STATE OF NEW YORK
PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

COMMITTEE MEETING

July 25, 2012
10:15 a.m.

Century House
997 New Loudon Road (Route 9)
Main Ball Room
Latham, New York 12110

I. COMMITTEE ON CODES, REGULATIONS AND LEGISLATION — Exhibit #1

Angel Gutiérrrez, M.D., Chair

For Emergency Adoption

Subpart 86-2 of Title 10 NYCRR – Sprinkler Systems

For Discussion

Section 400.25 of Title 10 NYCRR – Nursing Quality Indicators

II. COMMITTEE ON PUBLIC HEALTH

Dr. Jo Ivey Boufford, Chair, Committee on Public Health

III. COMMITTEE ON HEALTH PLANNING

Dr. John Rugge, Chair, Committee on Health Planning

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by section 2803(2) of the Public Health Law, Subpart 86-2 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended by adding a new section 86-2.41 to be effective upon filing with the Secretary of State, to read as follows:

86-2.41 Sprinkler systems

(a) Subject to the availability of federal financial participation, the capital cost components of the rates of eligible residential health care facilities for periods on and after the effective date of this regulation shall be adjusted in accordance with the following:

(1) For the purposes of this subdivision, eligible facilities are those facilities which the commissioner determines are financially distressed in terms of their being unable to finance, at terms acceptable to the commissioner, the installation of automatic sprinkler systems, in conformity with the provisions of federal regulations set forth in 42 CFR 483.70(a)(8). In making such determinations of eligibility the commissioner shall consider information obtained from a facility's cost report, other more recent financial information to be provided by the facility, and such other information as may be required by the commissioner, including, but not limited to:

(i) operating profits and losses;

(ii) eligibility for funding pursuant to subdivision twenty-one of section 2808 of the Public Health Law;

(iii) unrestricted fund balances;

(iv) documentation demonstrating the inability of the facility to obtain credit, at terms acceptable to the commissioner, without the reimbursement treatment accorded pursuant to this section;

(v) working capital;

(vi) days of cash expense on hand;

(vii) days of revenue in accounts receivable;

(viii) transfers and withdrawals;

(ix) information related to the health and safety of a facility's residents;

(x) other financial information as may be required from the facility by the commissioner; and

(xi) the filing of a Notice pursuant to Subdivision 1-a of Section 2802 of the Public Health Law, or the receipt of required CON approvals, as appropriate.

(2) The capital cost component of the Medicaid rates of each eligible facility shall be adjusted in an amount, as determined by the commissioner, to reflect the costs of the annual debt service related to the financing of equipment and other capital improvements directly related to the financing of an automatic sprinkler system that will be in compliance with applicable federal regulations.

(3) As a condition for receipt of funding pursuant to this section, each such facility shall submit to the commissioner the costs of the project, the proposed terms of the financing, including interest rate and term of the financing, and other such information as may be required by the Commissioner. Prior to the due date of the first debt service payment related to such financing, each eligible facility shall prepare a schedule setting forth by month the estimated debt service payable over the life of the financing. Such schedule, project and

financing terms, along with such other information as may be required by the commissioner, shall be provided to the commissioner for review and approval at least sixty days prior to the due date of such first debt service payment, or such shorter period as the commissioner may permit.

(4) As a condition for receipt of funding pursuant to this section, Medicaid revenues attributable to the rate adjustments authorized by this subdivision and any other additional facility revenues needed to cover scheduled debt service payments relating to the financing of an automatic sprinkler system that is in compliance with federal regulation as described in this section, shall be deposited into a separate account maintained by the facility and the deposits in such account shall be used solely for the purpose of satisfying such debt service payments.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authority for this regulation is contained in the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by section 2803(2) of the Public Health Law, Subpart 86-2 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York.

