

New York
Appendix II

APPENDIX II

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF NEW YORK

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

INPATIENT HOSPITAL CARE

10 N.Y.C.R.R. PART 86-1

*Mandated Federal Reference

TN #85-34

Approval Date July 23, 1987

Supersedes TN #81-36

Effective Date July 1, 2011

**New York
Preface**

Preface

General Reimbursement Provisions

January 1, 1988 the New York State Department of Health implemented a new Medicaid reimbursement methodology for hospitals utilizing case based rates of payment. This was a departure from the per diem methodology whereby hospitals received the same dollar amount per inpatient day of care regardless of the services rendered. The new system is more reflective of the amount of services rendered to each patient and makes a lump sum payment to the hospital based in part on an average per case cost of a hospital's peer group and the actual services that a particular patient receives during the inpatient stay.

This major change in reimbursement policy led to a change in the way methodology and rate changes are implemented since a portion of the rate is now based on a group average price. To stabilize the group price and hospital rates, the Department of Health calculates two rate changes per year, January 1 and July 1. However, the Department still makes modifications to the Medicaid State Plan for inpatient hospital reimbursement on a quarterly basis to reflect changes in the rate calculation methodology. Generally, the State Plan amendments effective in the second and fourth quarter of each year and on other than the first day of the first and third quarter of each year are prospectively implemented in inpatient hospital rates on the next rate calculation date of July 1 or January 1, unless otherwise noted in the State Plan or unless the prospective adjustment would seriously impact a general hospital's financial stability. Initial rate adjustments related to such amendments will be increased or decreased to take into account the effective period prior to the rate cycle.

TN #92-26

Approval Date May 19, 1993

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[SUBPART 86-1]
MEDICAL FACILITIES
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(Statutory authority: Public Health Law, 2803, 2807, 2807-a, 2807-c, 2808-c, 3612; L 1983, ch. 758, 7)
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TN #10-33-B

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Effective Date July 1, 2011

New York Contents

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- Federal upper limit compliance
- Adding or deleting hospital services or units
- New hospitals and hospitals on budgeted rates
- Swing bed reimbursement
- Mergers, acquisitions and consolidations, restructurings, and closures
- Administrative rate appeals
- Out-of-state providers
- Supplemental indigent care distributions
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- Reimbursement for language assistance services in hospital inpatient settings

TN #13-13 Approval Date January 28, 2014 Supersedes TN #10-33-B Effective Date January 1, 2013

**New York
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Across the Board Reductions to Payments

- (1) For dates of service on and after September 16, 2010, through and including March 31, 2011, payments for services as specified in paragraph (2) of this Attachment shall be reduced by 1.1%, provided payment is made no later than March 31, 2011.
- (2) Payments in this Attachment subject to the reduction in paragraph (1) include the following:

Part I – Methods and Standards for Establishing Payments – Inpatient Hospital Care

- | | |
|--|---|
| a) <u>Hospital Inpatient Reimbursement as calculated pursuant to Part 1 of this Attachment.</u> | <u>Pages 103-139</u> |
| b) <u>Supplemental Indigent Care Adjustments as calculated pursuant to Part 1 of this Attachment.</u> | <u>Pages 144-144(d) and 161(b)-161(c)</u> |
| c) <u>Graduate Medical Education – Medicaid Managed Care Reimbursement as calculated pursuant to Part 1 of this Attachment.</u> | <u>Pages 149-150</u> |
| d) <u>Hospital Disproportionate Share payments made to governmental general hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment.</u> | <u>Pages 153-154</u> |
| e) <u>Indigent Care Adjustments to hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment.</u> | <u>Page 160</u> |
| f) <u>Additional Disproportionate Share Payments to voluntary non-profit hospitals as calculated pursuant to Part 1 of this Attachment.</u> | <u>Page 162</u> |

Part II – Methods and Standards for Setting Payment Rates for Inpatient Services Provided by Hospitals Operated by the NYS Office of Mental Health

- | | |
|--|---------------------|
| g) <u>Inpatient Reimbursement for services provided by hospitals operated by the New York State Office of Mental Health as calculated pursuant to Part 2 of this Attachment.</u> | <u>Pages 1-5(a)</u> |
| h) <u>Disproportionate Share Adjustments as calculated pursuant to Part 2 of this Attachment.</u> | <u>Pages 7-11</u> |

TN #10-36
Supersedes TN NEW

Approval Date March 9, 2011
Effective Date September 16, 2010

**New York
A (1)**

Part III – Methods and Standards of Setting Payment Rates for Hospitals Licensed by the Office of Mental Health

- | | |
|---|---------------------------------------|
| k) <u>Inpatient Reimbursement for services provided by hospitals licensed by the New York State Office of Mental Health as calculated pursuant to Part 3 of this Attachment.</u> | <u>Pages 1-2(a)</u>
<u>and 3-5</u> |
| l) <u>Disproportionate Share Adjustments as calculated pursuant to Part 3 of this Attachment.</u> | <u>Pages 2(c) and 7</u> |
| m) <u>Hospital Inpatient Reimbursement for services in private psychiatric hospitals calculated pursuant to Part 3 of this Attachment.</u> | <u>Pages 8-9</u> |
| n) <u>Hospital Inpatient Reimbursement for psychiatric services for individuals under 21 who are admitted to Residential Treatment Services for Youth programs as calculated pursuant to Part 3 of this Attachment.</u> | <u>Pages 10-14</u> |

Part VII – Methods and Standards for Establishing Payment rates for Specialty Hospitals

- | | |
|---|-------------------|
| o) <u>Specialty Hospital Inpatient Reimbursement as calculated pursuant to Part 7 of this Attachment.</u> | <u>Pages 7-20</u> |
| p) <u>Disproportionate Share Adjustments as calculated pursuant to Part 7 of this Attachment.</u> | <u>Page 24</u> |

TN #10-36

Supersedes TN NEW

Approval Date March 9, 2011

Effective Date September 16, 2010

**New York
A(1)(a)**

Across the Board 2% Payment Reduction

(1) For dates of service on and after April 1, 2011 through March 31, 2013, payments for services as specified in paragraph (2) of this Section will be reduced by 2%.

(2) Payments in this Attachment subject to the reduction in paragraph (1) include the following:

Part I – Methods and Standards for Establishing Payments – Inpatient Hospital Care

- | | |
|--|---|
| a) <u>Hospital Inpatient Reimbursement as calculated pursuant to Part 1 of this Attachment.</u> | <u>Pages 103-139</u> |
| b) <u>Supplemental Indigent Care Adjustments as calculated pursuant to Part 1 of this Attachment.</u> | <u>Pages 144-144(d) and 161(b)-161(c)</u> |
| c) <u>Graduate Medical Education – Medicaid Managed Care Reimbursement as calculated pursuant to Part 1 of this Attachment.</u> | <u>Pages 149-150</u> |
| d) <u>Hospital Disproportionate Share payments made to governmental general hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment.</u> | <u>Pages 153-154</u> |
| e) <u>Indigent Care Adjustments to hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment.</u> | <u>Page 160</u> |
| f) <u>Additional Disproportionate Share Payments to voluntary non-profit hospitals as calculated pursuant to Part 1 of this Attachment.</u> | <u>Page 162</u> |

TN #11-70

Supersedes TN New

Approval Date July 29, 2011

Effective Date April 1, 2011

**New York
A(1)(b)**

Across the Board 2% Payment Reduction – effective 4/1/13 - 3/31/[15]14

- (1) For dates of service on and after April 1, 2013 through March 31, 20[15]14, payments for services as specified in paragraph (2) of this Section will be reduced by 2%.
- (2) Payments in this Attachment subject to the reduction in paragraph (1) are the following:

Part I – Methods and Standards for Establishing Payments – Inpatient Hospital Care

- | | |
|---|-------------------------|
| a) Hospital Inpatient Reimbursement as calculated pursuant to Part 1 of this Attachment. | Pages 103-139 |
| b) Indigent Care Pool Reform – as calculated pursuant to Part 1 of this Attachment. | Pages 161(d)-
161(j) |
| c) Graduate Medical Education – Medicaid Managed Care Reimbursement as calculated pursuant to Part 1 of this Attachment. | Pages 149-150 |
| d) Hospital Disproportionate Share payments made to governmental general hospitals operated by the State of New York or the State University of New York as calculated pursuant to Part 1 of this Attachment. | Pages 153-154 |
| e) Government General Hospital Indigent Care Adjustment as calculated pursuant to Part 1 of this Attachment. | Page 160 |

TN #14-0028

Supersedes TN #13-0020

Approval Date January 30, 2015

Effective Date April 1, 2014

**New York
A(1)(c)**

Across the Board Hospital Inpatient Increase

(1) For dates of service on and after November 1, 2018, the inpatient rate components listed below for Article 28 hospitals, as calculated pursuant to Part 1 of this Attachment, will be adjusted to reflect an across the board increase of two percent (2%). Only those Article 28 hospitals whose total estimated annual Medicaid impact from the two percent (2%) across the board hospital inpatient increase is \$75,000 or greater are eligible for adjustments to the rate components.

a. Sections in this Attachment subject to the two percent (%) hospital inpatient increase are as follows:

i. Statewide Base Price

ii. Add-Ons to the Acute Rate Per Discharge

iii. Exempt units and hospitals

1. Physical medical rehabilitation inpatient services - operating component
2. Chemical dependency rehabilitation inpatient services – operating component
3. Critical access hospitals – operating component
4. Cancer hospitals – operating component
5. Specialty long term acute care hospital – operating component
6. Acute care children's hospitals – operating component
7. Substance abuse detoxification inpatient services – operating component
8. Inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals, specializing in such inpatient psychiatric services – operating component and Direct Graduate Medical Education (DGME)

iv. Graduate Medical Education - Medicaid Managed Care Reimbursement

v. Alternate Level of Care Payments (ALC)

TN **#18-0064**

Supersedes TN **#NEW**

Approval Date **September 9, 2020**

Effective Date **November 1, 2018**

**New York
A(1)(c.1)**

1905(a)(1) Inpatient Hospital Services

Across the Board Hospital Inpatient Increase

(1) For dates of service on and after April 1, 2022, the inpatient operating rate components listed below for Article 28 hospitals, as calculated pursuant to Part 1 of this Attachment, will be adjusted to reflect an across-the-board increase of one percent (1%).

- a. Sections in this Attachment applicable to the one percent (1%) hospital inpatient increase are as follows:
 - i. Statewide Base Price
 - ii. Add-Ons to the Acute Rate Per Discharge except as follows:
 - 1. Minimum wage add-on
 - iii. Exempt units and hospitals
 - 1. Physical medical rehabilitation inpatient services - operating component
 - 2. Chemical dependency rehabilitation inpatient services – operating component
 - 3. Critical access hospitals – operating component
 - 4. Cancer hospitals – operating component
 - 5. Specialty long term acute care hospital – operating component
 - 6. Acute care children’s hospitals – operating component
 - 7. Substance abuse detoxification inpatient services – operating component
 - 8. Inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals, specializing in such inpatient psychiatric services – operating component and Direct Graduate Medical Education (DGME)
 - iv. Graduate Medical Education - Medicaid Managed Care Reimbursement
 - v. Alternate Level of Care Payments (ALC)
 - vi. Swing Bed inpatient services – operating component
 - vii. Out-of-State inpatient hospital services – operating component

**New York
A(1)(d)**

Across the Board 1% Payment Reduction – effective 1/1/2020 - 3/31/2022

- (1) For dates of service on and after January 1, 2020 – March 31, 2022, payments for services as specified in paragraph (3) of this Section will be reduced by one percent (1%).
- (2) For dates of service on or after April 2, 2020 – March 31, 2022, payments for services as specified in paragraph (3) of this Section will be reduced by an additional one-half percent (0.5%) to the percent referenced in paragraph (1), resulting in a one and one-half percent (1.5%) reduction.
- (3) Payments pursuant to Part I in this Attachment subject to the reduction in paragraphs (1) and (2) are the following:

Part I – Methods and Standards for Establishing Payments – Inpatient Hospital Care

- a) Hospital Inpatient Reimbursement.
- b) Capital Expense Reimbursement.
- c) Adding or Deleting Hospital Services or Units.
- d) New Hospitals and Hospital on Budgeted Rates.
- e) Swing Bed Reimbursement.
- f) Mergers, Acquisitions, Consolidations, Restructurings and Closures.
- g) Administrative Rate Appeals.
- h) Out-of-State Providers.
- i) Hospital Physician Billing.
- j) Graduate Medical Education – Medicaid Managed Care Reimbursement.
- k) Government General Hospital Additional Disproportionate Share Payments.
- l) Government General Hospital Indigent Care Adjustment.
- m) Voluntary Supplemental Inpatient Payments.
- n) Indigent Care Pool Reform.

86-1.1 [Definitions.] Reserved

TN #88-6

Supersedes TN #85-34

Approval Date August 1, 1991

Effective Date January 1, 1988

New York
2

86-1.2 [Medical facility rates.] Reserved

TN #88-6

Approval Date August 1, 1991

Supersedes TN #85-34

Effective Date January 1, 1988

New York

3

86-1.3 Financial and statistical data required. (a) Each medical facility shall complete and file with the New York State Department of Health and/or its agent annual financial and statistical report forms supplied by the department and/or its agent. Medical facilities certified for title XVIII (Medicare) shall use the same fiscal year for title XIX (Medicaid) and title B (children's bureau programs) as is used for title XVIII. All medical facilities must report their operations from January 1, 1977 forward on a calendar-year basis.

- (b) Financial and statistical reports required by the Subpart shall be submitted to the department and/or its agent no later than 120 days following the close of the period. Extensions of time for filing reports may be granted by the commissioner upon application received prior to the due date of the report only in those circumstances where the medical facility establishes, by documentary evidence, that the reports cannot be filed by the due date for reasons beyond the control of the facility.
- (c) In the event a medical facility fails to file the required financial and statistical reports on or before the due dates, or as the same may be extended pursuant to subdivisions (b) or (e) of this section, or fails to comply with the provisions of section 86-1.6 of this Subpart, the State Commissioner of Health shall reduce the current rate paid by governmental agencies by two percent for a period beginning on the first day of the calendar month following the original due date of the required reports and continuing until the last day of the calendar month in which said required reports are filed.
- (d) In the event that any information or data which a facility has submitted to the Department of Health on required reports, budgets or appeals for rate revisions intended for use in establishing rates is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the department a correction of such information or data which meets the same certification requirements as the document being corrected.
- (e) If the financial and statistical reports required by this Subpart are determined by the department or its agent to be incomplete, inaccurate or incorrect, the facility will have 30 days from date of receipt of notification to provide the corrected or additional data. Failure to file the corrected or additional data that was previously required within [that period] 30 days, or within such period as extended by the Commissioner, will result in application of subdivision (c) of this section.
- (f) Data required to be filed with the department pursuant to section 400.18(b) of this Title shall be submitted according to the specified format for at least 80 percent of all discharged patients within 60 days from the end of the month of patient billing and for at least 100 percent of all patients discharged during the hospital's twelve month fiscal reporting period within 120 days from the end of the hospital's fiscal year reporting period. Where the 80 percent criterion is not met for a given quarter, the provisions of subdivision (c) of this section shall apply, except where the facility demonstrates that the delay in submission of the data is beyond its control.

TN #92-46Approval Date November 4, 1993Supersedes TN #92-06Effective Date October 1, 1992

New York
3(a)

~~[Where the 100 percent criterion is not met for the given twelve month fiscal period, the commissioner shall notify the facility and the facility shall, within 100 days from the end of the hospital's fiscal year reporting period, meet the 100 percent criterion. If the 100 percent criterion is not then met, the provisions of subdivision (c) of this section shall apply, except where the facility demonstrates the delay in submission is beyond its control.]~~

TN #94-06

Supersedes TN #

Approval Date November 21, 1997

Effective Date January 1, 1994

New York

4

- (g) ~~{Data required to be filed with the department pursuant to section 400.18(c) of this Title shall be submitted according to the specified format for at least 95 percent of all discharged patients within 60 days from the end of the month of patient discharge. Where in each of two successive quarters this criterion is not met, the provisions of subdivision (c) of this section shall apply, except where the facility demonstrates that the delay in submission of the data is beyond its control. Such data shall be submitted according to the specified format for at least 95 percent of all patients discharged during the hospital's twelve month fiscal reporting period within 120 days from the end of that fiscal reporting period. Where this criterion is not met for the given fiscal period, the provisions of subdivision (c) of this section shall apply, except where the facility demonstrates that the delay in submission of the data is beyond its control.}~~

Reserved

- (h) Specific additional data related to the rate setting process may be requested by the State Commissioner of Health. These data, which may include but are not limited to those for use in a wage geographic differential survey, a peer grouping data survey, a medical supplies survey, a malpractice insurance survey, a graduate medical education survey, and a quarterly utilization survey must be provided by the medical facility within 30 days from the date of receipt of notification to supply such information. The commissioner must supply to each facility, prior to the start of each rate period, a preliminary listing of the data that will be required. Failure to submit the additional data shall result in

New York
4(a)

rate in accordance with] application of the provisions of subdivision (c) of this section, unless the medical facility can prove by documentary evidence that the data being requested is not available.

- (i) General hospitals shall submit to the commissioner at least 120 days prior to the commencement of each revenue cap year, a schedule of anticipated capital-related inpatient expenses for the forthcoming year pursuant to the provisions of section 86-1.30 of this Subpart.
- (j) General hospitals shall submit to the Commissioner of Health a report of hospital expenses incurred in providing services during the period covered by the reports required under this section for which payment was not received and is not anticipated. The report shall be completed in accordance with definitions of bad debt and charity care found in section 86-1.11 of this Subpart. The report shall identify as bad debts or charity care the cost of services provided to emergency inpatients, nonemergency inpatients, emergency ambulatory patients, clinic patients and referred or private ambulatory patients for which the hospital did not receive and does not anticipate payment.
- (k) Medical facilities shall submit to the Commissioner of Health discrete financial and statistical data for medical/surgical services, maternity services, pediatric services, normal newborns, premature newborns, psychiatric services, intensive care services, coronary care unit and other intensive care-type inpatient hospital units, and statistical data for alternate level of care services.

TN #92-06

Approval Date October 18, 1993

Supersedes TN NEW

Effective Date March 11, 1992

New York
4(b)

- (l) General hospitals with exempt psychiatric units shall submit hospital data regarding patients in such units as required by the Office of Mental Health.
- (m) Each medical facility shall file with the New York State Department of Health a complete copy of the Department of the Treasury, Internal Revenue Service Form 990, for that facility. The Form 990 shall be submitted to the department no later than 30 days following the annual filing with the Internal Revenue Service. Failure to submit the Form 990 shall result in application of the provisions of subdivision (c) of this section.

TN #92-06

Supersedes TN NEW

Approval Date October 18, 1993

Effective Date March 11, 1992

New York
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Section 86-1.4 Uniform system of accounting and reporting. (a)
Medical facilities shall maintain their records in accordance with:

- (1) section 405.23 of Article 2 of Subchapter A of Chapter V of this Title;
and
- (2) Article 8 of Subchapter A of Chapter V of this Title.

(b) Rate schedules shall not be certified by the Commissioner of Health unless medical facilities are in full compliance with reporting requirements of this Subpart and section 405.23 of this Title.

(c) For purposes of rate setting, medical facilities shall submit to the New York State Department of Health, or its authorized agent, a certified uniform financial report and a uniform statistical report in accordance with the policies and instructions as set forth in section 405.23(b) of Article 2 of Subchapter A of Chapter V of this Title.

(d) The institutional cost report and supplementary schedule form as adopted by the department shall be used to report financial and statistical data for 1981 in order to establish rates of payment for title 19 providers in 1983.

(e) Failure of a medical facility to file the reports required pursuant to this section will subject the medical facility to a rate reduction as set forth in section 86-1.3 of this Subpart.

TN #85-34

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Effective Date January 1, 1986

New York
6

Section 86-1.5 Generally accepted accounting principles. The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the medical facility, unless the reporting instructions authorize specific variation in such principles.

TN #85-34

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Effective Date January 1, 1986

New York

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Section 86-1.6 Accountant's certification. (a) The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant. The minimum standard for the term independent shall be the standard used by the State Board of Public Accountancy.

(b) The requirements of subdivision (a) of this section shall apply to medical facilities operated by units of government of the State of New York heretofore exempt from the requirements of this section. Certification of reports from these facilities will be required effective with report periods beginning on or after January 1, 1977.

TN #85-34Approval Date July 23, 1987Supersedes TN #81-36Effective Date January 1, 1986

New York
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Section 86-1.7 Certification by operator, officer or official.

(a) The financial and statistical reports shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility, or the public official responsible for the operation of a public medical facility.

(b) The form of the certification required in subdivision (a) of this section shall be as prescribed in the annual fiscal and statistical report forms provided by the State Commissioner of Health.

TN #85-34

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Effective Date January 1, 1986

New York

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Section 86-1.8 Audits. (a) All fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports, filed by the medical facility with the department, shall be kept and maintained by the facility for a period of time not less than six years from the date of filing or the date upon which the fiscal and statistical records were to be filed, whichever is the later date. In this respect, any rate of payment certified or established by the State Commissioner of Health prior to audit shall be construed to represent a provisional rate until such audit is performed and completed, at which time such rate or adjusted rate will be construed to represent that audited rate.

(b) Subsequent to the filing of fiscal and statistical reports, field audits shall be conducted of the records of medical facilities in a time, manner and place to be determined by the State Department of Health. Where feasible, the department shall enter into an agreement to use a combined audit (Medicare/Medicaid and other organizations and agencies having audit responsibilities) to satisfy the department's auditing needs. In this respect, the State Department of Health reserves the right, after entering into an agreement to use a combined audit, to reject the audit findings of other organizations and agencies having audit responsibilities and to perform a limited scope or comprehensive audit of their own for the same fiscal period audited by the organization and/or agency.

