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State/Territory Name: **NEW YORK**

State Plan Amendment (SPA) #: **14-0018**

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

FEB 1 9 2015

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) 14-0018

Dear Commissioner Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 14-0018. Effective February 12, 2015, 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. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of February 12, 2015. 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.

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

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **14-0018**

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: **February 12, 2015**

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(a) of the Social Security Act, and 42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 02/12/15-09/30/15 $ 0
b. FFY 10/01/15-09/30/16 $ 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)(23.1), 110(d)(24), 110(d)(25), 110(d)(25.1), 110(d)(26)

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)(23), 110(d)(23.1), 110(d)(24), 110(d)(25), 110(d)(26)

10. SUBJECT OF AMENDMENT:
2014 Nursing Home Quality Incentive Pool
(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:

13. TYPED NAME: **Jason A. Helgerson**

14. TITLE: **Medicaid Director**
Department of Health

15. DATE SUBMITTED: June 30, 2014

16. RETURN TO:
New York State Department of Health
Bureau of Federal Relations & Provider Assessments
99 Washington Ave – One Commerce Plaza
Suite 1460
Albany, NY 12210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: FEB 19 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: FEB 12 2015

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

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

FEB 1 9 2015

Jason A. Helgerson
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Sincerely,

Timothy Hill
Director

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 for September 1, 2011 through March 31, 2012 will be subject to a per diem reduction. The per diem reduction 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] 2014, the Commissioner will calculate a quality score, based on quality data from the [2012] 2013 calendar year (January 1, [2012] 2013 through December 31, [2012] 2013), for each non-specialty facility. For purposes of calculating a [2013] 2014 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] Efficiency 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 Who Received [Assessed and Given, Appropriately,] the Pneumococcal Vaccine
3	Percent of Long Stay Residents Who Received [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

13	[Annual Percent Level of Temporary Contract Staff] Percent of Contract/Agency Staff Used
14	CMS Five-Star Quality Rating for Staffing as of April 1, 2014
	Compliance Measures
15	CMS Five-Star Quality Rating for Health Inspections as of April 1, [2013] 2014 (By Region)
16	Timely Submission and Certification of Complete [2012] 2013 New York State Nursing Home Cost Report to the Commissioner
17	Timely Submission of Employee Influenza Immunization Data for the September 1, [2012] 2013 - March 31, [2013] 2014 Influenza Season by the two deadlines of November 15, 2013 and May 1, 2014
	[Potentially Avoidable Hospitalizations] Efficiency Measure
18	Rate of Potentially Avoidable Hospitalizations for Long Stay Episodes January 1, [2012] 2013 – December 31, [2012] 2013 (As Risk Adjusted by the Commissioner)

The maximum points a facility may receive for the Quality Component is [60] 70 [points]. The applicable percentages or ratings for each of the 14 measures will be determined for each facility. Three measures will be awarded points based on threshold values. The remaining 11 measures [and] will be ranked and grouped by quintile with points awarded as follows:

Scoring for [14] 11 Quality Measures	
Quintile	**Points**
1st Quintile	[4.29] 5
2nd Quintile	[2.57] 3
3rd Quintile	[0.86] 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 long stay residents who received the pneumococcal vaccine: 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.

[Long stay resident seasonal influenza and pneumococcal vaccine quality measure, and the annual percent level of temporary contract staff annual level of temporary contract/agency staff used quality measure will not be ranked into quintiles. For the long stay resident seasonal influenza and pneumococcal measure, 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.]

Awarding for Improvement

Effective in the 2014 Nursing Home Quality Initiative (NHQI), 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. Five quality measures will not be eligible to receive improvement points. These include the three quality measures that are based on threshold values, the CMS Five-Star Quality Rating for Staffing, and the Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine. The Percent of Long Stay Residents Who Received the Seasonal Influenza Vaccine measure was based on a threshold value in the 2013 NHQI, but has been changed to quintiles in the 2014 NHQI. The nine quality measures 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 Received an Antipsychotic Medication
- 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

The grid below illustrates the method of awarding improvement points.

		2013 Performance				
	Quintiles	1 (best)	2	3	4	5
2014 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

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.
- 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 annual level of temporary contract/agency staff used 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.]

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;

- When a quality measure has a denominator of less than 30; or
- When a facility does not have a CMS Five-Star Quality Rating for Staffing

For example, if 2013 NHQI performance is in the third quintile, and 2014 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.

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
[Submission of Timely Filed, Certified, and Complete Cost Report] Timely Submission and Certification of Complete 2013 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 total; [5] 2.5 for the November 15, 2013 deadline 2.5 for the May 1, 2014 deadline (Facilities that fail to submit timely influenza data by the deadline will receive zero out of the 2.5 points for that specific deadline)

CMS Five-Star Quality Rating for Staffing Regional Adjustment

The CMS Five-Star Quality Rating for Health Inspections as of April 1, 2014 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.

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

Reduction of Points Base: When a compliance measure is not available for a nursing home, the number of points the measure is worth will be reduced from the 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 when a facility does not have a CMS Five-Star Quality Rating for Health Inspections.

[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] Efficiency Component is [20] 10 points. The rates of potentially avoidable hospitalizations will be determined for each facility and each such rate will be ranked and grouped by quintile with points awarded as follows:

Scoring for Efficiency (Potentially Avoidable Hospitalizations) Measure	
Quintile	**Points**
1st Quintile	[20] 10
2nd Quintile	[16] 8
3rd Quintile	[12] 6
4th Quintile	[4] 2
5th Quintile	0

The Efficiency [Potentially Avoidable Hospitalizations m] 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.

Attachment 4.19-D

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 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
[illegible]
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
[illegible]
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

Reduction of Points Base: When the number of long stay episodes 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 [2013] 2014 calendar year, will be made to fund the NHQI [quality pool] and to make quality payments based upon the scores calculated 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 [Quality Pool]. Each such non-specialty facility, as defined by this paragraph, will be subject to a negative per diem adjustment to fund the NHQI [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

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] Each such non-specialty facility will be subject to a negative per diem adjustment 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 [2012] 2013 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] 2013 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 NHQI [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] 2014 calendar year. Such shares and payments will be calculated as follows:

New York
110(d)(25.1)

[illegible]	[illegible]	[illegible]	[illegible]
1st Quintile	Each facility's [2012] 2013 Medicaid days multiplied by [2013] 2014 Medicaid Rate as of January 1, [2013] 2014 = 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] 2013 Medicaid days
2nd Quintile	Each facility's [2012] 2013 Medicaid days multiplied by [2013] 2014 Medicaid Rate as of January 1, [2013] 2014 = 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] 2013 Medicaid days
3rd Quintile	Each facility's [2012] 2013 Medicaid days multiplied by [2013] 2014 Medicaid Rate as of January 1, [2013] 2014 = 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] 2013 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.

The following facilities will not be eligible for [2013] 2014 quality payments and the scores of such facilities will not be included in determining the share of the NHQI [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] time period of July 1, 2013 through June 30, 2014. Deficiencies will be reassessed on October 1, [2013] 2014 to allow a three-month window (after the June 30, [2013] 2014 cutoff date) for potential Informal Dispute Resolutions (IDR) to process. The deficiency data will be updated to reflect IDRs occurring between July 1, [2013] 2014 and September 30, [2013] 2014. Any *new* J/K/L deficiencies between July 1, [2013] 2014 and September 30, [2013] 2014 will *not* be included in the [2013] 2014 [Nursing Home Quality Pool] [(NHQP)] 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