Legislative Objectives:

Federal regulations require that on or before August 13, 2013, all nursing homes be protected throughout by a supervised automatic sprinkler system. Subpart 86-2 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended by adding a new section 2.41 to assist eligible nursing homes (i.e., those which are determined to be financially distressed) with accessing the credit markets to finance the costs of equipment and other capital costs directly related to the installation of an automatic sprinkler system that is compliant with the Federal regulations. To provide an immediate source of revenue to financially distressed nursing homes to pay the debt service on loans to finance sprinkler systems, the Medicaid capital rate will be adjusted to accelerate the reimbursement of such costs (e.g., reimbursement will begin in 2012 rather than 2014 – the normal 2 year lag under which capital reimbursement normally occurs). In addition, to provide assurance to prospective lenders that such funds will be available to pay debt service, the proposed regulation also requires eligible facilities to deposit in a separate account Medicaid revenues attributable to the capital rate adjustments for sprinklers, and other facility revenues as may be required to cover 100% of debt service payments due. The funds held in such separate account may only be used

for the purpose of paying the debt service on the outstanding sprinkler loans. The Department of Health estimates there are approximately 98 nursing homes that are financially distressed and that do not meet the Federal mandate for sprinklers.

Needs and Benefits:

Federal regulations require that all nursing homes be protected by an automatic sprinkler system. There are roughly 98 nursing homes that are not compliant with the Federal mandate and that are estimated to be financially distressed (as described by the criteria established in the regulation). This regulation will ensure that the health and safety of nursing homes residents is protected and access to care is maintained by ensuring that financially distressed nursing homes avoid penalties for non-compliance (i.e., civil monetary penalties, the denial of Medicare and Medicaid payment for new admissions, the termination of Medicaid and Medicare provider certifications).

Costs to Private Regulated Parties:

There will be no additional costs to private regulated parties.

Costs to State Government:

There is no additional aggregate increase in Medicaid expenditures anticipated as a result of these regulations. The acceleration of the reimbursement of Medicaid capital costs anticipated by this provision will be accommodated in the nursing home appeals cap and in the processing of annual capital rates. Depending on the terms of the financing, it is likely the acceleration of capital costs will reduce over the life debt service costs and result in long term savings for the State.

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 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 regulation will require nursing homes to apply to the Department to determine if they meet the financially challenged criteria established by the regulation and to submit a schedule of debt service payments. This additional paperwork is expected to be minimal, as the Department will primarily use information already required to be submitted by nursing homes (i.e., annual cost report data) to determine eligibility and to reimburse capital costs.

Duplication:

These regulations do not duplicate existing state or federal regulations. These regulations will assist financially distressed nursing homes with meeting the requirements of an existing federal regulation for sprinkler systems.

Alternatives:

The regulation is prompted by the requirement that nursing homes comply with the Federal mandate for sprinklers and the lack of alternative financing vehicles for financially distressed homes that cannot, in the absence of this regulation, independently access the credit

markets. Absent this regulation, nursing homes that are unable to comply with the Federal mandate are at risk for losing their provider certifications.

Federal Standards:

The regulation will assist nursing homes with meeting an existing Federal mandate which requires nursing homes to be equipped with an automatic sprinkler system.

Compliance Schedule:

This proposed regulation will help nursing homes meet the August 13, 2013 deadline for becoming compliant with Federal regulations that require homes to be equipped with an automatic sprinkler system.

Contact Person: Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
Corning Tower Building, Rm 2438
Empire State Plaza
Albany, NY 12237
(518) 473-7488
(518) 473-2019 (FAX)
REGSQNA@health.state.ny.us

REGULATORY FLEXIBILITY ANALYSIS
FOR
SMALL BUSINESSES AND LOCAL GOVERNMENTS

Effect of Rule:

For the purpose of this regulatory flexibility analysis, small businesses were considered to be residential health care facilities with 100 or fewer employees. Based on recent financial and statistical data extracted from Residential Health Care Facility Cost Reports, approximately 60 residential health care facilities (i.e., nursing homes) were identified as employing fewer than 100 employees. It is estimated that 7 of these small business nursing homes are not currently compliant with Federal regulations requiring automatic sprinklers and will meet the financially distressed criteria established by this regulation.

This rule will have no direct effect on local governments.

Compliance Requirements:

There are no new compliance requirements. The regulation will assist financially distressed nursing homes, 7 of which are estimated to be small businesses, with meeting an existing Federal mandate which requires all nursing homes be protected throughout by an automatic sprinkler system.