(c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department or from the date when due, whichever is later. This limitation shall not apply to situations in which fraud may be involved, or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this section.

(d) Upon completion of the audit, the medical facility shall be afforded a closing conference. The medical facility may appear in person or by anyone authorized in writing to act on behalf of the medical facility. The medical facility shall be afforded an opportunity at such conference to produce additional documentation in support of any modifications requested in the audit.

(e) The medical facility shall be provided with the audit report and the rate computation sheet per audit. The audit report shall be final unless within 30 days of receipt of the audit report, the medical facility initiates a bureau review of such final audit report by notifying the Division of Health Care Financing by registered or certified mail, detailing the specific items of the audit report with which the provider disagrees, and such other material as the provider wishes to submit in its behalf, and forwarding all material documentation in support of the medical facility's position.

(f) The medical facility shall be notified in writing of the determination of the controverted items of the final audit report, including a statement of the reasons for such adjustments and the appropriate citation to applicable law, regulation or policy. The audit

TN #85-34Approval Date July 23, 1987Supersedes TN #81-36Effective Date January 1, 1986

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findings as adjusted in accordance with the determination of the bureau review shall be final, except that the medical facility may, within 30 days of receipt of the determination of the bureau review, initiate a hearing to refute those items of the audit report adverse to the interests of the medical facility presenting a factual issue by serving on the commissioner, by certified or registered mail, a notice containing a statement of the legal authority and jurisdiction under which the hearing should be held, a reference to the particular sections of the statutes and rules involved and a statement of the controverted items of the audit report and bureau determination, together with copies of any documentation relied on by the medical facility in support of its position.

- (1) Upon receipt of such notice the commissioner shall:
 - (i) designate a hearing officer to hear and recommend;
 - (ii) establish a time and place for such hearing;
 - (iii) notify the medical facility of the time and place of such hearing at least 15 days prior thereto; and
 - (iv) include in a notice of hearing those issues of the audit report which are controverted in the notice served on the commissioner by the medical facility.
- (2) The issues and documentation presented by the medical facility at such hearing shall be limited to the factual issues and documentation presented at the bureau review.

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- (3) The audit report shall be presumptive evidence of its content. The burden of proof at any such hearing shall be upon the medical facility to prove by substantial evidence that the items therein contained are incorrect.
- (4) The hearing shall be conducted in conformity with section 12-a of the Public Health law and the State Administrative Procedure Act.
- (5) At the conclusion of the hearing the medical facility may submit memoranda on any legal issues which it deems relevant to the proceeding. Such memoranda shall become part of the official record of the hearing.
- (g) Rate revisions resulting from the procedure set forth in this section shall be made retroactive to the period or periods during which the rates based on the periods audited were established. Any resulting overpayment or underpayment shall be satisfied by either retroactive adjustment of the provisional rate paid, based on the period audited, or prospective adjustment of the current certified rate at the discretion of the State Commissioner of Health.
- (h) [All overpayments resulting from rate revisions shall be subject to such penalties as the Commissioner of Health may impose for

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the incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions. The penalties assessed under this section are separate from and shall not be construed to be in mitigation of damages which may be recovered pursuant to section 145-b of the Social Services Law.] reserved.

- (i) Notwithstanding the provisions of this section, the commissioner may promulgate rate revisions based on audits completed by another State agency. Unless otherwise indicated, such audits shall not be considered final and shall not prelude conduct of a complete audit by the State Department of Health or its agent.

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Section 86-1.9 Patient days. (a) A patient day is the unit of measure denoting lodging provided and services rendered to one inpatient between the census taking hour on two successive days.

(b) In computing patient days, the day of admission shall be counted but not the date of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes, three newborn days shall be reported as the equivalent of one adult or child day. The following types of care shall not be treated as being rendered to newborns for patient day calculations: premature infant, newborn remaining in hospital after mother's discharge, sick infant care requiring general hospital service, and infant care to those born outside the hospital and not placed in the newborn nursery.

(d) For reimbursement purposes, patient days for medical/surgical, pediatrics, and maternity shall be computed as follows:

(1) Medical-surgical patient days for facilities located in counties having an average population density of 100 or more persons per square mile shall be determined by using the higher of the minimum utilization factor of 85 percent of certified beds or actual patient days of care furnished by the facility. Medical-surgical patient days for facilities located in counties having an average population density of less than 100 persons per square mile shall be determined by using the higher of the minimum utilization factor of 80 percent of certified beds or actual patient days of care furnished by the facility.

(2) Pediatric patient days shall be determined by using the higher of the minimum utilization factor of 70 percent of certified beds or actual patient days of care furnished by the facility.

(3) Maternity patient days for facilities located in areas having a plan approved by the commissioner for the regionalization of obstetrical service, and subsequent to January 1, 1978 for all facilities including those services in areas not having an approved plan shall be determined as follows:

(i) Maternity patient days for facilities in counties with an average population density of 100 or more persons per square mile shall be determined by using the lower of the minimum utilization factor of 75 percent of certified beds or, if the facility generated less than 1,500 live births, the difference between 1,500 and the actual number of live births generated by the facility multiplied by the average length of stay for a maternity patient plus the actual days of care furnished by the facility or, if the facility generated more than 1,500 live births, the actual days of care furnished by the facility.

(ii) Maternity patient days for facilities in counties with an average population density of less than 100 persons per square mile shall be determined by using the lower of the minimum utilization factor of 60 percent of certified beds or, if the facility generated less than 500 live births, the

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difference between 500 and the actual number of live births generated by the facility multiplied by the average length of stay for a maternity patient plus the actually days of care furnished by the facility or if the facility generated more than 500 live births, the actual days of care furnished by the facility.

(iii) Maternity service patients for purpose of computations pursuant to subparagraphs (i) and (ii) of this paragraph shall include obstetrical and gynecological patients housed in the maternity unit.

(4) The provisions of paragraphs (1) and (2) of this subdivision shall be waived in total or in part by the Commissioner of Health in those cases where waiver has demonstrated to be a matter of public interest and necessity. Where a facility could reach its minimum utilization factor by reducing the certified bed capacity by more than five beds or one percent of its certified bed complement, whichever is greater, the commissioner may grant a waiver only if the facility decertifies the total number of beds necessary to reach the minimum utilization factor. Where the minimum bed utilization factor would be reached by decertifying no greater than five beds or one percent of its certified bed complement, a waiver shall be granted and decertification of beds shall not be required.

(5) The provisions of paragraph (3) of this subdivision shall be waived by the Commissioner of Health in those cases wherein there is an approved regional plan and wherein the service in question, its capacity and operation are consistent with the approved regional plan. The provisions of paragraph (3) of this subdivision may be waived by the commissioner where it is a matter of public interest and necessity; if such a waiver is granted, maternity patient days shall be determined by using the higher of the applicable minimum utilization factor or live birth formula as set forth in paragraph (3) of this subdivision.

(6) The provision of paragraphs (1) – (3) of this subdivision shall be waived for rural hospitals as defined in this Title.

(7) No waiver pursuant to this subdivision shall be granted for periods predating the first day of the month following 30 days after receipt by the commissioner of the request and justification for the waiver, and fulfillment of conditions to the waiver, where such conditions exist.

(e) For reimbursement purposes, patient days for open heart surgery, cardiac invasive diagnostic procedures and kidney transplants shall be computed as follows for those facilities engaged in such operations or procedures:

(1) Patient days for any facility engaged in performing open heart surgery and carrying out less than 100 adult and/or 50 pediatric (less than age 21) operations during the reporting period shall be increased by an amount equal to the average length of stay for the adult and/or pediatric open heart surgery cases multiplied by the difference between 100 adult or 50 pediatric and

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the actual number of adult or pediatric open heart surgery operations carried out by the approved cardiac surgical center as referenced in Part 405 of this Title.

(2) Patient days for any facility engaged in performing adult or pediatric (less than 21) cardiac invasive diagnostic procedures and carrying out less than 200 adult and/or 100 pediatric procedures during the reporting period shall be increased by an amount equal to the average length of stay for the adult or pediatric procedures multiplied by the difference between 200 adult and/or 100 pediatric cardiac invasive diagnostic procedures and the actual number of procedures carried out by the approved cardiac diagnostic center as referenced in Part 405 of this Title.

(3) Patient days for any facility engaged in kidney transplants and carrying out less than 25 such transplants during a reporting period shall be increased by an amount equal to the average length of stay for kidney transplants multiplied by the difference between 25 and the actual transplants carried out by the facility.

The provisions of this subdivision may be waived by the State Commissioner of Health upon application by the health facility in those cases where waiver is found to be a matter of public interest and necessity. No waiver shall be granted for periods predating the first day of the month following 30 days after receipt by the commissioner of request and justification for the waiver.

(f) Patient days for all alternate level of care (ALC) services shall be reported separately. Patient days for alternate level of care services shall be utilized in the determination of minimum utilization standards as set forth in section 86-1.9(d) of this Subpart.

(g) For rate year 1985 hospitals located in an HSA region where the average daily medical/surgical occupancy is less than the appropriate minimum utilization factor set forth in paragraph (1) of subdivision (d) of this section and the hospital itself has an average daily medical/surgical occupancy of less than the appropriate minimum utilization factor set forth in paragraphs (1) and (4) of subdivision (d) of this section and the hospital provides alternate level of care services, the hospital's title XIX rate shall be reduced by the difference between its title XIX rate and the facility's allowable routine cost as determined pursuant to this Subpart and a statewide average of allowable ancillary costs for hospital-based skilled nursing or health related facilities, as appropriate to the level of care actually provided to the patient and as determined pursuant to Subpart 86-2 of this Title. Beds for which a facility has applied for decertification by January 1, 1986 and which are decertified by the commissioner shall not be counted in the calculation of occupancy rates for the purposes of this subdivision. The provisions of this subdivision shall be waived for hospitals which in 1985 meet the definition of rural hospital set forth in section 405.2(m) of this Title and which are not identified as unnecessary in the state and regional medical facilities plan established pursuant to section 710.13 of this Title.

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Section 86-1.10 Effective period of reimbursement rates. Certification of reimbursement rates of payment by governmental agencies shall be for a 12-month calendar year period or for such other period as may be prescribed. Certification of reimbursement rates by article IX-C corporations shall be for the periods specified in the reimbursement formula approved by the Commissioner of Health.

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(b) Payment rates for the period January 1, 1983 through December 31, 1983 shall be established on a prospective basis. Such payments shall be computed on the basis of allowable historical inpatient expense based on the fiscal and statistical data submitted by the medical facility for the fiscal year ended at least six months prior to January 1, 1983 and upon the data described below. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days, except as stated in subdivision (1) of this section and section 86-1.41 of this Subpart. Total allowable costs of a facility shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the Federal Social Security Act and article IX-C of the New York State Insurance Law and other patients, so that the share borne by each program is based upon actual services received by that program's beneficiaries. To accomplish this apportionment, for each program the ratio of beneficiary charges to total patient charges for the services of each ancillary department shall be applied to the cost of the department; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem.

(1) Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diems, unless the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(2) After July 1, 1984 the apportionment computed in this section will be revised to reflect 1982 charge data and patient day data received by the Commissioner pursuant to section 86-1.3 of this Subpart.

(3) In 1983, costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned among programs on the basis of average cost. In 1984 and 1985, one-third and two-thirds, respectively, of malpractice costs will be apportioned on the basis of payor experience. Apportionment on the basis of experience shall be based on the dollar ratios for each payor of the facility's malpractice losses paid by that payor to its total paid malpractice losses for the current cost reporting period and the preceding four-year period. If a facility has no malpractice loss experience for the five-year, the costs of malpractice insurance premiums or self-insurance fund contributions must be apportioned among the programs based on the national ratio of malpractice awards paid to program beneficiaries to malpractice awards paid to all patients. If a facility pays allowable uninsured malpractice losses incurred by program beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as

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a governmental provider, such losses and related direct costs must be directly assigned to a respective program for reimbursement.

(c) (1) To the allowable basic rate, computed in accordance with ceiling limitations and to the discrete alternate level of care rate if applicable, and prior to the addition of capital costs (depreciation, leases and interest), there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. This factor shall be developed in accordance with section 86-1.15 of this Subpart. The allowances specified in subdivisions (e)-(g) of this section shall be computed on the basis of, and added to, the trended basic rate plus capital costs.

(2) reserved

(d) General hospital inpatient revenue cap. (1) An inpatient revenue cap for each general hospital for each of the rate years 1984 and 1985 shall be established as follows and shall include only the revenues set forth below. An initial inpatient revenue cap shall be calculated for each general hospital by first trending to each rate year the allowable historical inpatient operational expenses reimbursed in 1983. The initial allowable historical inpatient operational expenses to be trended shall reflect all closed appeals and audit adjustments pursuant to this Subpart. The trend factors used shall be developed in accordance with section 86-1.15 of this Subpart. The following revenues shall then be added to trended allowable historical inpatient operational expenses for each rate year:

- (i) capital related inpatient expenses determined in accordance with sections 86-1.29 and 86-1.30 of this Subpart;
- (ii) the allowances provided for in subdivisions (e)-(g) of this section, calculated for each rate year utilizing the sum of trended allowable historical inpatient operational expenses and capital related inpatient expenses; and
- (iii) any anticipated additional revenues generated by a general hospital's charge schedule, developed in accordance with section 86-1.2 of this Subpart, for each respective rate year.

(2) The initial revenue caps for rate years 1984 and 1985 shall be adjusted to reflect the following:

- (i) case mix changes pursuant to the provisions of subdivision (s) of this section and volume changes;
- (ii) appeals filed and/or adjustments made pursuant to sections 86-1.16 and 86-1.17 of this Subpart; and

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(iii) any adjustments made in payments under title XVIII of the Federal Social Security Act (Medicare) pursuant to section 86-1.43 of this Subpart.

(3)(i) The commissioner shall require direct repayment or adjust a subsequent year's inpatient revenue cap to reflect actual inpatient revenues received for inpatient services provided by a general hospital that exceed a previous year's inpatient revenue cap initially established or adjusted in accordance with this Subpart. A general hospital determined to have such excess revenues shall be subject to direct repayment or adjustment of a subsequent revenue cap when such excess is due to establishment of a charge schedule that is not in compliance with section 86-1.2(c) of this Subpart. Revenue received established as a result of the provisions of title XVIII of the Federal Social Security Act (Medicare) phase-in policies or from charges authorized under section 86-1.17(h) of this Subpart in excess of the revenue cap shall not be included in the adjustment.

(ii) A facility that maintains charge schedules less than the maximum set forth in section 86-1.2(c) of this Subpart such that it results in it receiving less than the maximum allowable charge paying rate shall not be compensated by other payors for the amount by which its charge revenues are less than the maximum amount allowed.

(4) That portion of the revenue cap that is related to utilization of inpatient services shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the Federal Social Security Act and article IX-C of the New York State Insurance Law, and those enrolled in organizations operating in accordance with the provisions of article 44 of the Public Health Law, so that the share borne by each program is based upon actual services received by that program's beneficiaries. To accomplish this apportionment, for each ancillary department, the ratio of total department costs to total department charges will be applied to program beneficiary charges for the services of that ancillary department to develop an ancillary cost per day for beneficiaries of that program; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem.

(i) Any adjustment in the overall revenue cap in accordance with this Subpart shall be reflected in an appropriate adjustment to this portion of the revenue cap and payment levels by these programs.

(ii) After such adjustments, the portion of the revenue cap initially established, or as adjusted, that is related to the actual utilization of covered inpatient services of the above programs, shall constitute guaranteed revenue to the general hospital.

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(iii) Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diem, unless the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(e) reserved

(f) reserved

(g) Bad debt and charity care regional pools and allowances. Regional pools will be established from which allowances will be added to hospital rates to help pay for the costs of bad debt and charity care for the three year period commencing January 1, 1983, and ending December 31, 1985. Such pools shall receive funds from hospitals pursuant to this subdivision and section 86-1.37 of this Subpart. For the rates established in 1983, the resources available for purposes of establishing the bad debt and charity care pools shall be calculated on the basis of two percent of the total statewide general hospital (including both major public hospitals and all other hospitals) reimbursable inpatient operating costs after application of the trend factor plus the addition of capital costs. For the rates established in 1984 and 1985, the resources available for establishing these pools shall be calculated on the basis of three percent and four percent, respectively of total statewide general hospital reimbursable inpatient operating costs in the respective rate year after application of the trend factor plus the addition of capital costs.

(1) To be eligible to receive an allowance from the bad debt and charity care pool funded by paragraph (4) of this subdivision and the financially distressed hospital pool funded by subdivision (g)(8) of this section, a facility must meet the following criteria. Compliance with these criteria shall be subject to audit.

(i) The costs of bad debt and charity care must be determined according to the following definitions and must be reported in the appropriate sections of the facility's Institutional Cost Report.

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(a) Bad debt. Bad debts are the amounts which are considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services, and are collectable in money in the next operating cycle. Bad debts shall be determined in accordance with generally accepted accounting principles which recognize the direct charge-off method, the reserve method, or a combination of the direct charge-off method and the reserve method. Additionally, the debt must be related to a service which the facility has been authorized by the commissioner to provide. If an amount previously written off as a bad debt is recovered in a subsequent accounting period, the amount written off must be used to reduce the cost of bad debt for the period in which the collection is made.

(b) Charity care. Charity care is the reduction in charges made by the provider of services because the patient is indigent or medically indigent. Reductions in charge for employees which are accounted for as fringe benefits, such as hospitalization and personal health programs, are not considered charity care. Courtesy allowances, such as free or reduced-charge services provided to other than the indigent or medically indigent, are not considered charity care.

(ii) The facility must maintain reasonable collection efforts and procedures.

(a) The hospital must utilize commonly accepted business methods and practices to collect unpaid amounts from all classes of payors. Such methods may differ for inpatient and outpatient services. The hospital shall utilize good business judgment and practices in determining the amounts to be collected.

(b) The hospital must determine the patient's ability to pay for the services rendered and document the method under which the determination was made.

(c) The hospital must generate and maintain written documentation of requests for payment for services provided.

(d) The hospital must take any subsequent actions as appropriate within good business practice such as subsequent billings, collection letters or telephone calls. These subsequent actions must be documented.

(e) The hospital may turn accounts over to a collection agency. Amounts turned over may be written off as a bad debt at the time of turnover. Amounts collected by the facility after write-off

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constitute a recovery of bad debts in the period collected.

(f) The hospital shall not be required to pursue judgment claims before the account can be written off.

(g) A policy which is consistent and follows commonly accepted business methods and practices concerning the time period that must elapse between initial billing and the determination that an unpaid bill is a bad debt must be maintained from January 1, 1981 to December 31, 1985. A finding of inconsistency may be waived upon demonstration by the facility that a policy change served to make bad debt determination policies consistent with the requirements of this subdivision.

(iii) The facility shall submit by October 1, 1983 and thereafter within 120 days from the beginning of a rate year, a report containing an opinion by its independent certified public accountant or independent licensed public accountant in a form approved by the commissioner after consultation with the New York State Society of Certified Public Accountants, as to whether the facility meets the criteria of this subdivision for eligibility for a distribution from the bad debt and charity pool. The commissioner may accept a report containing an opinion that the facility is in compliance with the criteria of this subdivision as establishing initial eligibility as of the first day of each rate year for distribution from the pool. Thereafter if the commissioner determines that the facility is not in compliance, such noncompliance shall be applicable for the entire rate year. The facility may appeal this noncompliance determination pursuant to the provisions of section 86-1.17(i) of this Subpart. If the facility chooses to appeal the commissioner's determination, the facility will continue to receive payments from its regional pools, if otherwise eligible, until a final determination has been made. If it is finally determined that the facility is not in compliance or if the facility chooses not to appeal the commissioner's determination that it is out of compliance, the facility shall repay to its regional pools all monies received from these pools for the period during which it was out of compliance. If a facility fails to repay such monies to its regional pools within a reasonable period of time, major third-party payors shall adjust the facility's rate as directed by the commissioner to reflect money owed to the pools and shall pay these monies to the pool administrator.

(2) For the purposes of this subdivision only, the following words or phrases shall be defined as follows:

(i) Major public sector shall mean all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospitals Corporation as established in chapter 1016 of the Laws of 1969, as amended and all other

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public general hospitals having annual inpatient operating costs in excess of \$25 million.

(ii) Voluntary sector shall mean all voluntary nonprofit, private proprietary and public general hospitals other than major public general hospitals.

(3) reserved

(4) reserved

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Reserved

(g)(5) reserved

(g)(6) reserved

(g)(7) reserved

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(8) reserved

(g)(9) reserved

(h) reserved

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(1)(1) reserved

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(1)(2) reserved

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(m) Payment rates for the periods January 1, 1986 through December 31, 1986 and January 1, 1987 through December 31, 1987 shall be established on a prospective basis and shall be based on the reimbursable operating costs used in determining payments for services provided during 1985. Such costs shall include the annualized cost impact of rate revisions or adjustments made with respect to such services. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days, except as stated in section 86-1.41 of this Subpart.

