R6521
Urinary tract infection	590.00-590.9, 595.0-595.4, 595.9, 595.89, 597, 598, 598.01, 599, 601.0-604	N10, N110, N118, N12, N151, N159, N16, N2884, N2885, N2886, N3000, N3001, N3010, N3011, N3020, N3021, N3030, N3031, N3080, N3081, N3090, N3091, N340, N35111, N37, N390, N410, N411, N412, N413, N414, N418, N419, N420, N421, N423, N4289, N429, N430, N431, N432, N433, N451, N452, N453, N454, N51

Electrolyte imbalance	276.0-276.9	E860, E861, E869, E870, E871, E872, E873, E874, E875, E876, E878
Congestive heart failure	428.0-428.9, 398.91	I0981, I501, I5020, I5021, I5022, I5023, I5030, I5031, I5032, I5033, I5040, I5041, I5042, I5043, I509
Anemia	280-280.9, 281.0-281.9, 285.1, 285.29	D500, D501, D508, D509, D510, D511, D513, D518, D520, D521, D528, D529, D530, D531, D532, D538, D539, D62, D638

*The healthcare industry began using ICD-10 in the last quarter of 2015, therefore both ICD-9 and ICD-10 codes must be used.

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.

The following rate adjustments, which will be applicable to the [2015] 2016 calendar year, will be made to fund the [NHQI] NHQP and to make [quality] payments based upon the scores calculated from the NHQI as described above.

- [Specialty facilities, such as AIDS and pediatrics facilities, and discrete units within facilities that provide extensive nursing, medical, psychological and counseling support services solely to children, are excluded from the NHQI. Each such non-specialty facility, as defined by this paragraph, will be subject to a negative per diem adjustment to fund the NHQP. 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 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.] Each [such] non-specialty facility will be subject to a [negative per diem adjustment] 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 promulgated rate in effect for such period by reported Medicaid days, as reported in a facility's 2015 [2014] 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 2015 [2014] cost report, the [previous year's] most recent 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 NHQI 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 [2015] 2016 calendar year. Such shares and payments will be calculated as follows:

New York
110(d)(25.1)

Distribution of [NHQI and Quality] NHQP Payments			
Facilities Grouped by Quintile	**A Facility's Medicaid Revenue Multiplied by Award Factor**	**B Share of $50 Million NHQI Allocated to Facility**	**C Facility Per Diem Quality Payment**
1st Quintile	Each facility's [2014] 2015 Medicaid days multiplied by [2015] 2016 Medicaid Rate as of January 1, [2015] 2016 = 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 [2014] 2015 Medicaid days
2nd Quintile	Each facility's [2014] 2015 Medicaid days multiplied by [2015] 2016 Medicaid Rate as of January 1, [2015] 2016 = 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 [2014] 2015 Medicaid days
3rd Quintile	Each facility's [2014] 2015 Medicaid days multiplied by [2015] 2016 Medicaid Rate as of January 1, [2015] 2016 = 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 [2014] 2015 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.

New York
110(d)(26)

The following facilities will not be eligible for [2015] 2016 [quality] payments and the scores of such facilities will not be included in determining the share of the [NHQI or facility quality] NHQP payments:

- A facility with health inspection survey deficiency data showing a level J/K/L deficiency during the time period of July 1, [2014] 2015 through June 30, [2015] 2016. Deficiencies will be reassessed on October 1, [2015] 2016 to allow a three-month window (after the June 30, [2015] 2016 cutoff date) for potential Informal Dispute Resolutions (IDR) to process. The deficiency data will be updated to reflect IDRs occurring between July 1, [2015] 2016 and September 30, [2015] 2016. Any *new* J/K/L deficiencies between July 1, [2015] 2016 and September 30, [2015] 2016 will *not* be included in the [2015] 2016 NHQI.

[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 will be made by the Department pursuant to subparagraphs (i) and (ii) below and per diem rate adjustments 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), 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, 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) will be identical.

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

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