Professional Services:

No new or additional professional services are required by small business nursing homes to apply to the Department to determine if they are eligible to receive accelerated Medicaid reimbursement of capital costs for sprinklers.

Compliance Costs:

There are no new compliance costs. The regulation will assist financially distressed nursing homes, 7 of which are estimated to be small businesses, with meeting an existing Federal mandate which requires all nursing homes be protected throughout by an automatic sprinkler system.

Economic and Technological Feasibility:

The proposed rule doesn't require additional technological or economic requirements.

Minimizing Adverse Impact:

This regulation will assist homes, some of which will be small businesses as described above, with meeting the requirements of Federal regulations that mandate all nursing homes be protected by an automatic sprinkler system. Assisting nursing homes (including nursing homes which are small businesses), with meeting this mandate will minimize the adverse implications of failing to comply, which include potentially jeopardizing the health and safety of nursing home residents, civil monetary penalties, the denial of Medicare and Medicaid payment for new admissions, and the termination of Medicaid and Medicare provider certifications.

Small Business and Local Government Participation:

The Department, in collaboration with the Nursing Home Industry Associations (which include representation of small business nursing homes) worked collaboratively to develop the regulation. In addition, a Federal Public Notice, published in the New York State Register invited comments and questions from the general public.

RURAL AREA FLEXIBILITY ANALYSIS

Effect on Rural Areas:

Rural areas are defined as counties with populations less than 200,000 and, for counties with populations greater than 200,000, include towns with population densities of 150 persons or less per square mile. The following 43 counties have populations of less than 200,000:

Allegany	Hamilton	Schenectady
Cattaraugus	Herkimer	Schoharie
Cayuga	Jefferson	Schuyler
Chautauqua	Lewis	Seneca
Chemung	Livingston	Steuben
Chenango	Madison	Sullivan
Clinton	Montgomery	Tioga
Columbia	Ontario	Tompkins
Cortland	Orleans	Ulster
Delaware	Oswego	Warren
Essex	Otsego	Washington
Franklin	Putnam	Wayne
Fulton	Rensselaer	Wyoming
Genesee	St. Lawrence	Yates
Greene		

The following nine counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

There are no new compliance requirements. The regulation will assist approximately 98 financially distressed nursing homes that are located across the State, including in many of the counties listed above, with meeting an existing Federal mandate which requires all nursing homes be protected throughout by an automatic sprinkler system.

Professional Services:

No new or additional professional services are required by nursing homes located in rural areas to apply to the Department to determine if they are eligible to receive accelerated Medicaid reimbursement of capital costs for sprinklers.

Compliance Costs:

No additional compliance costs are anticipated as a result of this regulation. The regulation will assist financially distressed nursing homes located across the State, including in many of the counties listed above, with meeting an existing Federal mandate which requires all nursing homes be protected throughout by an automatic sprinkler system.

Minimizing Adverse Impact:

This regulation will assist nursing homes located across the State, with meeting the requirements of Federal regulations that mandate all nursing homes be protected by an automatic sprinkler system. Assisting nursing homes (including nursing homes located in many of the counties listed above), with meeting this mandate will minimize the adverse implications of failing to comply, which include potentially jeopardizing the health and safety of nursing home residents, civil monetary penalties, the denial of Medicare and Medicaid payment for new admissions, and the termination of Medicaid and Medicare provider certifications.

Rural Area Participation:

The Department, in collaboration with the Nursing Home Industry Associations (which include representation of rural nursing homes) worked collaboratively to develop the regulation. In addition, a Federal Public Notice, published in the New York State Register invited comments and questions from the general public.

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 not expected that the proposed rule to accelerate capital reimbursement for costs related to the installation of automatic sprinkler systems will have a material impact on jobs or employment opportunities across the Nursing Home industry.