(1) Total allowable costs of a facility shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the federal Social Security Act and article 43 of the New York State Insurance Law and other patients, so that the share assigned to each program is based upon actual services received by that program's beneficiaries. To accomplish this apportionment, for each program the ratio of beneficiary charges to total patient charges for the services of each ancillary department shall be applied to the cost of the department; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem. This apportionment shall be based on 1984 data. Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diems, unless the the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(2) The costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned among programs on the basis of payor experience. Apportionment on the basis of experience shall be based on the dollar ratios for each payor of the facility's malpractice losses paid by that payor to its total paid malpractice losses for the 1984 cost reporting period and the preceding four-year period. If a facility has no malpractice loss experience for the five-year period, the costs of malpractice insurance premiums or self-insurance fund contributions must be apportioned among the programs based on the statewide ratio of malpractice awards paid to program beneficiaries to malpractice awards paid to all patients. If a facility pays allowable uninsured malpractice losses incurred by program beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as a governmental provider, such losses and related direct costs must be directly assigned to a respective program for reimbursement.

(3) reserved

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(4) To the allowable basic rates, computed in accordance with ceiling limitations and prior to the addition of a factor for capital costs, there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. This factor shall be developed in accordance with section 86-1.15 of this Subpart. The allowances specified in subdivisions (p) and (q) of this section shall be computed on the basis of, and added to, the trended basic rate plus capital costs.

(5) Adjustments to rates shall be made to reflect case mix and volume changes and appeals filed and/or adjustments made pursuant to this Subpart.

(n)(1) reserved

(2) reserved

(3) reserved

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(o) reserved

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(p) Regional pools in 1986 and 1987: bad debt and charity care. Regional pools will be established from which allowances will be added to hospital rates to help pay for the costs of bad debt and charity care for the rate years 1986 and 1987. Such pools shall receive funds from hospitals pursuant to the provisions of this subdivision and section 86-1.37 of this Subpart. For the rates established in 1986 and 1987, the resources available for the purposes of establishing the bad debt and charity care pools shall be calculated on the basis of four and one-half percent of the total statewide calculated on the basis of four and one-half percent of the total statewide general hospital (including both major public hospitals and all other hospitals) reimbursable inpatient costs after application of the trend factor excluding inpatient costs related to services provided to beneficiaries of subchapter XVIII of the federal Social Security Act, and inpatient uncollectible amounts.

(1) To be eligible to receive an allowance from the bad debt and charity care pool funded by paragraph (4) of this subdivision and the financially distressed hospital pool funded by subdivision (q) of this section, a facility must meet in 1986 and 1987 the criteria specified in paragraphs (1) and (2) of subdivision (g) of this section with the following exception: a policy which is consistent and follows commonly accepted business methods and practices concerning the time period that must elapse between initial billing and the determination that an unpaid bill is a bad debt must be maintained from January 1, 1981 to December 31, 1987. Compliance with these criteria shall be subject to audit.

(2) For the purpose of this subdivision only, the following words or phrases shall be defined as follows:

(i) Major public sector shall mean all State-operated general hospitals, all general hospitals operated by the New

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York City Health and Hospitals Corporation as established by chapter 1016 of the Laws of 1969, as amended, and all other public general hospitals having annual inpatient operating costs in excess of \$25 million.

(ii) Voluntary sector shall mean all voluntary nonprofit, private proprietary and public general hospitals other than major public general hospitals.

(3) Hospital need shall be calculated pursuant to the provisions of paragraph (3) of subdivision (g) of this section.

(4) reserved

(p)(5) reserved

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(p)(6) reserved

(p)(7) reserved

(q) reserved

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(r) reserved

(s) a case mix adjustment to general hospitals' rates of payment and revenue caps shall be made in 1984 and 1985 and to general hospitals' rates of payment in 1986 and 1987 according to the provisions of this subdivision.

(1) For 1984 and 1985, a hospital shall have its case mix changes from 1981 to the appropriate rate year calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the department, and diagnosis related group (DRGs). (The SIWs are the relative cost weights established by the department for DRGs such that the SIW for any given DRG indicates how expensive the average patient is in those DRGs compared to the average patient in all DRGs). The operating cost per day SIWs shall be all-payor SIWs.

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(2) For 1986 and 1987, a hospital shall have its case mix changes from the previous rate year to the appropriate rate year calculated on the basis of the non-Medicare patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.2 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the department and diagnosis related groups (DRGs). The operating cost per day SIWs shall be non-Medicare payor SIWs.

(3) [In 1984 and 1985, hospitals] Hospitals whose case mix as measured according to the provisions of [paragraph] paragraphs (1) and (2) of this subdivision increased by an amount less than or equal to 1 percent but did not decrease by an amount greater than [or equal to] 2 percent shall not receive any adjustment. Hospitals whose case mix increased by more than 1 percent [or more] or decreased by more than 2 percent [or more] shall receive an adjustment to their operating rates of payment and revenue caps pursuant to the provisions of paragraph [(5)] (4) of this subdivision.

[(3) For 1986, a hospital shall have its case mix change from 1985 to 1986 calculated as follows:

(i) The department shall evaluate all hospitals' patient discharge data used as the basis upon which the hospital's case mix change is calculated for the percentage of patient records which, relevant to the data necessary to assign a patient to a diagnosis related group, are either inconsistent, incomplete, or not sufficiently specific.

(ii) A hospital having 10 percent or less of its discharge data which is incomplete, inconsistent or not sufficiently specific shall have its case mix change calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights (SIWs) developed by the Department, and diagnosis related groups. The SIWs that shall be used shall be payor-specific.

(iii) A hospital having more than 10 percent of its discharge data which is incomplete, inconsistent or not sufficiently specific shall have its case mix change calculated on the basis of the patient discharge data submitted to the commissioner by the hospital pursuant to the provisions of subdivisions (f) and (g) of section 86-1.3 of this Subpart and section 405.29 of Chapter V of this Title, operating cost per day service intensity weights, and patient groupings which shall include major diagnostic categories and may include such factors as:

(a) presence of surgical procedures other than imaging procedures;

(b) sex; and

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(c) age.

The SIWs that shall be used shall be payor specific.

(4) In 1986, hospitals shall have their operating rates adjusted for only those payors whose case mix index calculated according to the provisions of paragraph (3) of this subdivision changes by 1 percent or more. Adjustment shall be made according to the provisions of paragraph (5) of this subdivision.

(5)] (4) The rates of payment and revenue caps of hospitals eligible for a case mix adjustment shall be adjusted as follows:

(i) [in no case shall the first 1 percent of change in case mix be reflected in an adjustment to hospital rates of payment and revenue caps, except as calculated for rate years 1984 and 1985 pursuant to paragraph (2) of this subdivision;

(ii)] for those hospitals receiving an adjustment pursuant to the provisions of paragraph (3) of this subdivision the operating cost per diems paid to hospitals shall be adjusted upward or downward in direct proportion to the percent of change in case mix, as measured according to the provisions of either paragraph (1) or [(3)] (2) of this subdivision, as appropriate, that exceeds [1 percent, except as provided in paragraph (2) of this subdivision] the corridors established in paragraph (3) of this subdivision and in accordance with subparagraph [(iii)]ii of this paragraph; and

[(iii)]ii the commissioner shall not recognize the total upward case mix adjustment provided for in this subdivision if he finds that prior rate year adjustments have previously reimbursed a portion of all of such case mix associated cost increases. Such prior rate year adjustments shall include adjustments pursuant to section 86-1.12 of this Subpart which included an adjustment for case mix and that portion of any rate adjustment made pursuant to paragraphs (1), (3), (4) and/or (7) of section 86-1.17(a) of this Subpart which accounted for a change in case mix.

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86-1.12* Volume adjustment. Within six months following the rate period, a volume adjustment to the rate will be made for those hospitals which meet the following criteria and which are entitled pursuant to the following calculations:

(a) The adjustment will be available for all hospitals except those:

- (1) which closed during the rate year of the volume adjustment; and
- (2) with rates calculated based on budget.

(b) The rate will be adjusted according to the following rules:

- (1) The change in total certified days will be construed as the net change in total certified days attributable to a change in the facility's average length of stay from the base year to the rate year and a change in the facility's number of discharges from the base year to the rate year.
- (2) And change of less than one percent in total certified days from the base year to the rate year, adjusted for leap years, will result in no rate adjustment.
- (3) Any change of less than five percent but greater than or equal to one percent in total certified days from the base year to the rate year, adjusted for leap years, will result in an automatic rate adjustment, from which there shall be no administrative appeal.
 - (i) In calculating this automatic rate adjustment, it will be recognized that all of a facility's capital costs are fixed. Operating costs shall be considered fixed where there are decreases in volume as measured by discharges and/or average length of stay. Operating costs shall be considered variable where there are increases in volume as measured by discharges and/or average length of stay.
 - (ii) That portion of the automatic rate adjustment for operating costs attributable to the facility's change in average length of stay from the base year to the rate year shall be made incrementally according to the steps in the following table:

Decrease in Patient Days		Increase In Patient Days	
(% Change)	Fixed Variable Percent	(% Change)	Fixed Variable Percent
0 to 5	80/20	0 to 5	80/20
5+ to 7	75/25	5+ to 7	75/25
7+ to 10	70/30	7+ to 10	70/30
10+	65/35	10+	65/35

- (iii) That portion of the automatic rate adjustment for operating costs attributable to the facility's change in discharges from the base year to the rate year shall be made incrementally according to the steps in the following table:

* Used in the calculation of rates for the period January 1, 1983 through December 31, 1987.

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Decrease in Patient Discharges		Increase in Patient Discharges	
(% change)	Fixed Variable Percent	(% change)	Fixed Variable Percent
0 to 6	60/40	0 to 6	60/40
6+	50/50	6+	50/50

- (4) A change greater than or equal to five percent in total certified days between the base year and the rate year, adjusted for leap years, will result in a further rate adjustment which will be in accordance with subparagraphs (3)(i)-(iii) of this subdivision.
- (i) A facility having a change in total certified days of greater than or equal to five percent may ask the commissioner to review the reasons for the change in volume and to revise the target volume and/or fixed and variable percentage(s). The commissioner shall determine the cause for the change and its relation to the efficient costs of providing patient care services. Based upon this review, the commissioner may adjust the target volume and/or the fixed and variable percentage(s) cited in paragraph (3) of this subdivision upward and/or downward, independent of the facility's request to allow the hospital to be reimbursed for the costs of efficient production of services for the change in volume.
- (ii) Facilities having a change in total certified days of greater than or equal to five percent shall have the right to administratively appeal their rate adjustment pursuant to section 86-1.17 of Subpart, within 120 days of receipt of the initial notice of said adjustment.
- (c) Similarly, when utilization in the base year or rate year is affected by labor strikes, lockouts, or by the establishment of a certified hospital-based ambulatory surgery service as defined in section 405.2(n) of this Title, a proportionate revision to the target volume will be determined.
- (d) All payment adjustments resulting from the application of this provision shall be made within six months following the republication of rate referred to above.
- (e) Volume adjustment for 1986 and 1987. Within six month following the rate period, a volume adjustment to the rate will be made in accordance with subdivisions (a) through (d) of this section based upon changes in utilization between 1985 as the base year and 1986 as the rate year, and 1986 as the base year and 1987 as the rate year, with the following exceptions:
- (1) The volume adjustment shall take into consideration only changes in total certified days for other than beneficiaries of title XVIII of the Federal Social Security Act.
 - (2) The commissioner may provide for the volume adjustment in the rate year if the facility submits in writing a request for such an adjustment and the facility decertifies at a minimum the equivalent of the number of beds comprising one nursing unit.
 - (3) If a hospital has experienced a change of greater than five percent in total certified days between 1981 (base year) and 1985

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(rate year), and did not meet , minimum medical/surgical utilization requirements of section 86-1.9 of this Subpart in 1985, and received a rate adjustment in accordance with this section, 86-1.12, for the 1985 rate year, the commissioner shall adjust such hospital's 1987 rate for changes in certified days from 1986 to 1987 and shall, in calculating such hospital's 1987 per diem inpatient rate, include those imputed medical/surgical days necessary to meet the minimum medical/surgical utilization requirements pursuant to section 86-1.9 unless such hospital submits in writing by December 31, 1987 a request to decertify the beds necessary to meet such minimum medical/surgical utilization requirements. In no event shall the volume adjustment computed in accordance with this paragraph result in a per diem rate greater than the hospital's actual rate year inpatient per diem costs.

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Section 86-1.13 Groupings. (a) For the purpose of establishing routine and ancillary cost ceilings (for other than specialty hospitals), peer groups of hospitals shall be developed taking into consideration, but not limited to, the following general criteria:

- (1) case mix;
- (2) service mix;
- (3) patient mix;
- (4) size of facility;
- (5) teaching activity; and
- (6) geographic location.

(b) Based on the variable listed in subdivision (a) of this section, the commissioner shall establish a group for each facility in which the facility is at the center of its group—called seed clustering. The size of each group may be variable and shall be determined using acceptable statistical parameters which define the degree of comparability within each group. For the purpose of grouping in accordance with seed clustering, hospitals will be stratified to separate facilities located in the Blue Cross/Blue Shield of Greater New York region from facilities in the rest of the State.

(c) In the event a hospital fails to submit the data required for inclusion in a group which is developed in accordance with subdivision (a) of this section, the commissioner, on the basis of available data, shall develop proxy measures for the required variables, and based on these measures shall construct a peer group. The proxy variables shall not have a financial impact on any facility except that which failed to submit the requisite data.

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Section 86-1.14 Ceilings on payments. (a) Reimbursement rate ceilings will be established as specified in this section for comparable groups of medical facilities (except specialty hospitals) developed in accordance with section 86-1.13 of this Subpart. The ceilings shall be established after the application of a wage equalization factor and a power equalization factor but prior to the addition of a factor to bring costs to projected expenditure levels during the effective period of the reimbursement rate.

(b) Facilities with ancillary costs less than 75 percent or over 125 percent of the peer group weighted average shall have such costs raised or lowered to the specified limits. The peer group weighted ancillary average cost of the respective groups shall then be recomputed with these adjustments. The original ancillary costs of such facilities shall be subject to the ceilings.

(c)(1) In computing the allowable costs for inpatient routine services for hospitals, no amount shall be included that is in excess of 107.5 percent of the weighted average per diem cost, using total expected patient days developed from application of the length of stay standards, of routine inpatient services of all hospitals in the peer group. For the purposes of this calculation, the total expected patient days shall also include imputed days. For the purpose of this computation, routine inpatient services shall not include capital costs, or costs of schools of nursing, ambulance services, interns and residents, supervising physicians and other physicians. In computing the allowable costs for ancillary services for hospitals, no amount shall be included that is in excess of 105 percent of the weighted average per discharge cost of ancillary services (including imputed discharges) of all hospitals in the peer group. For the purpose of this computation, ancillary services shall not include capital costs, costs of schools of nursing, ambulance services, interns and residents, supervising physicians and other physicians. In determining a facility's disallowances, its routine and ancillary ceilings shall subsequently be adjusted to consider differences in a hospital's case mix complexity relative to its peers.

(2) For the purpose of establishing limits on allowable costs for interns and residents, supervising physicians and other individual physicians, no amount shall be included which is in excess of their operational cost per day in the prior year inflated by the price index used for physician services as developed in section 86-1.15 of this Subpart. For the purpose of this computation, other costs excluded from peer group ceiling calculations as set forth in paragraph (1) of this subdivision, shall not be included.

(d) For the purposes of adjusting the allowable costs for inpatient routine services for other than specialty hospitals, a total length of stay standard for each hospital will be developed which shall take into consideration the following variables:

- (1) patient mix characteristics;
- (2) whether the hospital is a teaching or nonteaching institution;

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- (3) the diagnostic mix of the hospital, including whether the hospital has a certified hospital-based ambulatory surgery service;
- (4) presence or absence of surgery; and
- (5) the geographic region the hospital is located in.

For the purpose of establishing standards a teaching hospital is one which has a special educational index greater than 100, as determined by the commissioner.

(e) For the purpose of establishing limits on allowable costs for a specialty hospital, a weighted average percentage change in operational cost per day from the prior year to the base year will be computed for facilities in that hospital's region. In computing the allowable cost for specialty hospitals no amount shall be included which is in excess of their operational cost per day in the prior year inflated by the aforementioned average percent change. For the purpose of this computation, costs excluded from peer group ceiling calculations, as set forth in subdivision (c) of this section shall not be included. In addition, reimbursement for specialty hospitals shall be limited to the movement in the application of the trend factor established under section 86-1.15 of this Subpart for 1984 and 1985 reimbursement periods. The allowances and pool distributions described in 86-1.11 shall be available to specialty hospitals pursuant to the conditions of that section.

* * *

(h) Limits on ceiling disallowances. (1) The total percentage of regional operational disallowances, excluding the minimum utilization disallowances, will be limited to the percentage of 1982 regional costs disallowed as a result of routine disallowances and one-half the length of stay disallowances, adjusted by a statewide adjustment factor, plus ancillary disallowances and the professional component limitation as set forth in subdivision (c) of this section. This maximum disallowance and the rate year disallowance subject to it will be adjusted to reflect appeals. Any excess disallowance in 1983 will result in proportionate relief to all hospitals subject to the disallowance within the affected region.

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86-1.15* Calculation of trend factor. (a) The commissioner shall establish a trend factor for allowable operating cost increases during the effective period of the reimbursement rate. Such factor shall be determined as follows:

(1) The elements of a medical facility's costs shall be weighted based upon data for the following categories:

- (i) salaries;
- (ii) employee health and welfare expense;
- (iii) nonpayroll administrative and general expense;
- (iv) nonpayroll household and maintenance expense;
- (v) nonpayroll dietary expense; and
- (vi) nonpayroll professional care expense.

(2) Each weight shall be adjusted by the appropriate price index for each category noted above, as well as for subcategories. Included among these cost indicators are elements of the United States Department of Labor consumer and wholesale price indices and special indices developed by the State Commissioner of Health for this purpose.

(3) Geographic differentials may be established where appropriate.

(4) The cost indicators used in determining the projection factors shall be compared on a semiannual basis with available data on such indicators, and any other economic indicators as deemed appropriate by the Commissioner of Health. Based upon such review the commissioner may, in his discretion, either certify new rates or adjust subsequent rates for any period or portion thereof when he determines that such new rates or adjusted rates are necessary to avoid substantial inequities arising from the use of previously certified rates.

(5) This subdivision has been superseded by section 2807-a(8) of the Public Health Law. The commissioner shall implement adjustments to the trend factor semiannually; provided, however, that adjustments, except for the final adjustment, in the trend factor, shall not be required unless such adjustment would result in the weighted average of the operating cost component of the rates of charge limits differing by more than one half of one percent from that which was previously determined.

(b) (1) The maximum increase in allowable charges shall be calculated by the use of the trend factors calculated in accordance with the methodology described in subdivision (a) of this section.

(2) The maximum allowable increase in gross inpatient charges shall be the product of allowable 1982 gross inpatient charges, the 1983 trend factor, and the ratio of 1981 inpatient costs to 1980 gross inpatient charges.

* Used in the calculation of rates for the period January 1, 1983 through December 31, 1987.

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- (3) The provisions of this subdivision shall expire on December 31, 1983.
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Section 86-1.16 Adjustments to provisional rates based on errors.
Rate appeals pursuant to section 86-1.17(a)(1)-(2) of this Subpart, if not commenced within 120 days of receipt of the commissioner's initial rate computation sheet, may be initiated at time of audit of the base year cost figures upon or prior to receipt of the notice of program reimbursement. Such rate appeals shall be recognized only to the extent that they are based upon mathematical or clerical errors in the cost and/or statistical data as originally submitted by the medical facility, or revisions initiated by a third-party fiscal intermediary or, in the case of a governmental facility, by the sponsor government, or mathematical or clerical errors made by the Department of Health. Such notice of appeal must be presented in writing prior to or at the exit conference for such audits.

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Section 86-1.17 Revisions in certified rates

- (a) The State Commissioner of Health shall consider only those applications for prospective revisions of certified rates and any established revenue cap in the current year which are in writing and are based on one or more of the following:
- (1) reserved
 - (2) reserved
 - (3) reserved
 - (4) Documented increases in the overall operating costs of a medical facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved for the medical facility by the commissioner through the certificate of need (CON) process. The provisions of this paragraph shall be applicable with respect to appeals filed with payors, including article 43 corporations and intermediaries responsible as payors for titles XVIII and XIX Social Security Act programs. To receive consideration for the reimbursement of such

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costs in the current rate year, a facility shall submit, at time of appeal or as requested by the commissioner, detailed staffing documentation, proposed budgets and financial data, anticipated unit costs and incremental costs for all directly and indirectly affected cost centers, initiated by the approved CON application involving any of the aforesaid activities pursuant to section 710.1 of this Title.

(i). reserved

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(ii) If after the application of the programmatic and cost analyses, the commissioner determines that the budgeted incremental operating costs are more than 7.5 percent of the base year reimbursable operating costs for the rate(s) and rate year being appealed, a facility shall be reimbursed as follows:

(a) Net incremental costs, which are based on budgeted data, shall be determined by the commissioner after programmatic and cost analyses. Such analyses shall include, but not be limited to, a facility-wide review of cost centers directly and indirectly affected by the approved CON project. Such analyses shall result in a determination which limits budgeted costs as follows:

(1) Net increases in staffing shall be evaluated in accordance with the department peer group guidelines. For the purpose of establishing peer group staffing guidelines, at least the following general criteria shall be considered:

(i) number of certified beds;

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- (ii) allocation statistics appropriate to each cost center or unit of service; and
- (iii) number of full-time equivalents (FTE's) per each cost center or unit of service.

Based on the groups established pursuant to the above, the commissioner shall develop staffing guidelines which shall be the average of staffing within a group for each cost center or unit of service. The guidelines developed through this process in conjunction with the programmatic review shall be used to evaluate the appealing facility's requested FTE complement per cost center or unit of service.

(2) Nonsalary reimbursable operating costs shall be limited to the facility's base year unit costs or, if these are not available, to group average unit costs, trended forward to the respective rate year by the trend factor established according to section [86-1.15] 86-1.58 of this Subpart, multiplied by the appropriate budgeted statistics.

(3) Energy costs shall be reimbursed in full if the facility can document that it has:

- (i) performed an energy audit pursuant to the guidelines of the State Energy Office in the "Energy Audit Report, EA-1 10-80 (revised as of October 1980), General

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Instructions, Grant Programs for Schools and Hospitals and Buildings Owned by Units of Local Government and Public Care Institutions" and the accompanying Energy Audit Report, which are hereby incorporated by reference. Copies of the Energy Audit General Instructions and Report may be obtained from the New York State Energy Office, Empire State Plaza, Agency Building 2, 20th Floor, Albany, New York 12223. A copy is available for inspection and copying at the Records Access Office of the New York State Department of Health, Erastus Corning 2nd tower, Empire State Plaza, Albany, New York 12237, and at the New York State Department of State, 162 Washington Avenue, Albany, New York 12231; and

(ii) adhered to Subchapter C, Chapter 2, Subtitle BB of Title 9 NYCRR (New York State Lighting Standards), as adopted by the New York State Energy Office on September 16, 1980, hereby incorporated by reference with respect to any new construction which is the subject of an appeal hereunder.

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(4) If compliance with the above energy standards has not been documented, then energy costs shall be limited to the base year costs trended forward to the respective year by the trend factor established pursuant to section [86-1.15] 86-1.58 of this Subpart, multiplied by the appropriate budgeted statistics.

(b) reserved

(c) reserved

(d) reserved

(e) reserved

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(5) reserved

(6) reserved

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(8) reserved

(9) reserved

(b) reserved

(c) An application by a medical facility for review of a certified rate is to be submitted on forms provided by the department and shall set forth the basis for the appeal and the issues of fact. Documentation shall accompany the application, where appropriate, and the department may request such additional documentation as determined necessary.

(1) The affirmation of revision of the rate upon such staff review shall be final, unless within 30 days of its receipt a hearing is requested, by registered or certified mail, before a rate review officer on forms supplied by the department. The request shall contain a statement of the factual issues to be re-

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solved. The facility may submit memoranda on legal issues which it deems relevant to the appeal.

(2) Where the rate review officer determines that there is no factual issue, the request for a hearing shall be denied and the facility notified of such determination. No administrative appeal shall be available from this determination. The rate review officer, where he determines that there is factual issue, shall issue a notice of hearing establishing the date, time and place of the hearing and setting for the factual issues as determined by such officer. The hearing shall be held in conformity with the provisions of section 12-a of the Public Health Law and the State Administrative Procedure Act.

(3) The recommendation of the rate review officer shall be submitted to the Commissioner of Health for final approval or disapproval and recertification of the rate where appropriate.

(4) The procedure set forth in this subdivision shall apply to all applications for rate reviews which are pending as of April 1, 1978. Rate appeals filed prior to April 1, 1978 will not be required to be resubmitted subsequent to April 1, 1978.

(d) Reserved

(e) In reviewing appeals for revisions to certified rates, the commissioner may refuse to accept or consider an appeal from a medical facility:

(1) providing an unacceptable level of care as determined after review

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(2) operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council in one of its facilities;

(3) where it has been determined by the commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law; or

(4) where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid. In such instances subdivision (d) of this section shall not be effective until the date the appeal is accepted by the commissioner.

(f) Any medical facility eligible for title XVIII (Medicare) certification providing services to patients insured under title XIX which is not, or ceases to be, a title XVIII provider of care shall have its current reimbursement rate reduced by 10 percent. This rate reduction shall remain in effect until the first day of the month following certification of such a provider by the title XVIII program. Such rate reductions shall be in addition to any revision of rates based on audit exceptions.

(g) reserved

(h) reserved

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(i) reserved

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86-1.18 Rates for services. (a) The State Commissioner of Health shall, in certifying schedules for government payments to hospitals, separately identify all-inclusive prospective rates for inpatient services, emergency services, clinic services and such other services for which a separate rate is deemed appropriate by the commissioner.

(b) Payment for newborns shall be made at one third of the mother's rate.

(c) The State Commissioner of Health shall, in certifying schedules for government payments to hospitals, establish one all-inclusive prospective rate for inpatient hospital care to reflect the services provided by each facility possessing a valid operating certificate. In addition, the commissioner shall identify and certify all-inclusive prospective rates for emergency services, clinic services and for such other services as deemed appropriate.

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Section 86-1.19 Rates for medical facilities without adequate cost experience. (a) This subdivision shall apply where the fiscal and statistical data of the facility are unavailable through no fault of the provider or its agents, and due to circumstances beyond its control, or when there is a new facility without adequate cost experience, or when there is a new service for which there is a discrete rate and which is without adequate cost experience.

(b) The rates certified for such medical facilities or approved services as set forth in subdivision (a) of this section, shall be determined on the basis of generally applicable factors, including but not limited to the following:

- (1) the usual and customary rates, for comparable services, in the geographic area;
- (2) satisfactory cost projections;
- (3) allowable actual expenditures; and
- (4) an anticipated utilization of no less than the average for the geographic area or the minimums established in this Part, whichever is greater.

* * *

(d) All rates of reimbursement certified pursuant to this section shall be subject to audit pursuant to section 86-1.8 of this Subpart. After audit, the facility shall receive a rate based upon actual allowable costs incurred during the rate period, consistent with the provisions of this Subpart.

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Section 86-1.20 Less expensive alternatives. Reimbursement for the cost of providing services may be the lesser of the actual costs incurred or those costs which could be reasonably anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served as effective alternatives or substitutes for the whole or any part of such service. In this respect, the chief executive officer of a medical facility will be required to submit to the State Department of Health as an attachment to the uniform financial report, effective with report periods beginning on or after January 1, 1977, an affidavit delineating the medical facility's practices of pursuing joint central services or less expensive alternatives. There must be a letter accompanying the affidavit, reflecting the health systems agency's acknowledgement that they have received such affidavit.

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Section 86-1.21 Allowable costs. (a) To be considered as allowable in determining reimbursement rates, costs must be properly chargeable to necessary patient care. Except as otherwise provided in this Part, or in accordance with specific determination by the commissioner, allowable costs shall be determined by the application of the principles of reimbursement developed for determining payments under the title XVIII (Medicare) program.

(b) Allowable costs may not include costs for services that have not been approved by the commissioner.

(c) Allowable cost shall include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a facility.

(d) Allowable costs may not include amounts in excess of reasonable or maximum title XVIII (Medicare) costs or in excess of customary charges to the general public. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(e) Allowable costs shall not include expenses or portions of expenses reported by individual facilities which are determined by the commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item.

(f) Any general ceilings applied by the commissioner, as to allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.

(g) [Reserved]

(h) Allowable costs shall not include costs which principally afford diversion, entertainment or amusement to their owners, operators or employees.

(i) Allowable costs shall not include any interest charged or penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty.

(j) Allowable costs shall not include the direct or indirect costs of advertising, public relations and promotion except in those instances where the advertising is specifically related to the operation of the facility and not for the purpose of attracting patients.

(k) Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(l) Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated, to the satisfaction of the commissioner, to be allocable to expenditures other than for public relations, advertising and political contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the commissioner pursuant to subdivision (f) of this section.

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(m) [Reserved]

(n) Allowable costs shall not include any element of cost, as determined by the commissioner, to have been created by the sale of a medical facility.

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Section 86-1.22 Recoveries of expense. Operating costs shall be reduced by the cost of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs of these services and activities. Examples of activities and services covered by this provision include:

- (a) drugs and supplies sold for use outside the medial facility;
- (b) telephone and telegraph services for which a charge is made;
- (c) discount on purchases;
- (d) living quarters rented to employees;
- (e) employee cafeterias;
- (f) meals provided to special nurses or patients' guests;
- (g) operation of parking facilities for community convenience;
- (h) lease of office and other space of concessionaries providing services not related to medical service;
- (i) tuitions and other payments for educational service, room and board and other services not directly related to medical service.

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86-1.23 Depreciation. (a) Reported depreciation based on historical cost is recognized as a proper element of cost. Useful lives shall be the higher of the reported useful life or those useful lives from the Estimated Useful Lives of Depreciable Hospital Assets, 1983 edition, American Hospital Association, consistent with title XVIII provisions. This regulation is effective for depreciable assets purchased on or after January 1, 1978. Copies of this publication are available from the American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611, and a copy is available for inspection and copying at the offices of the records access officer of the Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.

(b) In the computation of rates effective January 1, 1975 for voluntary facilities, depreciation shall be included on a straight-line method on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight line method or accelerated under a double declining balance or sum-of-the-years' digit method. Depreciation shall be funded unless the Commissioner of Health shall have determined, upon application by the facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. Effective with the fiscal year starting on or after January 1, 1981 in instances where funding is required (that being the transfer of monies to the funded accounts), depreciation on major movable equipment shall be funded in the year revenue is received from the reimbursement of each expense and in the amount included in reimbursement for that year. In instances where funding is required, such fund may be used only for capital expenditures with approval as required for the amortization of capital indebtedness. Funding for plant and fixed equipment shall mean that the transfer of monies to the funded accounts shall occur by the end of the fiscal period in which the depreciation is recorded. Board- designated funds and the accrual of liabilities to the funded depreciation accounts (due to/from accounts) shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts [for six months or more] to be considered as valid funding transactions unless expended for the purposes for which it was funded.

(c) In the computation of rates effective January 1, 1975 for public facilities, depreciation is to be included on a straight-line method on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years' digits method.

(d) In the computation of reimbursement rates for proprietary facilities, depreciation is to be computed on a straight-line basis on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years' digits method.

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66(a)**

(e) Medical facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Subpart. In lieu of depreciation and interest, on the loan financed portion of the facilities, the State Commissioner of Health shall allow level debt service on the mortgage loan, for all loans approved for financing prior to January 1, 1990, together with such required fixed charges, sinking funds and reserves as may be determined by the Commissioner as necessary to assure repayment of mortgage indebtedness. For loans approved for financing on or after January 1, 1990, medical facilities shall receive reimbursement in the form of interest and depreciation in accordance with the remainder of this Subpart.

TN #92-36
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Section 86-1.24 Interest. (a) Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities.

(b) To be considered as an allowable cost, interest shall be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained. Financial need for capital indebtedness relating to a specified project shall exist when all available restricted funds designated for capital acquisition of that type have been considered for equity purposes.

(c) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trusted malpractice insurance funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense. Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss shall not be allowable. Rate year investment income shall reduce rate year interest expense allowed for reimbursement as follows:

(i) for all medical facilities, investment income shall

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67(a)**

(ii) any remaining amount of investment income, after application of paragraph (i), shall be used to reduce capital interest expense reimbursed that year for medical facilities; and

(iii) any remaining amount of investment income after application of paragraph (ii) shall not be considered in the determination of allowable costs.

(d) Interest on current indebtedness shall be treated and reported as an operating, administrative expense.

(e) Interest on capital indebtedness is an allowable cost if the debt generating the interest is approved by the commissioner, incurred for authorized purposes, and the principal of the debt does not exceed either the approval of the commissioner or the cost of the authorized purposes. Capital indebtedness shall mean all debt obligations of a facility that are:

(1) evidenced by a mortgage note or bond and secured by a mortgage on the land, building or nonmovable equipment; a note payable secured by the nonmovable equipment of a facility; a capital lease;

(2) incurred for the purpose of financing the acquisition, construction or renovation of land, building or nonmovable equipment;

(3) found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility. Interest related to refinancing indebtedness shall be considered an allowable cost only to

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the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness then being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable on acceptance demonstration to the Commissioner of Health that such refinancing will result in a debt service savings over the life of the indebtedness; or

(4) incurred for the purpose of advance refunding of debt. [~~Losses~~] Gains and losses resulting from the advanced refunding of debt shall be treated and reported as a deferred charge or asset. This deferred charge or asset is to be amortized on a straight-line basis over the period to the scheduled maturity day of the refunding debt.

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67(c)

(f) Where a public finance authority has established a mortgage rate of interest such that sufficient cash flows exist to retire the mortgage prior to the stated maturity, the amount of the mortgage to be forgiven, at the time of such forgiveness, shall be capitalized as a deferred asset and amortized over the remaining mortgage life, as a reduction to the facility's capital expense.

(g) Voluntary facilities shall report mortgage obligations, financed by public finance authorities for their benefit and which they are responsible to repay, as liabilities in the general fund, when such mortgage obligations are incurred.

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Section 86-1.25 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understandings, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

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[Section 86-1.26 Educational activities. The costs of educational activities less tuition and supporting grants shall be included in the calculation of the basic rate provided such activities are directly related to patient care services.]

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Section 86-1.27 Compensation of operators and relatives of operators.

(a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a nonrelated employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law and regulation.

(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators, the commissioner may consider the quality of care provided to patients by the facility during the year in question.

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Section 86-1.28 [Costs of related] Related organizations. (a) A related organization shall be defined as any entity which the medical facility is in control of or is controlled by, either directly or indirectly, or an organization or institution whose actions or policies the facility has the power, directly or indirectly, to significantly influence or direct, or a special purpose organization, or where an association of material interest exists in an entity which supplies goods and/or services to the medical facility, or any entity which is controlled directly or indirectly by the immediate family of the operator. Immediate family shall include each parent, child, spouse, brother, sister, first cousin, aunt and uncle, whether such relationship arises by reason of birth, marriage or adoption. A special purpose organization shall be defined as an organization which is established to conduct certain of the facility's patient-care-related or non-patient-care-related activities. The special purpose organization shall be considered to be related if:

(1) the facility controls the special purpose organization through contracts or other legal documents that allow direct authority over the organization's activities, management and policies; or

(2) the facility is, for all practical purposes, the sole beneficiary of the special organization's activities. The facility shall be considered the special purpose organization's sole beneficiary if one or more of the three following circumstances exist:

(i) a special purpose organization has solicited funds in the name of and with the expressed or implied approval of the facility, and substantially all the funds solicited by the organization were intended by

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the contributor or were otherwise required to be transferred to the facility or used as its discretion or direction:

(ii) the facility has transformed some of its resources to a special purpose organization, substantially all of whose resources are held for the benefit of the facility; or

(iii) the facility has assigned certain of its functions (such as the operation of a dormitory) to a special purpose organization that is operating primarily for the benefit of the facility.

(b) The costs of goods and/or services furnished to a medical facility by a related organization are included in the computation of the basic rate at the lower of the cost to the related organization or the the market price of comparable goods and/or services available in the medical facility's region within the course of normal business operations.

(c) If the medical facility has incurred any costs in connection with a related organization, the final payment rate shall include the costs of such goods and/or services.

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Section 86-1.29 Return on investment. (a) In computing the allowable costs of a proprietary medical facility, there shall be included an allowance of a reasonable return on the average equity capital representing the investment by an owner used for the provision of patient care. The percentage to be used in computing the allowance shall be a rate determined annually by the commissioner as reasonably related to the then current money market.

(b) Equity capital is the net worth of the provider adjusted for those assets and liabilities which are not related to the provision of patient care. Equity capital consists of the provider's investment in plant, property and equipment, net of depreciation, and working capital for necessary and proper operation for patient care activities.

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Section 86-1.30 Capital cost reimbursement. The capital cost of a facility for purposes of determining and certifying the capital cost component of a rate shall be determined and computed in accordance with the provisions of sections 86-1.23, 86-1.24, 86-1.29, 86-1.59 of this Subpart and be certified and audited as actually having been expended; provided, however, that:

(a) with respect to a facility for which a rate has been determined and certified by the Commissioner of Health prior to March 10, 1975, the Commissioner of Health may continue such method and computation of such rate or make such modifications and changes to lower such rate as in his judgement are necessary and proper and in the public interest; and

(b) with respect to a facility which has been established by the Public Health Council, and for which a rate has not been determined and certified by the Commissioner of Health prior to the effective date of this section, and a legally binding arms length lease was the basis for the establishment approval granted by the Public Health Council, the Commissioner of Health may determine and certify a rate on the basis of such lease. A lease with a related organization described in subdivision (a) of section 86-1.28 of this Subpart shall be deemed to be a non-arms length lease.

(c)(1) The provisions of this section shall not apply to any facility which, as of the effective date of this Subpart, is located in and operated from leased space pursuant to a lease:

(i) which was entered into and approved for reimbursement prior to March 10, 1975;

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73(a)**

- (ii) which the commissioner finds to be bona fide, valid and noncancelable;
- (iii) the terms of which the commissioner finds to be fair and reasonable; and
- (iv) the payments, or portion thereof made pursuant to which, are found by the commissioner to be the proper basis for reimbursement of capital cost paid to such facility pursuant to article 28 of the Public Health Law prior to March 10, 1975.

(2) The capital cost component of any facility within the provisions of paragraph (1) of this subdivision shall consist of a payment factor sufficient to reimburse the facility for the total payments required under the base thereof to the extent approved by the commissioner pursuant to paragraph (1) of this subdivision.

(d) In computation of rates for voluntary medical facilities which are rented from proprietary interests, capital reimbursement shall be computed as if the facility were operated under proprietary sponsorship, except where the realty was previously owned by the voluntary medical facility, or where the proprietary interest has representation on the board of directors of the voluntary medical facility.

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(e) reserved

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Supersedes TN #87-5

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**New York
74(a)**

(f) Any capital expenditures associated with non-arms length leases shall be approved and certified to, if required, under the hospital certificate of need process. In the computation of reimbursement for non-arms length leases, the capital cost shall be included in allowable costs only to the extent that it does not exceed the amount which the facility would have included in allowable costs if it had legal title to the asset (the cost of ownership), such as straight-line depreciation, insurance, and interest. Accelerated depreciation on these assets may not be included in allowable costs under any circumstances.

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Section 86-1.31 Termination of service. The Division of Health Care Financing in the Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notification shall include a statement indicating the date of the deletion or the withholding of such service and the cost impact on the medical facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 86-1.8(f) of this Subpart.

TN #85-34

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Section 86-1.32 Sales, leases and realty transactions.

(a) If a medical facility is sold or leased or is the subject of any other realty transaction before a rate for the facility has been determined and certified by the Commissioner of Health, the capital cost component of such rate shall be determined in accordance with the provisions of sections 86-1.23, 86-1.24, 86-1.29 and 86-1.30 of this Subpart.

(b) If a medical facility is sold or leased or is the subject of any other realty transaction after a rate for the facility has been determined and certified by the commissioner, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction had not occurred. This subdivision shall not be construed as limiting the powers and rights of the commissioner to change rate computations generally under section 86-1.30 of this Subpart, or specifically when based upon previous error, deceit or any other misrepresentation or misstatement that has led the commissioner to determine and certify a rate which he would otherwise not have determined or certified. Further, this subdivision shall not be construed as limiting the powers and rights of the commissioner to reduce rates when one or more of the original property right aspects related to such a facility is terminated.

(c) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment prior to October 23, 1992, the incurred rental specified in the agreement is includable in allowable costs ¹ if the following conditions are met:

¹ Included in rates of payment effective on and after October 23, 1993.

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76(a)

[(i)] (1) the rental charges are reasonable based on consideration of rental charges of comparable equipment and market conditions in the area; the type, expected life, condition and value of the equipment rented and other provisions of the rental agreements;

[(ii)] (2) adequate alternate equipment which would serve the purpose are not or were not available at lower cost; and

[(iii)] (3) the leasing was based on economic and technical considerations.

[(iv)] (4) If all of these conditions are not met, the allowable rental cost shall not exceed the amount which the provider would have included in reimbursable costs had he retained legal title to the equipment, such as interest, taxes, depreciation, insurance and maintenance costs.

[(v)] (5) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving land, the incurred rental for the cost of land is not includable in allowable costs.

(d) An arms length lease purchase agreement with a nonrelated lessor involving plant facilities or equipment entered into on or after October 23, 1992 which meets any one of the four following condition, establishes the lease as a virtual purchase.

(1) The lease transfers title of the facilities or equipment to the lessee during the lease term.

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76(b)

(2) The lease contains a bargain purchase option.

(3) The lease term is at least 75 percent of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment.

(4) The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. Present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.

(e) If a lease is established as a virtual purchase under subdivision (d) of this section, the rental charge is includable in capital-related costs² to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership shall be limited to depreciation and interest. Further, the amounts to be included in capital-related costs are determined as follows:

(1) The difference between the amount of rent paid and the amount of rent allowed as capital-related costs is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchase.

² Included in rates of payment effective on and after October 23, 1993.

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(2) If an asset is returned to the owner instead of being purchased, the deferred charge may be included in capital related costs in the year the asset is returned.

(3) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental an amount not in excess of the cost of ownership.

(4) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to a fair rental value.

(5) If the lessee becomes the owner of the leased asset (either by operation of the lease or by other means), the amount considered as depreciation for the purpose of having computed the limitation on rental charges under subdivision (e) of this section, must be used in calculating the limitation on adjustments for the purpose of determining any gain or loss upon disposal of an asset.

(6) In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs had the provider legal title to the asset.

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(f) If a facility enters into a sale and leaseback agreement involving plant facilities or equipment on or after October 23, 1992, the amounts to be included in capital-related costs³ both on an annual basis and over the useful life of the asset shall not exceed the costs of ownership which shall be limited to depreciation and interest, and shall be determined as follows:

(1) If the annual rental or lease costs in the early years of the lease are less than the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are more than the annual costs of ownership, in the years that the annual rental or lease costs are more than the annual costs of ownership, the facility may include in capital-related costs annually the actual amount of rental or lease costs, except that in any given year, the amount included in capital related costs is limited to an amount which would not cause the aggregate rental or lease costs included up to that year in capital-related costs to exceed the costs of ownership that would have been included in capital-related costs up to that year if the provider had retained legal title to the asset.