EMERGENCY JUSTIFICATION

It is necessary to issue the proposed regulations on an emergency basis in order to ensure financially challenged nursing homes can secure the loans required to finance and perform the necessary work required to purchase and install a Federally compliant sprinkler system on or before August 13, 2013. Providing nursing homes as much time as possible to meet the Federal requirements will protect the health and safety of nursing homes residents by maintaining access to care and ensuring that financially distressed nursing homes avoid penalties for non-compliance (i.e., civil monetary penalties, the denial of Medicare and Medicaid payment for new admissions, and the termination of Medicaid and Medicare provider certifications).

Pursuant to the authority vested in the Public Health and Health Planning Council and the Commissioner of Health by Sections 2803 and 2805-t of the Public Health Law, a new Section 400.25 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is hereby added, to be effective upon publication of a Notice of Adoption in the New York *State Register*, to read as follows:

A new Section 400.25 is added to read as follows:

Section 400.25 Disclosure of Quality and Surveillance Related Information

(a) Scope. Every general hospital and residential health care facility with an operating certificate pursuant to the requirements set forth in Public Health Law Article 28 shall make available to any member of the public and to the commissioner of any state agency responsible for licensing or accrediting the facility, or responsible for overseeing the delivery of services either directly or indirectly, information regarding nursing quality indicators upon request.

(b) Definitions. For purposes of this section, current evidenced-based definitions and quality measures of nationally recognized governmental, health and nursing quality experts have been utilized. Expectations regarding the definitions and quality measures will be revised to comport with these changing standards. The following terms currently have the following meanings:

(1) *Acuity* means the nursing care requirements of patients or residents.

(2) *Case mix* means the differences in patients or residents within a population in terms of their physical and mental conditions, and the resources that are used in their care.

(3) *Methods used in determining and adjusting staffing levels to patient care needs* means the procedures and processes used to determine staffing based on patient or resident case mix and/or acuity.

(4) *Registered Professional Nurse* means a person who is licensed and currently registered as a Registered Professional Nurse pursuant to Article 139 of the New York State Education Law.

(5) *Licensed Practical Nurse* means a person who is licensed and currently registered as a Licensed Practical Nurse pursuant to Article 139 of the New York State Education Law.

(6) *Unlicensed assistive personnel* means individuals trained to function in an assistive role to nurses in the provision of patient care, as assigned by and under the supervision of the registered professional nurse.

(7) *Unit* means a distinct location providing patient care in a general hospital or residential health care facility distinguished from other distinct locations by name, number or other patient specific factors.

(8) *Shift*, for purposes of this regulation, means a 24 hour period of time as a whole or divided into parts as appropriate to the reporting facility.

(9) *Direct care nursing staff* are unit based Registered Professional Nurses, Licensed Practical Nurses and unlicensed assistive personnel who actually provide direct patient or resident care greater than 50% of their shift.

(10) *Skill mix means the p*ercentage of the total number of direct care patient/resident hours worked by Registered Professional Nurses, Licensed Practical Nurses and unlicensed assistive personnel each.

(11) *Patient/resident day means* the number of days of patient/resident care provided by a unit over a prescribed period of time.

(12) *Complaint and Survey outcomes* means the final conclusions of complaint investigation(s) filed with any state or federal regulatory agency or accrediting agency and survey(s) resulting in citation(s).

(13) *For General Hospitals Fall means* an unplanned descent to the floor with or without injury to the patient including unassisted and assisted falls whether they result from physiological or environmental reasons.

(14) *For Residential Health Care Facilities Fall* means an unintentional change in position coming to rest on the ground, floor or onto the next lower surface with or without injury to the resident including intercepted falls.

(15) *Fall Injury Levels for General Hospitals* means the degree of injury resulting from a fall and designated as moderate, major or fatal as follows:

(i) Moderate: falls that involve suturing, application of steri-strips/skin glue, splinting or muscle/joint strain.

(ii) Major: falls that involve surgery, casting or traction, or require consultation to rule out neurological or internal injury or patients with coagulopathy that receive blood products as a result of the fall.

(iii) Fatal: falls that involve injuries that cause the patient's death. Fatal falls do not include falls caused by physiologic events.