(2) If the annual rental or lease costs in the early years of the lease exceed the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are less than the annual costs of ownership, the facility may carry forward amounts of rental or lease costs that were not included in capital-related costs in the early years of the lease due to the costs of ownership limitation, and include these amounts in capital-related costs in the years of the lease when the annual rental or lease costs are less than the annual costs of ownership, provided, however, in any given year the amount of actual annual rental or lease costs plus the amount carried forward to that year

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³ Included in rates of payment effective on and after October 23, 1993.

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may not exceed the amount of costs of ownership for that year.

(3) In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs if the provider had retained legal title to the asset.

(4) If a facility enters into a sale and leaseback agreement involving land, the incurred rental for the cost of land is not includable in allowable costs.

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Section 86-1.33 Hospital Closure/Conversion Incentive Programs.

(a) Hospital Closure Incentive Program. To reduce excess beds by encouraging the closure of hospitals, the Commissioner of Health may consider proposals by hospitals which mutually agree that one or more of the hospitals in the group shall close. The plan must be approved by the appropriate health systems agency prior to submission to the Commissioner of Health. The variable costs associated with the closed facility or facilities (which include personal costs) shall become part of the operating expenses of the remaining facilities in the group. The Commissioner of Health may consider a reasonable incentive structure for increased costs of the remaining facilities if coupled with a strict attrition program that would, within a reasonable period of time, assure a return to an appropriate level of staffing.

(b) Hospital Conversion Incentive Program. (1) To encourage hospitals to reduce excess acute care beds by substantially reducing the certified capacity or by converting a substantial number of such beds to a level of care for which the commissioner has determined a need exists, the commissioner may consider proposals by one or more hospitals which provide for the substantial reduction of acute care beds. Each facility undergoing conversion of beds must submit an individual proposal. The proposal must be reviewed by the appropriate health systems agency prior to submission to the commissioner. The variable costs associated with any layoffs at the converting facility may become part of the operating expenses of the converting facility or the other facilities which are the subject of the proposal. The commissioner may consider a reasonable incentive structure for increased costs of the converting facility or the other facilities if coupled with a strict attrition program that would, within a reasonable period of time, assure a return to an appropriate level of staffing.

(2) Paragraph (1) of this subdivision shall not apply in the case of a conversion caused by a determination under section 2806(6) of the Public Health Law, or where the commissioner finds that a conversion is entered into primarily to avoid the imposition of a utilization penalty.

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New York
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Section 86-1.34 Pilot reimbursement projects. (a) The Commissioner of Health may waive the requirements of this Subpart to effect the development of additional knowledge and experience in different types of reimbursement mechanisms, contingent upon the approval of the United States Department of Health, Education and Welfare, and subject to the provisions of section 222(a) of the Social Security Act.

(b) Individual hospitals or groups of hospitals shall enter into such ventures with the understanding that the reimbursement received over the life of this pilot project shall be as defined in the experiment.

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Section 86-1.35 [Reserved]

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reserved

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reserved

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reserved

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86-1.37 Fund administration. (a) The commissioner or his designee shall create and administer the following pools of funds in each region defined in this section: a financially distressed hospital pool which will be funded by the allowances provided in section 86-1.11(g)(8) of the Subpart;

These pools shall be established for each of the following regions: Long Island (Nassau and Suffolk Counties); New York City (Richmond, Manhattan, Bronx, Queens, and Kings Counties); Northern Metropolitan (Delaware, Columbia, Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland and Westchester Counties); Northeastern Blue Cross Region; Utica/Watertown Blue Cross Region; Syracuse Blue Cross Region; Rochester Blue Cross Region; Western Blue Cross Region. Hospitals not participating as of December 31, 1985 in the regional bad debt and charity care pools established pursuant to section 86-1.11 of this Subpart and no longer exempt from the provisions of section 2807-a of the Public Health Law shall be assigned to a region for purposes of calculating the bad debt charity care add-on percentage and making distributions from such pool pursuant to subdivision (p) of section 86-1.11 of this Subpart. Assignment to a region shall be based upon but not limited to the following factors:

- (1) Numbers and types of hospitals within the region and
- (2) Geographical proximity of the hospital requiring such assignment to a particular region.

(b) Monthly, each of the major third-party payors (Medicare, Medicaid and article 9C and article 44) will issue separate checks based upon the pool allowances to the pool administrator for each region, based on inpatient hospital claims with a service date on or after January 1, 1983 which were paid for the preceding monthly: one for the financially distressed hospital pool, and one for the bad debt/charity care pool.

(c) reserved

- (1) reserved

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category. For 1984 and 1985 the proxy for the "all other payor" category shall be similarly computed using the facility's 1983 and 1984 RCCAC logs, respectively. The facility shall pay to the pool administrator the regional allowances based upon these proxies on a monthly basis, by issuing three checks, one for each pool. Payments for January, February and March of 1983 must be submitted to the pool administrator on or before July 31, 1983. Payments for the months thereafter shall be submitted on or before the 20th day of the fourth month following the calendar month to which the payment applies. The January and February payments to be made to the pool administrator on or before May 20th and June 20th of each year shall be based upon the previous year's proxy. The methodology used to determine the proxy for the 1983, 1984 and 1985 payments received for the "all other payor" category shall not thereafter be adjusted to actual using cash receipts. However, on or about July 1, of each year when the previous year's RCCAC data becomes available, facilities shall recalculate their annual liability for pool contributions for the previous year using this data. This recalculated amount shall also represent a new estimated liability for the current year. Facilities shall compare the newly calculated annual for the previous year to

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(2) reserved

(d) Concurrent with the submission of pool contribution checks, hospitals shall submit to the pool administrator, information for the "all other payor" category of the facility's RCCAC logs regarding patient days, gross charges, nonpatient care gross charges, such as telephone, television and personal care items, inpatient bad debt and charity care at gross charges, and payments received from billings to Workers' Compensation, No-Fault, and other per diem payors not included in the "all other payor" category, together with such other information as shall be deemed necessary by the commissioner or his designee, to verify the amounts due to the pools.

(e) If any hospital shall fail to timely file reports or submit checks in accordance with subdivision (d) of this section, then the distribution of any funds to such hospital will be withheld until such time as the reports and checks are appropriately submitted by such hospital. In addition, in the event that a hospital will have 30 days from the date of receipt of notification to provide the required reports and checks. Failure to file the reports and checks within this 30-day time period will result in the withholding of 10 percent of that hospital's payments from all major third-party payors until such time as the required reports and checks are received by the pool administrator.

(f) The commissioner or his designee shall receive and invest funds for the aforementioned pools and distribute such funds according to subdivision (g) of section 86-1.11 and 86-1.36 of this Subpart. Where the distribution of funds is not dependent on the processing of an application for the funds, the administrator of the pool will distribute any available funds to hospitals by the tenth business day of the month following the month in which such funds were received from the major third-party payors will be made on or before March 14, 1983.

(g) During 1983 in the initial funding process of the pools, the immediate demand for funds from a particular pool may exceed the available funds in such pool. Also, because of a lag in distribution from some pools associated with the application process, some pools may have cash available beyond immediate distribution needs. In order to meet distribution needs as they arise, the commissioner or his designee, may, in 1983, allow borrowing from one pool to another within a region. In no event, however, will such borrowing be allowed.

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by one pool from other pools in an amount in excess of projected amounts to be paid for the year by the major third-party payors to the borrowing pool, and in no event will borrowing be permitted if it will impair the ability of the lending pool to meet its distribution needs. All amounts borrowed shall be fully repaid during the first half of 1984.

(h) The major third-party payors shall provide the commissioner or his designee, at the time of check submission, with reports showing the paid claims by region, including, but not limited to the name of each hospital, patient days paid, and the computation by region and by pool of the amounts for which payments to the pools are made.

(i) The commissioner or his designee shall retain amounts in each regional pool, as are projected to be necessary to cover any payments due to third-party payors because of retroactive rate adjustments.

(j) The commissioner is authorized to make contingent distributions from the financially distressed hospital pool upon filing of this regulation, to hospitals participating in the transitional reimbursement program as of December 31, 1982 and to such other hospitals as are found by the commissioner to be in serious financial jeopardy, in amounts necessary to stabilize and maintain operations, taking into account available pool funds. Distributions shall be contingent upon subsequent determinations by the commissioner of hospital participation in the financially distressed hospital pool pursuant to standards to be adopted by the State Hospital Review and Planning Council. After these determinations by the commissioner, any contingent amounts to which such hospitals are found by the commissioner to be unentitled shall be repaid by the hospitals to the pool.

(k) Fund administration in 1986 and 1987 regional pools. The commissioner or his designee shall establish and administer the pools created by the provisions of subdivision (p) and (q) of section 86-1.11 of this Subpart according to the criteria contained in this section applicable to the period January 1, 1985 through December 31, 1985, with the following exceptions for regional pools:

(1) Article 43 corporations and Medicaid shall each issue separate monthly checks to the regional bad debt and charity care pools and to the regional financially distressed facility pools.

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(3) Concurrent with the submission of pool contribution checks, hospitals shall submit to the pool administrator information from the "all other payor" category of the facility's RCCAC logs regarding patient days, gross charges, nonpatient care gross charges, such as telephone, televisions and personal care items, inpatient bad debt and charity care at gross charges, and payments received from billings to Workers' Compensation, No-Fault, article 44 corporations, and other per diem payors not included in the "all other payor" category, together with such other information as shall be deemed necessary by the commissioner or his designee, to verify the amounts due the pools.

(4) If any hospital shall fail to timely file reports or submit checks in accordance with paragraph (3) of this subdivision, the distribution of any funds to such hospital in accordance with the distribution schedule in subdivisions (p) and (q) of section 86-1.11 of this Subpart shall be withheld until such time as the reports and checks are submitted by such hospital. In addition, in the event that a hospital fails to timely submit the required reports and checks, the hospital will have 30 days from the date of receipt of notification to provide the required reports and checks. Failure to file the reports and checks within this 30-day time period will result in the withholding of 10 percent of that hospital's payments from both major third-party payors until such time as the required reports and checks are received by the pool administrator.

(5) The commissioner or his designee shall receive and invest funds for the aforementioned pools and distribute such funds according to subdivisions (p) and (q) of section 86-1.11 and section 86-1.36 of this Subpart. Where the distribution of funds is not dependent on the processing of an application for the funds, the administrator of the pool will distribute any available funds to hospitals by the tenth business day of the month following the month in which such funds were received from both major third-party payors.

(6) Article 43 corporations and the New York State Department of Social Services shall provide the commissioner or his designee, at the time of the check submission, with reports showing the paid claims by region, including but not limited to the name of each hospital, patient days paid, and the computation by region and by pool of the amounts for which payments to the pools are made.

(7) The commissioner or his designee shall retain amounts in each regional pool as are projected to be necessary to cover any payments due to third-party payors because of retroactive rate adjustments.

(1) reserved.

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Section 86-1.38 Alternative reimbursement method for mergers or consolidations. As used in this section, the term merger shall mean the combining of two or more medical facilities, licensed under article 28 of the Public Health law, where such combination is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery. The provisions of this section shall apply only if facilities seek an alternative reimbursement mechanism to complete the merger. Otherwise, reimbursement for merged facilities will be consistent with all other provisions of this Subpart.

(a) Application for merger. A merger shall meet all of the following qualifying criteria and conditions:

(1) There is a demonstrated public need for the existing hospital service in whole or in part at the current site(s) of the applicant. The determination of public need shall be made pursuant to section 2802 of the Public Health Law and in accordance with Part 709 of this Title.

(2) The application must include a demonstration of overall financial savings that can be obtained within three years from the date of inception. This projection of savings should demonstrate reduction of overall costs for the separate entities, and reduction of gross reimbursement based on costs from third-party payors due primarily to reduction in beds or services.

(3) The medical facilities must demonstrate that adequate health care services are and will be provided; that conformity with the State Hospital Code is, and will be, maintained, and an approved plan of correction for any operational and structural deficiencies in accordance with State Hospital Code has been filed.

(b) In order to meet the requirements of paragraph (a)(2) of this section, the facility(s) must submit to the commissioner a plan of merger. This plan should include, but not be limited to:

(1) a description and composition of the proposed governing structure of the facilities submitting the applications;

(2) the development of a market analysis of the population being served;

(3) development of a functional consolidation of services, outlining:

(i) changes in the size and scope of the medical staff organization;

(ii) clinic and outpatient activities;

(iii) the integration of such areas as administration, operation of plant, laboratory, X-ray, therapies, for example;

(iv) redeployment of existing employees and future labor practices; and

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- (v) such other information as the commissioner may require
 - (4) financial plan which provides for:
 - (i) expected changes in revenues and expenditures due to the actions to be taken by the facilities. This shall be presented in the form of a projected budget for the merged entity and shall include compete budgeted uniform statistical and financial reports; and
 - (ii) projected changes in salaries, fringe and union benefits;
 - (5) a capital plan which outlines expected capital outlays necessary to effectuate the planned merger; and
 - (6) changes in the quality and volume of health services to be provided as a result of the planned merger.
- (c) Operating and capital costs reimbursement. Reimbursement under the provisions of this section for mergers meeting the requirements of subdivision (a) of this section shall be determined as follows and shall be for a period not to exceed three years from the date of approval of formal corporate merger of the involved facilities. Following a review of the budgeted statistical and financial data submitted by the facilities, the commissioner shall develop a new group for the merged institution, excluding the projected costs and statistics of the merged institution. All applicable ceilings shall be calculated as required by this Subpart.
- (1) Mergers with ceiling penalties. In the event that the merged institution incurs ceiling penalties, the commissioner may waive these penalties for the first full year of operation under the merger. In the second year of operation, facility rates will be the initial approved base year budgeted costs and statistics reduced by an amount that is no less than one third of the amount waived in the first year, increased by the trend factor into the current rate period. In the third year of operation, facility rates will be the initial approved base year budgeted costs and statistics reduced by an amount that is no less than two thirds of the amount waived in the first year, increased by the trend factor into the current rate period.
 - (2) Mergers without ceiling penalties. In the event that the merged institution incurs no ceiling penalties, rates during the first year of operation will be determined by taking the approved budgeted costs and statistics increased by the appropriate trend factor into the current rate period. In the second year of operation, facility rates will be the initial approved budgeted costs and statistics increased by the appropriate trend factor into the current rate period less two percent. In the third year of operation, facility rates will be the initial approved base year budgeted costs and statistics increased by the appropriate trend factor into the current rate period less four percent.

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(3) Facilities reimbursed under this section will not be eligible for waiver of ceiling penalties in the fourth year of operation as a merged facility. In the fourth year, the facility's reimbursement rate will be based on budgeted costs for the immediate preceding year subject to the standard Part 86 methodology applicable in the fourth year. In all years subsequent to the fourth year, actual base year costs of the facility will be subjected to the standard Part 86 methodology applicable at the time.

(d) Capital Reimbursement. Capital costs associated with a closure of a facility as part of an approved plan under this section will be reimbursable to the new, merged entity subject to appropriate Federal wavier.

(e) Upon application to the commissioner, a volume adjustment as specified in section 86-1.12 of this Subpart may be implemented.

(f) Where a facility(s) covered under this Subpart demonstrates to the commissioner, subsequent to its initial participation in this Subpart, that a deviation from the original approved plan and budget will provide a more cost effective result, a new plan and budget that has been approved by the commissioner will be accepted and utilized in formulation of revised reimbursement rates for the remaining time of participation in the Subpart.

(g) Annual report. Each year a facility(s) covered under this Subpart must demonstrate to the commissioner the cost savings arising from the improved efficiencies and more effective delivery of care due to the merger, consolidation or closure of the facilities participating in the plan. This report should reflect the objectives outlined in the approved plan and be issued by the governing authority of the facilities participating.

(h) Termination of facility(s) participation. Reimbursement under this section shall terminate if:

(1) the facility deviates from its plan of merger without written approval of the commissioner;

(2) the facility fails to continue to meet the criteria delineated in this section;
or

(3) three years have passed from the date of certification of the rate established pursuant to this section.

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86-1.39 [Workers' compensation and not fault reimbursement rates.] Reserved

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Section 86-1.40 Alternative reimbursement method for medical facilities with extended phase-in periods. The current reimbursement system may not enable new or substantially changed facilities which require an extended start-up period to proceed in a financially viable manner and, therefore, the following alternative reimbursement method is established to insure that needed and qualifying medical facilities can develop.

(a) Facilities which apply for alternative reimbursement under this section must demonstrate that the following qualifying criteria have been met:

(1) The commissioner is satisfied that adequate health care services are and will be provided by the facility.

(2) There has been a finding by the commissioner that the projected expansion and phase-in of the medical facility is appropriate and in the public interest.

(3) Pursuant to a plan of construction or expansion, approved by the commissioner, the facility will either be opening as a new facility or opening additional beds, commencing additional services, or projecting staffing increases.

(4) The facility can demonstrate to the satisfaction of the commissioner that its staffing and operational costs will, by the end of its approved transition period, be within acceptable staffing guidelines and capable of operating under the standard reimbursement methodology.

(5) The facility must demonstrate that it meets the criteria of a new facility or the criteria set forth in paragraph (4) of section 86-1.17 of this Subpart. A new facility is defined as one that has had no previous cost experience and no previous operating certificate.

(6) There are such other related indications of substantial changes as the commissioner may specify.

(b) Facilities which apply for alternative reimbursement under this section will be required to submit, subject to the approval of the commissioner, the following information at least 60 days prior to the start of the alternative reimbursement period:

(1) a market analysis of the population to be served;

(2) an organization description of the hospital, including a description of the medical staff organization and composition of the governing body;

(3) a detailed plan of the phase-in of routine and ancillary services, beds, staffing levels and expected utilization by major program area during the phase-in period in a manner prescribed by the commissioner;

(4) a detailed transitional financial plan which reflects anticipated revenues, including annual tax levy support and expenditures during the phase-in period, including a facility

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budget which reflects planned services expansion as described in paragraph (b)(3) of this section. If requested by the commissioner, the facility shall provide a line item budget with respect to staffing and personnel, and such detail as prescribed by the commissioner for other than personal service items, including capital.

(c) A facility which meets the criteria and informational requirements in subdivisions (a) and (b) of this section, and has received the commissioner's approval of its detailed transitional financial plan, shall have the operating and capital components of its rate established as follows:

(1) A reimbursement rate established under this section shall only be for a time period as approved in the facility's submitted plan, but no greater than five years.

(2) The capital cost component of the rate for each year of the plan will be based on approved annual budgeted cost, divided by the approved targeted patient volume for the rate year and retrospectively adjusted to actual certified cost.

(3) The operating component of the rate will be determined based on an approved budget subject to the following limitations and adjustments:

(i) Changes in personal service and nonpersonal service costs from the base period to the rate period shall be limited to the same factors for inflation which affect the hospital industry, except that costs associated with the phase-in of beds, programs and services which were not existent in a previous period will be allowed, subject to the review and approval of their incremental costs.

(ii) For each year in transition, a peer group will be simulated for the facility. The simulation will be based on the facility's approved budget and phase-in statistics for the facility. The operating component of the reimbursement rate will be subjected to a maximum of the peer group coiling increased by no greater than five percent times the remaining years of the transition period.

(iii) If the facility's volume is below the approved target volume, no adjustment shall be made.

(iv) If the facility's volume is above the approved targeted volume by five percent, the facility will be submitted to a volume adjustment to adjust their rate over the approved target for incremental costs.

(v) The hospital will be expected to meet the length of stay standards specified in section 86-1.17 of this Subpart.

(vi) The rates established under this section shall be prospective and be subject to adjustment and audit. A length of stay penalty, utilization penalty and volume adjustment

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may be implemented in the year succeeding the rate period in which the respective requirements are not met.

(d) Reimbursement under this section shall terminate if:

(1) the facility significantly deviates from its approved plan without the written approval of the commissioner;

(2) the facility fails to continue to meet the criteria delineated in this section;

(3) the facility requests to withdraw from this program with the understanding that participation in subsequent rate years is prohibited.

(e) The effective date of the reimbursement rate established pursuant to this section shall be the day on which Federal approval is effective.

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86-1.41 [Hospital –based ambulatory surgery rates.] Reserved

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Section 86-1.42 Hospital-based Physician Reimbursement Program.

(a) Definitions. As used in this section:

- (1) Physician shall mean hospital-based supervisory and other salaried physicians, excluding interns and residents.
- (2) Fringe benefits shall mean fringe benefits required by law, plus health, welfare, retirement, and educational benefits given in lieu of direct compensation.
- (3) Total physician compensation shall mean the prospectively set base year compensation for physicians responsible for a service or department plus a fringe benefit allowance not to exceed 25 percent of the base year compensation, less any portion of that compensation which is for other than that service or department.
- (4) Total employee staff compensation shall mean the prospectively set base year compensation for nonphysician employees assigned to a service or department, plus a fringe benefits allowance, less any portion of that compensation which is for other than that service or department.

(b) Notwithstanding any other provision of this Subpart, allowable reimbursable costs for physicians responsible for the inpatient diagnostic and therapeutic services or departments of radiology, radiation therapy, ultrasonography, laboratory medicine and pathology, nuclear medicine, electrocardiography and hospital cardiology services, exclusive of cardiac catheterization, shall be 104 percent of total physician and employee staff compensation for each of these services. Allowable reimbursable costs for physicians responsible for clinical laboratory services shall be 103 percent of total physician and employee staff compensation for such services. Reimbursement paid pursuant to this subdivision in excess of actual salaries, fringe benefits, and incentive payments, if any, shall be called professional development funds. These funds shall be distributed by the hospital among the clinical laboratory service and the aforementioned inpatient diagnostic and therapeutic services and departments. These funds shall be considered departmental funds and may be used to improve the clinical care of patients receiving services from the department, to enhance or supplement the department's educational program, and for purchases of hospital patient care equipment. These funds shall be committed annually.