(16) *Fall Injury Level for Residential Health Care Facilities* means the degree of injury resulting from a fall designated as major and defined as follows:

(i) Major: falls that involve bone fractures, joint dislocations, closed head injuries with altered consciousness or subdural hematoma.

(17) *Healthcare acquired pressure ulcer* means a localized injury to the skin and/or underlying tissue as a result of pressure or pressure in combination with shear acquired after admission to a healthcare facility.

(18) *Healthcare setting associated infections* means any localized or systemic patient condition that: (1) resulted from the presence of an infectious agent(s) or its toxin(s) as determined by clinical examination or by laboratory testing; and (2) was not found to be present or incubating at the time of admission unless the infection was related to a previous admission to the same setting.

(19) High risk residential health care facility residents who have pressure ulcers means those residents who have medical conditions that may predispose them to developing a pressure ulcer.

(c) *Nursing Quality Indicators.* Nursing quality indicators are nurse staffing indicators and nurse sensitive patient outcome indicators.

(1) Nurse Staffing Indicators

(i) Nurse staffing indicators for general hospitals:

(a) Nursing hours per patient day, which is the actual number of hours of nursing care provided by direct care nursing staff per patient day per unit per shift;

(b) Registered Professional Nurse staffing indicators as follows:

(1) Number of Registered Professional Nurses who actually provide direct nursing care per unit per shift;

(2) Percentage of total direct nursing care hours actually provided by Registered Professional Nurses per unit per shift;

(3) Registered Professional Nurse hours per patient day, which is the actual number of hours of nursing care provided by direct care Registered Professional Nurses per patient day per unit per shift; and

(4) Registered Professional Nurse to patient ratio, which is the number of patients assigned to and cared for by one direct care Registered Professional Nurse per unit per shift.

(c) Licensed practical nurse staffing indicators are as follows:

(1) Number of Licensed Practical Nurses who actually provide direct nursing care per unit per shift;

(2) Percentage of total direct nursing care hours actually worked by Licensed Practical Nurses per unit per shift; and

(3) Licensed Practical Nurse hours per patient day, which are the actual number of hours of nursing care provided by direct care Licensed Practical Nurses per patient day per unit per shift.

(d) Unlicensed assistive personnel staffing indicators are as follows:

(1) Number of unlicensed assistive personnel who actually provide direct patient/resident care per unit per shift; and

(2) Percentage of total direct patient/resident care hours actually provided by unlicensed assistive personnel per unit per shift.

(ii) Nurse Staffing Indicators for Residential Health Care Facilities:

(a) Total number of direct resident care staff and the number of Registered Professional Nurses, Licensed Practical Nurses, and unlicensed personnel utilized to provide direct resident care per facility, per unit and per shift;

(b) The percentage of the total direct resident care staff made up by Registered Professional Nurses, Licensed Practical Nurses, and unlicensed personnel each of per facility, per unit and per shift; and

(c) Total number of hours of direct resident care actually provided by Registered Professional Nurses, Licensed Practical Nurses and unlicensed personnel per facility, per unit, per shift; and

(d) Number of hours of direct nursing care actually provided by Registered Professional Nurses and Licensed Practical Nurses per resident day per facility, per unit, per shift.

(e) Staff to patient ratios for Registered Professional Nurses and Licensed Practical Nurses actually providing direct nursing care per facility, per unit, per shift.

(2) Nurse Sensitive Patient Outcome Indicators

(i) General Hospitals

(a) Falls with injury rate as indicated by the frequency in which falls result in a fall injury level of moderate, major or fatal per applicable unit calculated with a frequency consistent with federal quality improvement initiatives**;**

(b) Healthcare setting acquired pressure ulcers as indicated by the percent of patients with facility acquired pressure ulcer(s) of the skin that are determined to be stages II, III, IV, unstageable, and suspected deep tissue injury per applicable unit calculated with a frequency consistent with federal quality improvement initiatives**;** and

(c) Healthcare acquired infection (HAI) rates per applicable unit calculated with a frequency consistent with federal quality improvement initiatives for the following:

(1) Central line associated blood stream infection (CLABSI);

(2) Catheter associated urinary tract infection (CAUTI); and

(3) Ventilator associated (pneumonia) event (VAE).