(c) Notwithstanding any other provision of this Subpart, hospitals shall be reimbursed for the cost of a single adjustment to total physician compensation for physicians who are responsible for the inpatient diagnostic and therapeutic services or departments of radiology, radiation therapy, ultrasonography, laboratory medicine including all clinical laboratories and pathology, nuclear medicine, electrocardiography and hospital cardiology services exclusive of cardiac catheterization, provided that the overall compensation for such physicians in aggregate does not exceed the 80th percentile as reported in the American Association of Medical Colleges faculty compensation survey for the base year. This adjustment shall be in an amount sufficient to provide funds for overall compensation of such physicians in the aggregate equivalent to the 80th percentile as reported in the survey. The cost of such adjustment in excess of the

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limitation on allowable costs for such services as set forth in section 86-1.14(c) of this Subpart shall be excluded from the calculation of base period costs and shall be reimbursed.

(d) The provisions of this section shall apply only to those hospitals:

(1) which apply to the commissioner for participation in this program within six months of the effective date of this section;

(2) which have a written agreement with their physicians which specifies physician responsibility with regard to scope of service and education of all physicians on the prudent use of diagnostic services and which specifies productivity and utilization standards for all departments to reduce unit costs of services;

(3) which document a fixed prospective physician compensation arrangement set in advance of the rate year, which may include an incentive plan provided such plan does not exceed 15 percent of the aggregate prospective base compensation and provided such plan has been approved by the commissioner upon a showing by the hospital that incentive plan costs will be offset by equivalent productivity gains and cost savings; and

(4) which, following the first year of participation in the program, document annually an appreciable reduction in unit costs of services as a result of participation in the program.

(e) This section shall be contingent upon Federal financial participation.

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86-1.43 [Medicare adjustment] Reserved

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86-1.44 [Computation of rates of payment for licensed freestanding ambulatory surgery centers.] Reserved

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Section 86-1.45 Federal financial participation. The rates of payment made for inpatient hospital services rendered to title XIX recipients established in accordance with the methodology contained in this Subpart shall be contingent upon Federal financial participation (FFP) and approval.

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101(a)

86-1.46 Reserved

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101(b)

86-1.47 Reserved

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101(c)

86-1.48 Reserved

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86-1.49 Reserved

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1905(a)(1) Inpatient Hospital Services**Hospital Acute Inpatient Reimbursement – July 1, 2018**

Definitions. As used in this Section, the following definitions will apply:

1. *Diagnosis related groups (DRGs)* will mean the 3M Corporation All-Patient-Refined (APR) classification system, which utilizes diagnostic related groups with assigned weights that incorporate differing levels of severity of a patient's condition and the associated risk of mortality, and reflects such factors as the patient's medical diagnosis, severity level, sex, age, and procedures performed.
2. *Acute Rate DRG case-based payment per discharge (herein after referred to as Acute Rate)* will mean the payment to be received by a hospital for inpatient services, except for physician services (unless allowed under paragraph 12(c) of this Section), rendered to each patient based on the DRG to which that patient has been assigned, as determined by multiplying the statewide base price by the applicable service intensity weight (SIW) and facility-specific wage equalization factor (WEF) and as further adjusted for teaching hospitals by the inclusion of reimbursement for direct and indirect graduate medical education (GME) costs and for all hospitals, the inclusion of non-comparable costs.
3. *Service intensity weights (SIWs)* are the cost weights established such that the SIW for any given DRG indicates the relative cost of the average cost of the patient in the DRG as compared to the average cost of all patients in all DRGs. Weights are developed using cost data from Medicaid fee-for-service, Medicaid managed care and commercial payors as reported to the Statewide Planning and Research Cooperative System (SPARCS) and will be updated no less frequently than every four years, with the exception that the SIWs updated subsequent to July 1, 2018 will be effective on or after January 1, 2024, but no later than January 1, 2027.
4. *Case mix index (CMI)* will mean the relative costliness of a hospital's case mix relative to the case mix of all other hospitals as reflected in the weighted aggregate SIW for the hospital.
 - a. All payer CMI is developed using acute claims reported to the Statewide Planning and Research Cooperative System (SPARCS) which provides data for all payer sources.
 - b. Medicaid fee-for-service CMI is developed based on Medicaid fee-for-service acute claims submission to New York State.
 - c. Medicaid managed care CMI is developed based on Medicaid managed care acute claims submission to New York State.
5. *Reimbursable operating costs* will mean reported operating costs which relate to the cost of providing inpatient hospital services to Medicaid patients, trended for inflation between the base period, as defined in this Section, and the rate period in accordance with trend factors determined pursuant to the applicable provisions of this Attachment, but excluding the following costs:
 - a. ALC costs;
 - b. Exempt unit costs;
 - c. Transfer costs; and
 - d. High-cost outlier costs.

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6. *Graduate medical education (GME).*
 - a. *Direct GME (DGME) costs* will mean the reimbursable salaries, fringe benefits, non-salary costs and allocated overhead teaching costs for residents, fellows, and supervising physicians trended for inflation to the rate year by the applicable provisions of this section. Only the costs reported for Interns and Residents Services Salary and Fringes, Interns and Residents Services Other Program Costs, and Supervising Physician Teaching will be included in the direct GME cost development.
 - b. *Indirect GME (IME) costs* will mean an estimate of the costs associated with additional ancillary intensiveness of medical care, more aggressive treatment regimens, and increased availability of state-of-the-art testing technologies resulting from the training of residents and fellows.
7. *High-cost outlier costs* for payment purposes will mean 100 percent of the hospital's total billed patient charges, as approved by IPRO, that have been converted to cost using the hospital's most recent charge convertor for that same service period, as defined in this Section, that exceed the DRG specific high-cost thresholds calculated pursuant to the Outlier Rates of Payment Section.
8. *Alternate level of care (ALC) services* will mean those services provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available.
9. *Exempt hospitals and units* will mean those hospitals and units that are paid per diem rates of payment pursuant to the provisions of the Exempt Units and Hospitals Section, rather than receiving per discharge case-based rates of payment.
10. *The wage equalization factor (WEF)* will mean the mechanism to equalize hospital salary and fringe benefit costs to account for the differences in the price of labor among hospitals and groups of hospitals.
11. *Statewide Base Price* will mean the numeric value calculated pursuant to the Statewide Base Price Section, which will be used to calculate DRG case-based payments per discharge as defined in paragraph (2) of this Section.
12. *Non-comparable costs* will mean those base year costs, as defined in this Section, that are excluded from the statewide base price calculation and applied to the case-based rate of payment as an add-on payment. The following will be considered non-comparable costs:
 - a. Medicaid costs associated with ambulance services operated by a facility that are not reimbursed through a supplemental payment program and reported as inpatient costs in the Institutional Cost Report (ICR); and

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1905(a)(1) Inpatient Hospital Services

- b. Medicaid costs associated with schools of nursing operated by the facility and reported as inpatient costs in the ICR; and
 - c. Medicaid costs associated with hospital-based physicians at hospitals designated under the Medicare program as meeting the criteria set forth in §1861(b)(7) of the federal Social Security Act also referred to as Teaching Election Amendment (TEA) costs.
13. *Transfers*, For purposes of transfer per diem payments, a transfer patient will mean a patient who is not discharged as defined in this Section, is not transferred among two or more divisions of merged or consolidated facilities as defined in the Mergers, Acquisitions, Consolidations, Restructurings and Closure Section, is not assigned to a DRG specifically identified as a DRG for transferred patients only, and meets one of the following conditions:
- a. is transferred from an acute care facility reimbursed under the DRG case-based payment system to another acute care facility reimbursed under this system; or
 - b. is transferred to an out-of-state acute care facility; or
 - c. is a neonate who is being transferred to an exempt hospital for neonatal services.
14. *Discharges*, as used in this Section, will mean those inpatients whose discharge from the facility occurred on and after July 1, 2018, and:
- a. the patient is released from the facility to a non-acute care setting; or
 - b. the patient dies in the facility; or
 - c. the patient is transferred to a facility or unit that is exempt from the case-based payment system, except when the patient is a newborn transferred to an exempt hospital for neonatal services and thus classified as a transfer patient pursuant to this Section; or
 - d. the patient is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.
15. *Average Length of Stay (ALOS)* will mean the arithmetic average of the number of days a patient is in the hospital per admission as calculated by counting the number of days from and including the day of admission up to, but not including, the day of discharge. The ALOS will be calculated for each DRG on a statewide basis and will be rounded to the closest whole number.
16. *General hospital*, as used in this Section, will mean a hospital engaged in providing medical or medical and surgical services primarily to inpatients by or under the supervision of a physician on a twenty-four hour basis with provisions for admission or treatment of persons in need of emergency care and with an organized medical staff and nursing service, including facilities providing services relating to particular diseases, injuries, conditions, or deformities.

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17. *Charge converter* will mean the ratio of cost to charges using total inpatient costs and total inpatient charges as reported by the hospital in its annual institutional cost reports submitted to the Department.
18. *IPRO* will mean the Island Peer Review Organization, Inc., a New York not-for-profit corporation providing health related services.
19. *Medicaid*, when used to describe the calculation of the Medicaid Acute Rate in this section, will mean Medicaid Fee-for-Service (FFS) and Medicaid Managed Care (MC). Acute rates are developed using the FFS claims data and the MC encounter data using the methodologies described in this Attachment.
20. *Base year* will mean the period as determined pursuant to the applicable provisions of this Attachment and applies to the DRG case-based payment per discharge, based on the following:
 - a. For periods beginning on and after July 1, 2018, the base year will be the 2015 calendar year and the data and statistics will be the audited costs reported by each facility to the Department pursuant to the Financial and Statistical Data Required and Audits Sections.
 - b. For hospitals with a fiscal filing period that is other than a calendar year, the 2015 base year will be the 12-month period which ended between June 30, 2015 and May 31, 2016.
 - c. The base year used for rate-setting for operating cost components will be updated no less frequently than every four years, with the exception that the base year update subsequent to July 1, 2018 will be on or after January 1, 2024, but no later than January 1, 2027, and the new base period will be no more than four years prior to the first applicable rate period that utilizes such new base year provided.
21. *Divisor for add-ons to the acute rates per discharge*, as used in this Section, will mean the discharges used in the development of the add-ons pursuant to the Add-Ons to the Acute Rate Per Discharge Section of this Attachment.
 - a. For the period beginning on and after July 1, 2018, the discharges used as the divisor will be the 2015 base year reported to the Department prior to April 25, 2017.
22. *The year discharges* will mean the latest calendar year utilized pursuant to the Service Intensity Weights (SIWs) and Average Length of Stay (ALOS) Section of this Section.
 - a. For the period beginning on and after July 1, 2018, the latest calendar year will be 2014.
23. *Goal Seek* is the process of finding the correct input when only the output is known.
 - a. Wikipedia definition states, "In computing, goal seeking is the ability to calculate backward to obtain an input that would result in a given output. This can also be called "what-if analysis" or "back-solving."

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24. *Minimum wage costs* will mean the additional costs incurred by a hospital used in the calculation of a minimum wage add-on for the Acute Rate per Discharge, Specialty Long Term Acute Care Hospital, Cancer Hospital, Acute Care Children's Hospital, Critical Access Hospital, and Medical Rehabilitation Hospital rates beginning January 1, 2017, and thereafter, as a result of New York state statutory increases to minimum wage. The following regions' minimum wage will be increased on and after the stated periods as follows:

	December 31, 2016	December 31, 2017	December 31, 2018	December 31, 2019	December 31, 2020	December 31, 2021
New York City	\$11.00	\$13.00	\$15.00	\$15.00	\$15.00	\$15.00
Nassau, Suffolk, & Westchester counties	\$10.00	\$11.00	\$12.00	\$13.00	\$14.00	\$15.00
Remainder of the State	\$9.70	\$10.40	\$11.10	\$11.80	\$12.50	\$13.20*

*Effective January 1, 2022, the minimum wage value for the Remainder of the State will be \$13.20.

- a. For purposes of reimbursement the minimum wage in effect on January 1, 2017, and January 1st of each year thereafter, will be utilized in the calculation of the additional costs due to minimum wage increases until all regions of the State reach \$15.00 per hour.
- b. Minimum wage costs will be developed using collected survey data submitted and attested to by the hospital. If a hospital fails to submit a survey, the hospital's minimum wage costs will default to an average wage calculation based on the latest available institutional cost report (ICR) data.
 - i. Minimum wage cost development based on survey data collected.
 1. Survey data will be collected for hospital specific wage data.
 2. Hospitals will report by specified wage bands, the total count of FTEs and total hours paid of employees earning less than the statutory minimum wage applicable for the region.
 3. Hospitals will report an average fringe benefit percentage of the reported employees.
4. The minimum wage costs are calculated by multiplying the total hours paid by the difference between the statutory minimum wage and the midpoint of each wage band where the hospital has reported total hours paid. To this result, the hospital's average fringe benefit percentage is applied and added to the costs resulting in total minimum wage costs.

TN #22-0015

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- ii. Minimum wage cost development based on the latest available institutional cost report (ICR) data.
 - 1. If a hospital failed to submit a minimum wage survey the calculation for minimum wage costs will default to the use of hospital personnel wage data as reported in the ICR.
 - 2. Minimum wage costs will be developed by identifying average hourly wages (exclusive of overtime) of employees in occupational titles where the reported average hourly wage is below the regional statutory minimum wage.
 - 3. The total payroll hours (exclusive of overtime) of the titles identified are then multiplied by the regional statutory minimum wage resulting in a projected payroll (exclusive of overtime). The actual payroll as reported in the ICR is then subtracted from the projected payroll resulting in the expected wage costs.
 - 4. An average fringe benefit percentage is calculated based on a ratio of fringe benefit costs to total wage costs from the ICR. The fringe benefit percentage is applied to the increased wage costs and added resulting in the minimum wage costs.
- iii. The total minimum wage costs are included in the calculation of a minimum wage add-on component as described in the Add-Ons to the Acute Rate per Discharge Section.
- iv. Minimum Wage Reconciliation - After the end of each calendar year, the Department of Health will survey providers to obtain the following information for the purpose of reconciling annual minimum wage reimbursement. The state will release the survey by the end of March and providers will have two weeks to complete the survey or request an extension if a provider determines it is unable to complete the survey within that time. Approval of extensions, and the time of the extension, is at the discretion of the state. If the survey is not submitted within the two weeks or within the extension time frame, should one be granted, the provider's funding for the calendar year covered by the survey will be recouped.
 - 1. The total annual minimum wage costs incorporated into the inpatient Medicaid rates of payment as a minimum wage add-on for the period. (Supporting documentation detailing the calculation based on the original survey will be supplied by the Department of Health.)
 - 2. The total amount the provider was obligated to pay to bring salaries up to the minimum wage, including fringes for the calendar year. (This information will be completed by the provider.)

TN #17-0011Supersedes TN NEWApproval Date April 28, 2021Effective Date January 1, 2017

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3. The State agency will review providers' submissions for accuracy and reasonableness, following which it will process associated payments and recoupments via rate adjustments as quickly as practical thereafter.
 4. The agency's Chief Executive Officer or Chief Financial Officer must sign an Attestation verifying the data that is supplied in the survey.
- c. In the subsequent year, the Department will survey hospitals utilizing the methodology employed in year one. Once the minimum wage costs are in the base year for rate development, the additional minimum wages costs previously added will be removed.

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1905(a)(1) Inpatient Hospital Services**Statewide Base Price**

1. For periods on and after July 1, 2018, a statewide base price (SBP) will be established for operating cost payments and will be used in the calculation of the payment of a Medicaid acute claim as follows:

	RATE ELEMENT	STATE PLAN SECTION
	Operating cost neutral statewide base price per discharge	Statewide Base Price
x	(1+ Budget neutrality factor)	Statewide Base Price
x	(1 + Trend factor)	Trend Factor
x	Institution-specific wage equalization factor (WEF) adjustment	Wage Equalization Factor (WEF)
x	(1 + Transition adjustment factor)	Transition
x	APR-DRG weight with severity level	Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS)
=	FFS adjusted statewide base price per discharge	
+	IME per discharge add-on	Add-Ons to the Acute Rate Per Discharge
+	DGME per discharge add-on	Add-Ons to the Acute Rate Per Discharge
+	Capital per discharge add-on	Capital expense reimbursement for DRG case-based rates of payment
+	Non-comparable cost per discharge add-on	Add-Ons to the Acute Rate Per Discharge
=	Medicaid FFS rate per discharge	

- a. The rate elements included in the chart are developed as described within the sections of this Attachment.

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2. The SBP will be established based on the following process and mathematical sequence.
 - a. Steps in the mathematical sequence:
 - i. Step 1: Develop, by facility, an average facility specific, all payer, cost neutral per discharge rate.
 - ii. Step 2: Convert the by facility per discharge rates developed in Step 1 to a price.
 - iii. Step 3: Adjust the price developed in Step 2 for budget neutrality.
 - b. For the period May 1, 2012 through March 31, 2013 and for state fiscal year periods on and after April 1, 2013 through March 31, 2015, the statewide base price will be adjusted such that total Medicaid payments are decreased for such period and for each such state fiscal year period by \$19,200,000.
 - c. Step 1: Develop an average facility specific, all payer, cost neutral per discharge rate. This rate represents the operating costs that will be paid by the statewide base price and is converted to a price in Step 2. The average per discharge rate developed in this process is represented as H in the chart in paragraph (2)(c)(iii).
 - i. Step 1 uses the following data on a facility specific basis and the mathematical process in the chart in paragraph (2)(c)(iii):
 1. Total allowable facility ICR costs in the base year, as defined in the Definitions section. These costs are represented as A in the chart.
 2. Total allowable facility specific costs in the ICR from the base year, as defined in the Definitions Section of this Attachment, that are associated with the rate add-ons as defined in the Add-Ons to the Acute Rate Per Discharge Section of this Attachment. These costs are represented as B in the chart.
 3. Total facility ICR discharges in the base year, as defined in the Definitions section. These discharges are represented as D in the chart.
 4. The wage equalization factor (WEF) for the base year, as defined in the Definitions section, and calculated based on the Wage Equalization Factor (WEF) section of this Attachment. This WEF factor is represented as F in the chart.
 5. A facility specific all payer CMI, as defined in the definitions section.
 - a. Uses the all payer acute claims of the base year, as defined in the Definitions Section of this Attachment.

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106(b)**

- b. Requires grouping the all payer acute claims to determine the appropriate APR-DRG and Service Intensity Weight (SIW) for payment of the claim. This process uses the 3M grouper version and Service Intensity Weights (SIWs) that were used in the payment of claims during the base year, as defined in the Definitions section of this Attachment.
- c. This CMI represents an average of the APR-DRG weights assigned for all cases used in this process.
- d. The CMI is represented as G in the chart.
- ii. The average facility specific per discharge rate is cost neutral as it represents the base year costs that are reflected in the SBP excluding the differences in the WEF and case mix that are applied to the SBP in the payment method. This per discharge rate is represented as H in the chart.
- iii. Chart for mathematical sequence:

<u>A</u>	<u>ICR base year total all payer allowable facility specific operating costs</u>	<u>A</u>
	<u>Less: Costs associated with Add-ons</u>	
<u>B</u>	<u>IME</u>	
<u>B</u>	<u>DGME</u>	
<u>B</u>	<u>Ambulance</u>	
<u>B</u>	<u>TEA</u>	
<u>B</u>	<u>School of Nursing</u>	
<u>B Sum</u>	<u>Total costs associated with Add-ons</u>	<u>B Sum</u>
<u>C</u>	<u>Total facility allowable operating costs for SBP development</u>	<u>A – B Sum = C</u>
<u>D</u>	<u>Total facility all payer ICR Discharges</u>	<u>D</u>
<u>E</u>	<u>Facility Specific all payer cost per discharge rate</u>	<u>C / D = E</u>
<u>F</u>	<u>Facility Specific WEF</u>	<u>F</u>
<u>G</u>	<u>Facility Specific all payer CMI</u>	<u>G</u>
<u>H</u>	<u>Average Facility Specific all payer cost neutral per discharge rate (WEF and CMI neutral)</u>	<u>E / F / G = H</u>
	<u>Note: For payments, H will be replaced by the SBP</u>	

- d. Step 2: Convert the average facility specific all payer cost neutral per discharge rate calculated in Step 1 (letter H in the preceding chart) to a price (operating cost neutral SBP). The SBP is a constant value used across all hospitals in the Acute payment calculation. The SBP reflects the value that when multiplied by the total statewide discharges the statewide total result equals the same statewide sum total result as using the average facility specific all payer cost neutral per discharge rate developed in Step 1 times the facility specific discharges. This process requires the development of the proposed statewide total Medicaid operating payments using the new proposed rate components that are developed using the base year costs in Step 1.

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106(c)**

i. Step 2 uses the following data and mathematical process.