(ii) Residential Health Care Facilities

(a) Percent of long-stay residents who experienced one or more falls with major injury;

(b) Percentage of high-risk short-stay residents with new or worsening

pressure ulcers Stage II-IV;

(c) Percentage of long-stay residents with urinary tract infections.

(d) Disclosure.

(1) Hospitals and residential health care facilities shall provide upon request by a member of the public, by the Commissioner, or by any Commissioner of a state agency responsible for licensing or accrediting the hospital or residential health care facility or responsible overseeing the delivery of services either directly or indirectly, the following items:

(i) Methods used in determining and adjusting staffing levels to patient/resident nursing care needs;

(ii) Nursing quality indicators as set forth in subdivision (c) of this section;

(iii) Complaint and survey final conclusions as set forth at subdivision (b)(10) of this section; and

(iv) Identification of the source(s) and date(s) for data disclosed.

(2) Timeliness of data disclosed.

(i) Data disclosed shall cover a period of no less than three months and not to exceed the most recent twelve-month period prior to the date of request.

(ii) A facility shall make such information available to a requestor no later than 30 business days from the date of receipt of the request.

(3) Data disclosure

(i) The format of data to be disclosed to requestors should be guided by existing format of the data when the request is received and ease of translation of data from the existing format to format requested.

(ii) Existing data from different sources can be used as resources for the data to be disclosed as long as they satisfy the data request.

(iii) Facilities should make reasonable efforts to disclose requested data in the format requested.

(e) Policy, Procedure and Recordkeeping

(1) Facilities shall have policies and procedures for documentation and management of requests and responses to requests for nursing quality indicator data.

(2) Records shall be kept of requests made and filled for nursing quality indicator data for a period of no less than two years from the date the request for information was received.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The authority for the promulgation of this regulation is contained in Public Health Law (PHL) Sections 2803 and 2805-t.

PHL Section 2803 outlines the powers and duties of the Commissioner. It also authorizes the Public Health and Health Planning Council (PHHPC) to adopt and amend rules and regulations, subject to the approval of the Commissioner, to implement the purposes and provisions of PHL Article 28, and to establish minimum standards governing the operation of health care facilities.

Section 2805-t specifies that the Commissioner shall promulgate rules and regulations on the disclosure of nursing quality indicators including: (1) the number of hours of total nursing care per patient per day; (2) the number of registered nurses providing direct care, the ratio of patients per registered nurse providing direct care, the number of RN care hours per patient per day and the percent of RN hours out of the total number of direct care nursing hours; (3) the number of licensed practical nurses providing direct care, the number of LPN care hours per patient per day and the percent of LPN hours out of the total number of direct care nursing hours; (4) the number of unlicensed personnel utilized to provide direct patient care and the percent of unlicensed personnel hours out of the total number of direct care nursing hours; (4) the incidence of select adverse patient care occurrences; (5) the methods used for determining and adjusting

staffing levels and patient care needs and the facility's compliance with these methods; and (6) *outcomes* of complaint investigation(s) filed with any state or federal regulatory agency or accrediting agency and survey(s) resulting in citation(s), including but not limited to significant medication errors.

Legislative Objectives:

The legislative objective of PHL Article 28 includes the protection of the health of the residents of the State by assuring the efficient provision and proper utilization of health services, of the highest quality at a reasonable cost. The objective of PHL Section 2805-t is to provide the public with information regarding nursing staffing levels and nursing sensitive patient outcome indicators.

Needs and Benefits:

The Nursing Care Quality Protection Act, (Chapter 422 of the Laws of 2009), became law September 16, 2009, added PHL Section 2805-t and requires Article 28 facilities to disclose identified nursing quality indicator information upon request to any member of the public, and to the Commissioner of any state agency responsible for licensing the facility or responsible for overseeing the delivery of services by the facility, or any organization accrediting the facility. PHL Section 2805-t directs the Commissioner to promulgate regulations regarding disclosure of nursing quality indicators to such requestors. This regulation is to provide, consistent with PHL Section 2805-t, standards for the disclosure of data regarding nursing staffing levels and nursing

sensitive patient outcome indicators. These regulations will require the use of established, standardized definitions and measurement criteria that are, to the extent possible, already being collected by facilities when calculating and disclosing nursing quality indicators.

COSTS:

Costs for the Implementation of and Continuing Compliance with these Regulations to the Regulated Entity:

The Nursing Care Quality Protection Act, (Chapter 422 of the Laws of 2009), became effective March 15, 2010, 180 days after it was signed into law. Initial compliance was facilitated by guidance documents developed collaboratively with stakeholders and communicated to facilities via Dear Administrator letters. At this point, facilities have been complying with the requirements of the Nursing Care Quality Protection Act for over two years. In addition, (1) CMS makes information regarding a number of these indicators available to the public on the Nursing Home Compare website, (2) prior to this law becoming effective over 50% of hospitals already participated in the National Database for Nursing Quality Indicators which required measurement and reporting of these indicators and (3) at this time a CMS requirement for hospitals is becoming effective that requires measurement and reporting of these same indicators. Any costs associated with initial implementation have already been born. Ongoing costs of implementation will be variable and relative to the number and complexity of requests for information received.

Costs to Local and State Government:

Article 28 facilities that fall under the jurisdiction of local or state government such as county nursing homes, clinics, or hospitals are affected and incur costs the same as any other Article 28 facility. Ongoing costs of implementation will be variable and relative to the number and complexity of requests for information received.

Costs to the Department of Health:

There will be no additional costs to the Department of Health. Implementation and surveillance of these provisions will be accomplished utilizing existing staff.

Local Government Mandates:

Article 28 facilities that fall under the jurisdiction of local or state government such as county nursing homes, or general hospitals will be affected and be subject to the same requirements as any other Article 28 facility.

Paperwork:

New paperwork associated with this regulation is minimal. Tracking and measurement of staffing data for payroll purposes is routine in all Article 28 facilities. Approximately 140 hospitals currently measure staffing and nursing sensitive patient outcome indicators in the manner required by these regulations as a result of their participation in the National Database for Nursing Quality Indicators (NDNQI). In addition, many other hospitals measure and track

these indicators without formal participation in NDNQI in order to benchmark their nursing quality against other facilities. Residential Health Care Facilities currently report nursing quality indicator measures/information through Minimum Data Set (MDS) submissions, so a substantial amount of new paperwork is also not expected for these providers. Maintenance of requests for nursing quality indicator information for the required three year period of time will be new but should not create considerable paperwork for Article 28 providers.

Duplication:

This proposal does not duplicate any state regulation. In an effort to avoid duplication of work for regulated facilities, when appropriate, efforts have been made to define nursing staffing and patient outcome indicator measurement and calculation in the same way as defined by the Center for Medicaid and Medicare Services (CMS), Centers for Disease Control and Prevention (CDC), New York State Department of Health (NYSDOH), National Quality Forum (NQF) and/or NDNQI—entities where these indicators are either already required for submission or, a submission plan is under development or, in the case of NDNQI, have been elected voluntarily for submission by NYS hospitals and/or LTC facilities.

There is an initiative by CMS requiring hospitals to participate in a nursing registry and submit nursing quality indicators consistent with this proposed regulation. The planned implementation date for submission of 2012 data is between April 1 and May 15, 2012.

Alternative Approaches:

These regulations are mandated by PHL Section 2805 – t (1). Efforts have been made to minimize any adverse impact by requiring standardized indicators that in many cases are already being collected by the facilities. Acceptable methods of disclosure include facility report cards, website displays; information included in patient information materials, and tailored reports based on submitted requests for this information.

Federal Requirements:

CMS Hospital Inpatient Quality Reporting (IQR) Program requires that the Structural Measures are reported annually and assess the characteristics and capacity of the provider to deliver quality healthcare. This includes Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care. A hospital's Annual Payment Update is affected only when the hospital does not answer all required questions indicating participation or non-participation in a registry. For FFY 2013 those dates were April 1, 2012, and May 15, 2012 to complete.