1. By facility, develop historical claims detail using "the year discharges", as defined in the Definitions section, for the list below.
 - a. Medicaid fee-for-service (FFS) inlier discharges;
 - b. Medicaid managed care (MMC) inlier discharges;
 - c. Medicaid high cost cases;
 - d. Medicaid transfer cases.
2. By facility, develop the proposed statewide total Medicaid operating payments for each set of claims in paragraph 2(d)(i)(1) using the following:
 - a. Group the claims using the 3M grouper version as specified in the Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS) section, paragraph 3(a) to determine the APR-DRG and severity level assignment.
 - i. The service intensity weights (SIWs) that will be used are developed per the Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS) section.
 - ii. Develop an average Medicaid fee-for-service (FFS) CMI, as defined in the Definitions section, based on the APR-DRG/severity level assignment and SIWs applied to all FFS claims.
 - iii. Develop an average Medicaid managed care (MMC) CMI, as defined in the Definitions section, based on the APR-DRG/severity level assignment and SIWs applied to all MMC claims.
 - b. The by facility payment will be developed as follows:
 - i. The payment methodology for each of the claims in accordance with this Attachment.
 - ii. The average facility specific all payer cost neutral per discharge rate calculated in Step 1, letter H, is used and represents the SBP in the payment method for the claims.
 1. For the Medicaid FFS claims, apply the average Medicaid FFS CMI developed in paragraph 2(d)(i)(2)(a)(ii) to the SBP as the APR-DRG weight with severity level.
 2. For the Medicaid MMC claims, apply the average Medicaid MMC CMI developed in paragraph 2(d)(i)(2)(a)(iii) to the SBP as the APR-DRG weight with severity level.
 - iii. The new proposed acute rate components based on costs, developed in accordance with this Attachment, using the same base year costs that were used to develop the average facility specific all payer cost neutral per discharge in Step 1.
 - c. Sum the by facility results for a proposed statewide total Medicaid operating payment based on costs. The proposed statewide total Medicaid operating payments will equal the Medicaid share of the total costs that are represented as A in the preceding chart. Therefore, Medicaid payments equal Medicaid costs.

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106(d)**

3. Convert the average facility specific all payer cost neutral discharge rate in paragraph (2)(d)(i)(2)(b)(ii) to a price using "Goal Seek" as defined in the Definitions section. This will determine what value (price) can be consistently applied to replace the average facility specific all payer cost neutral per discharge rate within the payment of each case and the result is the same proposed statewide total Medicaid operating payments based on costs in paragraph (2)(d)(i)(2)(c), of this section.

4. The result is the "operating cost neutral SBP" that is based on costs.

e. Step 3: Develop a budget neutrality factor (BNF) to adjust the new proposed rate components to maintain budget neutrality to the statewide total existing Medicaid operating payments. Since rebased rates are implemented budget neutral, this will limit the proposed statewide total Medicaid operating payments to existing Medicaid operating payments.

i. Step 3 uses the following data and mathematical process.

1. Using the same cases developed in paragraph (2)(d)(i)(1)(a) thru (d), develop the statewide total existing Medicaid operating payments to be used as the targeted Medicaid operating payments for budget neutrality. These claims will be grouped using the 3M grouper version that was used with the latest effective acute rate paid (latest rate prior to the effective date of the Hospital Inpatient Reimbursement section) and the SIWs that were used in the payment of those rates. Grouping the claims will determine the appropriate APR-DRG and SIW for payment of the claims for the latest paid effective period.

2. By facility, develop the statewide total existing Medicaid operating payments using the data listed below.

a. The latest acute rate components for each facility used with the same 3M grouper version and SIWs in Step 3, paragraph (2)(e)(i)(1).

b. The operating budget neutral SBP used with the same 3M grouper version and SIWs in Step 3, paragraph (2)(e)(i)(1).

c. Medicaid fee-for-service (FFS) payment development utilizes an average FFS CMI, as defined in the Definitions section, based on the grouping and SIW assignment completed in paragraph (2)(e)(i)(1) of the FFS cases in paragraph (2)(d)(i)(1)(a) thru (d).

d. Medicaid managed care (MMC) payment development utilizes an average MMC CMI, as defined in the Definitions section, based on the grouping and SIW assignment completed in paragraph (2)(e)(i)(1) of the MMC cases in paragraph (2)(d)(i)(1)(a) thru (d).

e. The payment methodology for each of the cases in accordance with this Attachment.

f. Sum the by facility results for a statewide total existing Medicaid operating payment to be used as the targeted total statewide Medicaid operating payment.

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106(e)**

3. Using the "Goal Seek" data tool in Microsoft Excel, as defined in the Definitions Section, develop the Budget Neutrality Factor (BNF). This will derive the percent that can be consistently applied to all components of the proposed new rebased rates to reduce them by an equal percentage to limit the proposed operating payments to the targeted total statewide Medicaid operating payments developed in paragraph (2)(e)(i)(2)(f). This process uses the following:
 - a. The new proposed rate components used in Step 2, paragraph (2)(d)(i)(2)(a).
 - b. The operating cost neutral SBP developed in Step 2, paragraph (2)(d)(i)(3).
 - c. The targeted total statewide Medicaid operating payment developed in Step 3, paragraph (2)(e)(i)(2)(f).
4. The "operating cost neutral SBP" will be reduced by the BNF. The result is the "operating budget neutral SBP" that was based on targeted Medicaid operating payments. This is the SBP that will be used with the rebased rate add-on components in the payment of claims. The rebased rate add-on components are also adjusted by the BNF in accordance with the Add-Ons to the Acute Rate Per Discharge section.
- f. No reconciliation adjustment will be made to the SBP to account for changes in volume or CMI during the effective period of the SBP.
- g. The SBP will be updated at the time the SIWs are updated in accordance with the SIW and ALOS Section or at the time the base year, as defined in the Definitions Section, is updated.

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[Exclusion of outlier and transfer costs.] RESERVED

- [1. In calculating rates pursuant to this Section, high-cost outlier costs from hospitals with ancillary and routine charges schedules shall be excluded from the statewide base price and shall equal 100 percent of the excess costs above the high cost outlier threshold which shall be developed using acute Medicaid operating costs derived from the base period used to calculate the statewide base price.
2. In calculating rates pursuant to this Section, transfer case costs shall be excluded from the statewide base price by excluding the transfer discharges that occurred in the base period used to calculate the statewide base price, except for those transfer cases that are assigned to a DRG specifically identified as a DRG for transferred patients only.]

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1905(a)(1) Inpatient Hospital Services**Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS).**

1. The table of SIWs and statewide ALOS effective on and after July 1, 2018 is published on the New York State Department of Health website at:

<http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/weights/>

and reflects the cost weights and ALOS assigned to each All-Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each APR-DRG indicates the relative cost variance of that APR-DRG classification from the average cost of all inpatients in all APR-DRGs. Such SIWs are developed using three years of Medicaid fee-for-service cost data, Medicaid managed care data and commercial third party payor data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years set forth in paragraph (3) of this section. Costs associated with hospitals that do not have an ancillary charge structure or associated with hospitals and services exempt from the case payment methodology, and costs associated with statistical outliers are excluded from the SIW calculations.

2. For periods beginning on and after July 1, 2018, the SIWs and statewide ALOS table will be computed using SPARCS and reported cost data from the 2012, 2013 and 2014 calendar years as submitted to the Department.
3. The DRG classification system used in rates, as defined in paragraph (1) of the Definitions Section of this Attachment, will be as follows:
 - a. Effective on and after July 1, 2018, Version 34 of the APR-DRG classification system will be used.

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Wage Equalization Factor (WEF).

1. The statewide base price per discharge [shall]will be adjusted by a facility-specific wage equalization factor (WEF) to reflect differences in labor costs between hospitals. Such WEF adjustment [shall]will be used to adjust for the level of wage and fringe benefit costs for each hospital in accordance with the following:
 - a. The WEF [shall]will be based on each hospital's occupational mix and wages for registered nurses, licensed practical nurses, surgical technologists, nursing aides, orderlies, attendants, and medical assistants as reported and approved by the federal Medicare program for the Final Rule Wage Index, which is posted on the Centers for Medicare and Medicaid Services (CMS) website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/>, and the hospital's proportion of salaries and fringe benefit costs to total operating costs as reported [to]in the Institutional Cost Report (ICR). The WEF [shall]will be computed as follows:
 - (i) For all occupations described in paragraph (a), a statewide average salary [shall]will be calculated [by dividing the statewide sum of hospitals' total dollars paid by the statewide sum of hospitals' hours paid] utilizing an average of three years data by dividing the statewide sum of three years of hospitals' total dollars paid by the statewide sum of three years of hospitals' hours paid. The three years utilized for this calculation will be the base year as defined in the Definitions Section and two years prior to the base year; and
 - (ii) For each hospital, an actual [weighted] average salary [shall]will be calculated by dividing the [total dollars paid for such occupations by the total hours paid for such occupations] sum of three years total dollars paid for such occupations by the sum of three years total hours paid for such occupations. The three years utilized for each hospital will be the three years as identified in subparagraph (a)(i) of this paragraph; and
 - (iii) An initial WEF [shall]will be calculated for each hospital by dividing the hospital-specific actual [weighted] average salary as calculated pursuant to subparagraph (ii) of this paragraph by the statewide average salary calculated pursuant to subparagraph (i) of this paragraph; and
 - (iv) The final WEF [shall]will be calculated using the following formula:

$$(1 / ((\text{Labor Share} / \text{initial WEF}) + \text{Non-Labor Share}))$$
 where "Labor Share" is calculated by dividing the hospital's total salary cost plus the hospital's total fringe benefits by the hospital's total operating costs as reported in the ICR for the [same calendar year used to calculate the statewide base price for the applicable rate period.] base year as defined in the Definitions Section. One minus the "Labor Share" is the "Non-Labor Share."
 - b. A hospital [may]will submit updated occupational [service]mix data as approved by the federal Department of Health and Human Services prior to January 1 of a rate year for [use in] calculating the WEF, at the time the base year is updated, in accordance with this Section.

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- c. For those hospitals that are in bankruptcy proceedings in the base year and that have subrogated their labor contracts, the Commissioner shall use the higher of the hospital-specific or regional average WEF. These regions will be consistent with those used in the development of exempt unit cost ceilings.

TN #09-34

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New York
110

1905(a)(1) Inpatient Hospital Services**Add-Ons to the Acute Rate Per Discharge.**

Rates of payment computed pursuant to this Attachment will include operating cost add-on payments to the statewide base price payment as follows:

1. The base period used for the add-on development will be as defined in the Definitions Section.
2. The costs and discharges used in the development of the add-ons will be total acute inpatient costs and discharges.
3. All add-on components of the acute operating per discharge rate will be reduced by the Budget Neutrality Factor pursuant to the Statewide Base Price Section of this Attachment.
 - a. For rates beginning on and after January 1, 2017, the hospital specific minimum wage payment per discharge, as identified in paragraph (11) of this Section, will be not be subject to a reduction by the "Budget Neutrality Factor" pursuant to the Statewide Base Price Section of this Attachment and will continue until minimum wage costs have been included within the development of the Statewide Base price.
4. A direct graduate medical education (DGME) payment per discharge will be added to the acute rates of teaching general hospitals after the application of SIW, WEF, and Indirect Graduate Medical Education (IME) adjustments to the statewide base price. The DGME will be calculated for each hospital by dividing the facility's total reported [Medicaid] DGME costs by its total reported [Medicaid] discharges pursuant to paragraphs (1) through (3) of this Section. DGME costs will be those costs defined in the Definitions Section and trended forward to such rate period in accordance with applicable provisions of this Attachment
5. a. An indirect GME payment per discharge will be added to the acute rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and will be calculated by multiplying such rates by the indirect teaching cost percentage determined by the following formula:

$$(1 - (1 / (1 + 1.03(((1 + r) ^{0.0405}) - 1))))$$

where "r" equals the ratio of residents and fellows to beds based on the medical education statistics for the hospital based on paragraph (7) of this Section and the staffed beds for the general hospital reported in the base period, as defined in the Definitions Section, but excluding exempt unit beds and nursery bassinets.

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- b. Indirect GME costs are those costs defined in the Definitions Section, derived from the base year, as also defined in the Definitions Section, and trended forward to such rate period in accordance with applicable provisions of this Attachment.
- 6. For rates beginning on and after July 1, 2018, the ratio of residents and fellows to bed will be based on the medical education statistics as reported on Exhibit 3 of the Hospital Institutional Cost report for the base year, as defined in the Definitions Section.
- 7. A non-comparable payment per discharge will be added to acute rates after the application of SIW, WEF, and IME adjustments to the statewide base price and the addition of the DGME payment and will be calculated for each hospital by dividing the facility's total reported costs, pursuant to paragraphs (1) through (3) of this Section, for qualifying non-comparable cost categories by its total reported discharges pursuant to the Definitions Section. Non-comparable hospital costs are those costs defined in the Definitions Section, derived from the base year, as also defined in the Definitions Section, and trended forward to such rate period in accordance with applicable provisions of this Attachment.
- 8. At the time non-comparable base year costs are updated in accordance with applicable provisions of this Section, cost transfers between affiliated facilities, for non-comparable costs as defined in the Definitions Section for other than DME or IME, due to the transfer of an entire service for organizational restructuring, will be adjusted in the payment rate. The non-comparable costs will be eliminated from the rate for the hospital closing the service and included in the rate for the receiving hospital. The costs transferred and utilized in the receiving hospital's rate will be the base year costs of the facility closing the service as defined in the Definitions Section. No revisions to the costs will be allowed.
- 9. The add-ons described in this section will be adjusted to reflect the transition factor per paragraph (1)(a)(ii) of the Transition Section of this Attachment.

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- a. For rates beginning on and after January 1, 2017, the hospital specific minimum wage payment per discharge, as identified in paragraph (11) of this Section, will be not be subject to the PPNO and transition adjustments.

- 11. For rates beginning January 1, 2017, a hospital specific minimum wage payment per discharge will be calculated based on minimum wage costs as defined in paragraph 24 of the Definitions Section and will be added to the acute rate per discharge.
 - a. A per discharge add-on to the rates will be developed by dividing hospital specific total minimum wage costs by total acute discharges as reported in the latest available institutional cost report.

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1905(a)(1) Inpatient Hospital Services**1. Transition**

- a. For discharges beginning on July 1, 2018 through December 31, 2021, a transition factor will be applied as follows:
 - i. The factor will be applied to the operating statewide base price as stated in row 5 in the Medicaid acute claim payment chart of the Statewide Base Price Section of this Attachment.
 - ii. The factor will be applied to all add-on operating cost components of the acute rate per discharge as stated in paragraph (10) of the Add-ons to the Acute Rate Per Discharge Section of this Attachment.
- b. Hospital estimated losses and gains for the transition development will be calculated by comparing the estimated revenue, by provider, based on the newly developed rate using the updated base year and associated policy updates in comparison to the last rate developed with the previous base year and policy. Claims from the year discharges, as defined in the Definitions Section of this Attachment, will be used to calculate both the updated and previous base year revenue.
- c. Hospital estimated losses which are due to the implementation of the updated base year pursuant to the Definitions Section of this Attachment and associated policy updates, will be limited as follows:
 - i. for the period July 1, 2018 through December 31, 2018, hospital specific estimated losses will be limited to 1% of the hospital's current revenues;
 - ii. for the period January 1, 2019 through December 31, 2019, the limitation on estimated losses will be increased to 2% of the hospital's current revenues;
 - iii. for the period January 1, 2020 through December 31, 2020, the limitation on estimated losses will be increased to 3% of the hospital's current revenues.
 - iv. for the period January 1, 2021 through December 31, 2021, the limitation on estimated losses will be increased to 4% of the hospital's current revenues.
- d. The transition limitation on estimated losses, defined in paragraph (1)(b) of this section, will be offset as follows:
 - i. Utilizing two million four-hundred thousand dollars for hospitals that have closed since January 1, 2014;
 - ii. A cap on a hospital's estimated gain, as described in paragraph (1)(b) of this Section, shall be applied as necessary each year in order to achieve budget neutrality pursuant to the Statewide Base Price Section of this Attachment. This will be accomplished as follows:

TN #18-0057 Supersedes TN #14-0021 Approval Date August 24, 2023 Effective Date July 1, 2018

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1905(a)(1) Inpatient Hospital Services

1. The cap on the estimated gain is derived through the "Goal Seek" programming in Microsoft excel, as defined in the Definitions Section, to determine the percentage necessary to hold payments budget neutral to the target total Medicaid operating payments, per the Statewide Base Price Section of this Attachment, with the limit on the losses.
 2. For the period July 1, 2018 through December 31, 2018, the cap on gains is 3.5633%. When the cap on losses is revised, based on paragraph (c) of this section, the cap on gains will be increased.
- e. The facility specific transition factor is determined by dividing the dollars associated with the total transition adjustment from gains or losses by the total facility specific projected revenue based on the newly developed rates using the updated base year and associated policy updates.
 - i. The total projected facility specific revenue excludes revenue from cost outlier cases since the transition factor does not apply to cost outlier payments.
 - f. The transition factor will not be subject to reconciliation.

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- [e. Payments made pursuant to this section shall be added to rates of payments and not be subject to retroactive adjustment or reconciliation. The amount per discharge to be added on to the rates for the period October 20, 2010 through March 31, 2011 shall be established by dividing the total funds allocated in accordance with paragraph (b) by six months of the hospital's total reported Medicaid discharges in accordance with paragraph (3)(b) in the 'Statewide Base Price' section of this Attachment. For the periods on and after April 1, 2011 the amount per discharge to be added on to the rates shall be established by dividing the total funds allocated in accordance with paragraph (c) by the hospital's total reported Medicaid discharges in accordance with paragraph (3)(b) in the 'Statewide Base Price' section of this Attachment
- f. Hospitals receiving funds pursuant to this section that did not previously receive funds to facilitate improvements in hospital operations and finances beginning on December 1, 2009, shall, as a condition for eligibility for such funds, adopt and submit a restructuring plan that includes both an assessment of the hospital's current financial position and the plan to restructure and improve its financial operations. The plan must also provide for ongoing Board oversight of plan implementation, along with measurable objectives. Two years following receipt of funds, the Board of Directors must issue a report setting forth what progress has been made toward accomplishing the goals of the restructuring plan. The Commissioner shall be provided with copies of all such resolutions and reports. If such report fails to set forth adequate progress toward the goals of the hospital's restructuring plan as determined by the Commissioner, the Commissioner will deem such facility ineligible for further distributions and will redistribute such further distributions to other eligible facilities in accordance with the provisions of this section.
- g. Unallocated funds awarded to hospitals deemed ineligible by the Commissioner, as a result of paragraph (f) of this section, shall be redistributed to all remaining eligible hospitals using the proportion of each eligible hospitals' allocation of the funds distributed for the period October 20, 2010 through March 31, 2011, to the total funds distributed for that period.]

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1905(a)(1) Inpatient Hospital Services**Outlier Rates of Payment.**

1. High cost outlier rates of payment will be calculated by converting 100% of the total billed patient charges, as approved by IPRO, to cost by applying the hospital's charge converter as defined in the Definitions Section. Such calculation will use the most recent charge converter available as subsequently updated to reflect the data from the year in which the discharge occurred, and will equal the excess costs above the high cost outlier threshold.
 - i. For payment, the high cost outlier threshold will be adjusted by the hospital specific wage equalization factor (WEF), as defined in the Definitions Section of this Attachment, prior to determining the excess costs above the high cost outlier threshold as stated in paragraph (1)(a) of this Section.
2. The high cost outlier threshold will be developed for each Diagnosis Related Group (DRG) using acute Medicaid operating costs which are derived from the year discharges used in the Statewide Base Price Section and defined in the Definitions Section of this Attachment. The high cost thresholds will be scaled to maintain budget neutrality ⁷ to targeted outlier payments developed pursuant to the Statewide Base Price Section.
 - i. The high cost outlier thresholds will be updated at the time the Service Intensity Weights (SIWs) are updated in accordance with the SIW and ALOS Section.
 - ii. Cost outlier thresholds for each base APR-DRG effective on and after July 1, 2018, have been posted to the Department of Health's public website at the following:

<http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/tresholds/>

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Transfer Cases Rates of Payment.

- [2]1. Rates of payment to non-exempt hospitals for inpatients who are transferred to another non-exempt hospital [shall]will be calculated on the basis of a per diem rate for each day of the patient's stay in the transferring hospital, subject to the exceptions set forth in subparagraphs (a), (b), and (c) through (d) of this paragraph. The total payment to the transferring facility [shall]will not exceed the amount that would have been paid if the patient had been discharged. The per diem rate [shall]will be determined by dividing the DRG case-based payment per discharge as defined in the Definitions Section by the [arithmetic]average [inlier] length of stay (ALOS) for that DRG, as defined in the Definitions Section, and multiplying by the transfer case's actual length of stay and by the transfer adjustment factor of 120 percent. In transfer cases where the [arithmetic inlier] ALOS for the DRG is equal to one, the transfer adjustment factor [shall]will not be applied.
- a. Transfers among more than two hospitals that are not part of a merged facility as defined in the Mergers, Acquisitions, Consolidations, Restructurings and Closure Section [shall]will be reimbursed as follows:
 - i. the facility which discharges the patient [shall]will receive the full DRG payment; and
 - ii. all other facilities in which the patient has received care [shall]will receive a per diem rate unless the patient is in a transfer DRG.
 - b. A transferring facility [shall]will be paid the full DRG rate for those patients in DRGs specifically identified as transfer DRGs.
 - c. Transfers among non-exempt hospitals or divisions that are part of a merged [or consolidated] facility [shall]will be reimbursed as if the hospital that first admitted the patient had also discharged the patient.
 - d. Services provided to neonates discharged from a hospital providing neonatal specialty services to a hospital reimbursed under the case payment system for purposes of weight gain [shall]will be reimbursed and assigned to the applicable APR-DRG upon admission or readmission.

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114****1905(a)(1) Inpatient Hospital Services****Alternate Level of Care Payments (ALC).**

1. For rates beginning on and after July 1, 2018, hospitals will be reimbursed for ALC days at the appropriate 2013 group average operating cost component of rates of payment for hospital-based residential health care facilities established pursuant to Attachment 4.19-D, trended to the rate year.