The Centers for Medicare & Medicaid Services (CMS) began a national Nursing Home Quality Initiative (NHQI) in 2002. The nursing home quality measures come from resident assessment data that nursing homes routinely collect on the residents at specified intervals during their stay. These measures assess the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. These assessment data are converted to develop quality measures that show how well nursing homes are caring for their residents' physical and clinical needs. The Minimum Data Set (MDS) is currently in use to collect resident assessment data.

Compliance Schedule:

This regulation will take effect upon publication of a Notice of Adoption in the New York *State Register*.

Contact Person: Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel
Regulatory Affairs Unit
Corning Tower Building, Room 2438
Empire State Plaza
Albany, New York 12237
518-473-7488
518-486-4834-FAX
REGSQNA@health.state.ny.us

REGULATORY FLEXIBILITY ANALYSIS

FOR SMALL BUSINESS AND LOCAL GOVERNMENTS

Effect of Rule:

The provisions of this regulation will apply to hospital and residential health care facilities authorized to operate pursuant to Public Health Law Article 28. Such facilities include: 232 general hospitals, and 634 residential health care facilities. Three general hospitals and 84 residential health care facilities are considered small businesses.

Compliance Requirements:

General hospitals and residential health care facilities will be required to disclose identified nursing quality indicators, including information associated with complaint investigations and surveys, and methods used to determine and adjust staffing levels upon request. Records of requests and facility response must be kept for three years in order for organizations to be able to track and show evidence of their compliance with requests for this information.

Professional Services:

None

Compliance Costs:

At this point, facilities have been complying with the requirements of the Nursing Care Quality Protection Act for over two years. Ongoing costs of implementation will be variable and relative to the number and complexity of requests for information received.

Economic and Technological Feasibility:

It is be economically and technologically feasible for small businesses to comply with these regulations.

Minimizing Adverse Impact:

The regulations will require standardized measurement of nursing quality indicators and limit indicators to those that have been established as valid and reliable. The Department will not require hospitals and residential health care facilities to create additional reports to comply with these provisions. In order to minimize any adverse impact, the Department will allow facilities to use as acceptable methods of disclosure: facility report cards, website displays, information included in patient information materials, and tailored reports based on submitted requests for this information.

Small Business and Local Government Participation:

Outreach to the affected parties was and continues to be conducted. Affected parties were given the opportunity to contribute to the pre-publication development of the content and processes involved in implementation of this regulation. Organizations that represent the affected parties are given notice of this proposal by its inclusion on the agenda of the Codes and

Regulations Committee of the Public Health and Health Planning Council. The public, including any affected party, is invited to comment during the Codes and Regulations Committee meeting.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Number of Rural Areas

The proposed amendment will apply Statewide, including the 43 rural counties with less than 200,000 inhabitants, and the 10 urban counties with a population density of 150 per square mile or less.

Reporting, Recordkeeping and Other Compliance Requirements; and Professional Services

Costs

At this point, facilities have been complying with the requirements of the Nursing Care Quality Protection Act for over two years. Ongoing costs of implementation will be variable and relative to the number and complexity of requests for information received.

Minimizing Adverse Impact

The regulations will require standardized measurement of nursing quality indicators and limit indicators to those that have been established as valid and reliable. The Department will not require hospitals and residential health care facilities to create additional reports to comply with these provisions. In order to minimize any adverse impact, the Department will allow facilities to use as acceptable methods of disclosure: facility report cards, website displays, information included in patient information materials, and tailored reports based on submitted requests for this information.

Rural Area Participation

Outreach to the affected parties, including those in rural areas is being conducted. Organizations that represent the affected parties have been given notice of this proposal by its inclusion on the agenda of the Codes and Regulations Committee of the Public Health and Health Planning Council. The public, including any affected party, is invited to comment during the Codes and Regulations Committee meeting.

JOB IMPACT STATEMENT

Pursuant to the State Administrative Procedure Act (SAPA) Section 201-a(2)(a), a Job Impact Statement for this amendment is not required because it is apparent from the nature and purposes of the proposed rules that they will not have a substantial adverse impact on jobs and employment opportunities.