The determination of the group average operating rate for hospital-based residential health care facilities specified in this paragraph will be based on the combination of residential health care facilities as follows:

- a. The downstate group will consist of residential health care facilities located in the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess.
 - b. The upstate group will consist of all other residential health care facilities in the State.
2. Hospitals that convert medical/surgical beds to residential health care beds will be reimbursed for services provided in the converted beds in accordance with Attachment 4.19-D.

TN #18-0057 Supersedes TN #14-0021 Approval Date August 24, 2023 Effective Date July 1, 2018

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Exempt units and hospitals.

1. *Physical medical rehabilitation inpatient services* shall qualify for reimbursement as an exempt unit/hospital pursuant to this paragraph for periods on and after December 1, 2009, only if such services are provided in a hospital specializing in such services or in a distinct unit within a general hospital designated for such services and only if:
 - a. Such hospital or such unit qualified for exempt unit status for purposes of reimbursement under the federal Medicare prospective payment system as of December 31, 2001; or
 - b. On or before July 1, 2009, the hospital submitted a written request to the Department for exempt status providing assurances acceptable to the Department that the hospital or unit within the hospital meets the exempt status for 2009 for periods prior to December 1, 2009.
 - i. For periods on and after January 1, 2010, a hospital seeking exempt status for a hospital or a distinct unit within the hospital not previously recognized by the Department as exempt for reimbursement purposes shall submit a written request to the Department for such exempt status and shall provide assurances and supporting documentation acceptable to the Department that the hospital or unit meets qualifying exempt status criteria in effect at the time such written request is submitted . Approval by the the Department of such exempt status shall, for reimbursement purposes, be effective on the January 1 following such approval, provided that the request for such exempt unit status was received at least 120 days prior to such date.
 - ii. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, not including reported direct medical education costs, and held to a ceiling of 110% of the average of such costs in the region in which the facility is located, as described in paragraph (9) of this section. Such rates shall reflect trend adjustments in accordance with the applicable provisions this Attachment.
 - iii. For days of service occurring on and after May 12, 2016, the rates of payment for inpatient services for physical medical rehabilitation will be revised to include costs for pediatric ventilator services that receive Certificate of Need (CON) approval.

(1) A hospital that has been approved through the CON process to include pediatric ventilators within their physical medical rehabilitation unit will provide or report the following:

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(a) Documentation of CON approval of the pediatric ventilator service within their physical medical rehabilitation unit.

(b) Discretely report the costs and statistics for these services on a hospital's Institutional Cost Report.

(2) A hospital that has a full year experience of pediatric ventilator service costs (defined as audited costs) and statistics will have their physical medical rehabilitation rate, which includes pediatric ventilator service, calculated as follows:

(a) A separate rate will initially be calculated for the physical medical rehabilitation service, using data in 1(b)(ii), and for the pediatric ventilator service using the same base year data as utilized for the medical rehabilitation service (subject to the provisions in paragraph 3 below). Two separate rates will then be combined as detailed in 2(c) to develop one physical medical rehabilitation rate for payment.

(b) The method for calculating the pediatric ventilator service rate, prior to developing the combined rate, will be the same as utilized for the physical medical rehabilitation rate, as described in this section, with the exception that the pediatric ventilator services will not be held to the 110% ceiling of the regional average costs. The pediatric ventilator service rate will not be included in the physical medical rehabilitation services 110% ceiling regional average.

(c) A combined per day payment rate for medical rehabilitation services will be developed from the two separate rates as follows:

(i) The percentage of Medicaid days for each of the two services to the total Medicaid days for the two services is multiplied by each service's per day payment.

(ii) The Medicaid days utilized for this proportional calculation are those as referenced in 1(b)(iii)(2)(a).

(iii) The results of multiplying the respective proportional percentage to each service's respective per day rate are then added together to develop the physical medical rehabilitation rate to be paid for both the physical medical rehabilitation and pediatric ventilator service days.

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(3) A hospital without an initial full year of pediatric ventilator service cost and statistics experience will have their physical medical rehabilitation rate, which includes the pediatric ventilator service, calculated as above in 1(b)(iii)(2). Except rather than data from 1(b)(iii)(1)(b) the costs and statistics used for the pediatric ventilator service will be based on budgeted CON approved costs. The budgeted costs will be subject to review and limitation based on a comparison to other hospitals and nursing homes providing the service.

(a) Budgeted base year costs will be replaced with actual audited costs at the time a full year of actual audited costs are available using data in 1(b)(iii)(1)(b).

(b) The pediatric ventilator service rate developed from actual audited costs will be subject to the same review and limitation based on a comparison to other hospitals and nursing homes providing the service that was initially completed for budgeted costs.

iv. For days of service beginning January 1, 2017, a hospital specific minimum wage payment per day will be calculated based on minimum wage costs as defined in 24 of the Definitions Section and will be added to the physical medical rehabilitation rate. The add-on shall apply only to medical rehabilitation hospitals which do not receive an acute rate per discharge.

a. A per day add-on to the rates will be developed by dividing total hospital specific minimum wage costs by total physical medical rehabilitation days as reported in the latest available institutional cost report.

2. *Chemical dependency rehabilitation inpatient services* shall qualify for reimbursement pursuant to this paragraph for periods on and after December 1, 2009, only if such services are provided in a hospital specializing in such services or in a distinct unit within a general hospital designated for such services and only if:

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- a. The services provided in such hospital or unit are limited to chemical dependency rehabilitation care and do not include chemical dependency related inpatient detoxification and/or withdrawal services; or
 - b. Such hospital or unit is licensed to provide such services pursuant to both the Public Health Law and the Mental Hygiene Law and meets the applicable alcohol and/or substance abuse rehabilitation standards set forth in regulations;
 - i. Any such unit within a hospital must be in a designated area and consist of designated beds providing only chemical dependency rehabilitation inpatient services with adequate adjoining supporting spaces and assigned personnel qualified by training and/or by experience to provide such services and in accordance with any applicable criteria regarding the provision of such services issued by the New York State Office of Alcohol and Substance Abuse Services.
 - ii. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, not including reported direct medical education costs, and held to a ceiling of 110% of the average of such costs in the region in which the facility is located, as described in paragraph (9) of this section. Such rates shall reflect trend adjustments in accordance with the applicable provisions of this Attachment.
3. *Critical access hospitals.*
- a. Rural hospitals shall qualify for inpatient reimbursement as critical access hospitals for periods on and after December 1, 2009, only if such hospitals are designated as critical access hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act.
 - b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, and held to a ceiling of 110% of the average of such costs for all such designated hospitals statewide. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.
 - c. For days of service beginning January 1, 2017, a hospital specific minimum wage payment per day will be calculated based on minimum wage costs as defined in 24 of the Definitions Section and will be added to the critical access hospital rate.
 - i. A per day add-on to the rates will be developed by dividing total hospital specific minimum wage costs by total critical access days as reported in the latest available institutional cost report.
4. *Cancer hospitals.*
- a. Hospitals shall qualify for inpatient reimbursement as cancer hospitals for periods on and after December 1, 2009, only if such hospitals were, as of December 31, 2008, designated as comprehensive cancer hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act.

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- b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this Section shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.
 - c. For days of service beginning January 1, 2017, a hospital specific minimum wage payment per day will be calculated based on minimum wage costs as defined in 24 of the Definitions Section and will be added to the cancer hospital rate.
 - i. A per day add-on to the rates will be developed by dividing total hospital specific minimum wage costs by total cancer hospital days as reported in the latest available institutional cost report.
5. *Specialty long term acute care hospital.*
- a. Hospitals shall qualify for inpatient reimbursement as specialty long term acute care hospitals for periods on and after December 1, 2009, only if such hospitals were, as of December 31, 2008, designated as specialty long term acute care hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act.
 - b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this Section shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.
 - c. For days of service beginning January 1, 2017, a hospital specific minimum wage payment per day will be calculated based on minimum wage costs as defined in 24 of the Definitions Section and will be added to the specialty long term care hospital rate.
 - i. A per day add-on to the rates will be developed by dividing total hospital specific minimum wage costs by total specialty long term care days as reported in the latest available institutional cost report.
6. *Acute care children's hospitals.* Hospitals shall qualify for inpatient reimbursement as acute care children's hospitals for periods on and after December 1, 2009, only if:
- a. Such hospitals were, as of December 31, 2008, designated as acute care children's hospitals in accordance with the provisions of Title XVIII (Medicare) of the federal Social Security Act; and
 - b. Such hospitals filed a discrete 2007 institutional cost report reflecting reported Medicaid discharges of greater than 50 percent of total discharges.
 - i. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2007 operating costs as submitted to the Department prior to July 1, 2009. Such rates shall reflect trend factor adjustments in accordance with the applicable provisions of this Attachment.
 - ii. For days of service beginning January 1, 2017, a hospital specific minimum wage payment per day will be calculated based on minimum wage costs as defined in 24 of the Definitions Section and will be added to the acute care children's hospital rate.
- [7. *Substance abuse detoxification inpatient services.* For patients discharged on and after December 1, 2008, rates of payment for general hospitals which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS) to provide services to patients determined to be in the diagnostic category of substance abuse will be made on a per diem basis. This includes inpatient detoxification, withdrawal, and observation services:
- a. MDC 20, DRGs 743 through 751 effective December 1, 2008 through March 31, 2013.
 - b. MDC 20, APR-DRGs 770 through 776 effective April 1, 2013. APR-DRGs are more fully described in the Definitions section and the Service Intensity Weights (SIW) and Average Length-of-Stay section of this Attachment.]

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- (1) A per day add-on to the rates will be developed by dividing total hospital specific minimum wage costs by total acute care children's hospital days as reported in the latest available institutional cost report.

7. Substance abuse detoxification inpatient services. For patients discharged on and after December 1, 2008, rates of payment for general hospitals which are certified by the Office of Alcoholism and Substance Abuse Services (OASAS) to provide services to patients determined to be in the diagnostic category of substance abuse will be made on a per diem basis. This includes inpatient detoxification, withdrawal, and observation services:

a. MDC 20, DRGs 743 through 751 effective December 1, 2008 through March 31, 2013.

b. MDC 20, APR-DRGs 770 through 776 effective April 1, 2013. APR-DRGs are more fully described in the Definitions section and the Service Intensity Weights (SIW) and Average Length-of-Stay section of this Attachment.

Medically managed detoxification services are for patients who are acutely ill from alcohol and or substance related addictions or dependence, including the need or risk for the need of medical management of severe withdrawal, and/or are at risk of acute physical or psychiatric co-morbid conditions. Medically supervised withdrawal services are for patients at a mild or moderate level of withdrawal, or are at risk for such, as well as patients with sub-acute physical or psychiatric complications related to alcohol and/or substance related dependence, are intoxicated, or have mild withdrawal with a situational crisis, or are unable to abstain yet have no past withdrawal complications.

The per diem rates for inpatient detoxification, withdrawal, and observation services will be determined as follows:

- a. The operating cost component of the per diem rates will be computed using 2006 costs and statistics as reported to the Department by general hospitals prior to 2008, adjusted for inflation. The inflation factor will be calculated in accordance with the trend factor methodology described in this Attachment. The average operating cost per diem for the region in which the hospital is located will be calculated using costs incurred for patients requiring detoxification services. The operating cost component of the per diem rates will be transitioned to 2006 as follows:
1. For the period December 1, 2008 through March 31, 2009, 75% of the operating cost component will reflect the operating cost component of rates effective for December 31, 2007, adjusted for inflation, and 25% will reflect 2006 operating costs in accordance with paragraphs (b) through (f).
 2. For April 1, 2009 through March 31, 2010, 37.5% of the operating cost component will reflect the December 31, 2007 operating cost component, adjusted for inflation, and 62.5% will reflect 2006 operating costs in accordance with paragraphs (b) through (f).
 - [3. For periods on and after April 1, 2010, 100% of the operating cost component will reflect 2006 operating costs in accordance with paragraphs (b) through (f).]

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3. For periods on and after April 1, 2010, 100% of the operating cost component will reflect 2006 operating costs in accordance with paragraphs (b) through (f).
- b. For purposes of establishing the average operating cost per diem by region for medically managed detoxification and medically supervised withdrawal services, the regions of the state are defined as follows:
1. New York City – Bronx, New York, Kings and Richmond Counties;
 2. Long Island – Nassau and Suffolk Counties;
 3. Northern Metropolitan – Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester Counties;
 4. Northeast - Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties;
 5. Utica/Watertown – Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida Counties;
 6. Central – Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga, and Tompkins Counties;
 7. Rochester – Monroe, Ontario, Livingston, Wayne and Yates Counties; and
 8. Western – Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.
- c. For each of the regions, the 2006 operating costs incurred by general hospitals in such region for providing care to inpatients requiring detoxification services , as defined by OASAS, and reported in the 2006 ICR submitted to the Department prior to 2008, are adjusted by a length of stay (LOS) factor. This LOS factor reflects the loss of revenue due to the reduction of payments for services over the 5th day of stay. The total adjusted operating costs for each region, divided by the total regional days, is the average operating cost per diem for the region.
- d. The per diem rates for inpatients requiring medically managed detoxification services will reflect 100% of the average operating cost per diem for the region in which the hospital is located, adjusted for inflation, for the first 5 days of service. However, such payments will be reduced by 50% for services provided on the 6th through 10th day of service. No payments will be made for any services provided on and after the 11th day.
- e. Per diem rates for inpatients requiring medically supervised withdrawal services, will reflect 100% of the average operating cost per diem for the region in which the hospital is located, adjusted for inflation, for the period January 1, 2009 through December 31, 2009. For periods on and after January 1, 2010, the per diem rates for withdrawal services will reflect 75% of the average operating cost per diem for the region, adjusted for inflation, and will be reduced by 50% for care provided on the 6th through 10th day of service. No payments will be made for any services provided on and after the 11th day.

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117(c)**

- f. Per diem rates for inpatients placed in observation beds, as defined by OASAS, will reflect 100% of the average operating cost per diem for the region in which the hospital is located, adjusted for inflation, and will be paid for no more than 2 days of care. After 2 days of care the payments will reflect the patient's diagnosis as requiring either detoxification or withdrawal services. The days of care in the observation beds will be included in the determination of days of care for either detoxification or withdrawal services. Furthermore, days of care provided in observation beds will, for reimbursement purposes, be fully reflected in the computation of the initial five days of care.
- g. Capital cost reimbursement for the general hospitals which are certified by OASAS to provide substance abuse services will be based on the current reimbursement methodology for determining allowable capital for exempt unit per diem rates. Such capital cost will be added to the applicable operating cost component as a per diem amount to establish the per diem rate for each service.

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**New York
117(d)**

1905(a)(1) Inpatient Hospital Services

8. *Inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals, specializing in such inpatient psychiatric services*, for patients admitted on and after October 20, 2010, will be reimbursed on a per diem basis as follows:
- a. Reimbursement will use the All Patient Refined Diagnostic Related Group (APR-DRG) patient classification system.
 - b. The operating component of the rate will be a statewide price, calculated utilizing 2005 Medicaid fee-for-service (FFS) inpatient costs developed using the ratio of cost to charges approach to determine costs and a regression model to price out various components of the costs to determine cost significance in such components. The components include patient age, rural designation, comorbidities, length of stay, and presence of mental retardation. The costs of these components as developed in the regression model were excluded in developing the statewide price.
 - i. The facility-specific old operating per diem rates were trended to 2010, and for each case, these rates were multiplied by the length of stay (LOS) to calculate the "old payment."
 - ii. Facility-specific 2005 Direct Graduate Medical Education (DGME) costs were divided by 2005 patient days to calculate DGME per diem rates. These rates were then trended to 2010.
 - iii. The 2010 payment rate for Electroconvulsive Therapy (ECT) was established as \$281 (based on the ECT rate in effect for Medicare psychiatric patients during the first half of 2010). This rate was then adjusted by each facility's wage equalization factor (WEF).
 - iv. For each case, the proper DGME payment (DGME rate multiplied by the LOS) and ECT payment (WEF-adjusted ECT rate times the number of ECT treatments) was subtracted from the "old payments" to derive the "old payments subject to risk adjustment."
 - v. For each case, a payment adjustment factor was derived based on the regression model, including the LOS adjustment factor as defined by the new payment methodology.
 - vi. The sum of the old payments subject to risk adjustment from step iv (\$502,341,057), was divided by the sum of payment adjustment factors from step v (\$831,319), which resulted in the statewide per diem rate of \$604.27 as of October 20, 2010. The current statewide per diem rate of \$642.66 reflects the effect of restoring transition funds back into the statewide price pursuant to the Transition Fund Pool section of this Attachment. Effective October 1, 2018, the statewide price will be increased to \$676.21. Effective August 1, 2021, the statewide fee-for-service price will be increased to \$742.86. Effective April 1, 2022, the statewide fee-for service price will be increased to \$950.43.

TN #22-0047

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Effective Date April 1, 2022

**New York
117(e)**

- c. The non-operating component of the rate will reflect the 2010 budgeted capital costs per diem and the 2005 Medicaid fee-for-service Direct GME costs (DGME). Capital costs will be calculated in accordance with this section including an adjustment to reflect allowable capital costs as reflect in the applicable rate year's Institutional Cost Report. DGME costs are the 2005 reimbursable salaries, fringe benefits, non-salary costs and allocated overhead for residents, fellows, and supervising physicians. The DGME costs allocated to the psychiatric unit is divided by the total patient days spent in the psychiatric unit to derive the 2005 per diem cost of the DGME attributable to the psychiatric unit. This 2005 per diem psychiatric DGME cost is then inflated by 2.95% for 2006, 2.1% for 2007, and 0% thereafter to trend it to October 2010 payment levels.
- d. The statewide price will be adjusted for each patient to reflect the following factors:
- i. A facility-specific wage equalization factor (WEF), calculated in accordance with the Wage Equalization Factor (WEF) section of this Attachment, will reflect differences in labor costs between hospitals.
 - ii. A service intensity weight (SIW) associated with the case, calculated utilizing the grouper assigned APR-DRG, will be applied to the adjusted operating per diem. The SIWs for the APR-DRGs as noted in the Inpatient Psychiatric Services Service Intensity Weights (SIWs) table are different than those for the acute system. The SIWs reflect the cost weights assigned to each All Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each APR-DRG indicates the relative cost variance of that APR-DRG classification from the average cost of all inpatients in all APR-DRGs. The SIWs are developed using two years of Medicaid fee-for-service cost data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years 2005 and 2006. Costs associated with statistical outliers will be excluded from the SIW calculation.

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**New York
117(f)**

Inpatient Psychiatric Services Service Intensity Weights (SIWs)

<u>APR-DRG Codes</u>	<u>Severity of Illness</u>	<u>APR-DRG Description</u>	<u>APR- DRG SIW</u>
<u>042</u>	<u>1</u>	<u>Degenerative Nervous System Disorders Exc Mult Sclerosis, SOI-1</u>	<u>0.9317</u>
<u>042</u>	<u>2</u>	<u>Degenerative Nervous System Disorders Exc Mult Sclerosis, SOI-2</u>	<u>0.9317</u>
<u>042</u>	<u>3</u>	<u>Degenerative Nervous System Disorders Exc Mult Sclerosis, SOI-3</u>	<u>0.9317</u>
<u>042</u>	<u>4</u>	<u>Degenerative Nervous System Disorders Exc Mult Sclerosis, SOI-4</u>	<u>0.9317</u>
<u>052</u>	<u>1</u>	<u>Nontraumatic Stupor & Coma, SOI-1</u>	<u>1.0034</u>
<u>052</u>	<u>2</u>	<u>Nontraumatic Stupor & Coma, SOI-2</u>	<u>1.0034</u>
<u>052</u>	<u>3</u>	<u>Nontraumatic Stupor & Coma, SOI-3</u>	<u>1.0034</u>
<u>052</u>	<u>4</u>	<u>Nontraumatic Stupor & Coma, SOI-4</u>	<u>1.0034</u>
<u>561</u>	<u>1</u>	<u>Postpartum & Post Abortion Diagnoses w/o Procedure, SOI-1</u>	<u>1.0105</u>
<u>561</u>	<u>2</u>	<u>Postpartum & Post Abortion Diagnoses w/o Procedure, SOI-2</u>	<u>1.0105</u>
<u>561</u>	<u>3</u>	<u>Postpartum & Post Abortion Diagnoses w/o Procedure, SOI-3</u>	<u>1.0105</u>
<u>561</u>	<u>4</u>	<u>Postpartum & Post Abortion Diagnoses w/o Procedure, SOI-4</u>	<u>1.0105</u>
<u>566</u>	<u>1</u>	<u>Other Antepartum Diagnoses, SOI-1</u>	<u>0.9559</u>
<u>566</u>	<u>2</u>	<u>Other Antepartum Diagnoses, SOI-2</u>	<u>0.9559</u>
<u>566</u>	<u>3</u>	<u>Other Antepartum Diagnoses, SOI-3</u>	<u>1.0875</u>
<u>566</u>	<u>4</u>	<u>Other Antepartum Diagnoses, SOI-4</u>	<u>1.0875</u>
<u>740</u>	<u>1</u>	<u>Mental Illness Diagnosis w O.R. Procedure, SOI-1</u>	<u>1.1418</u>
<u>740</u>	<u>2</u>	<u>Mental Illness Diagnosis w O.R. Procedure, SOI-2</u>	<u>1.1418</u>
<u>740</u>	<u>3</u>	<u>Mental Illness Diagnosis w O.R. Procedure, SOI-3</u>	<u>1.1418</u>
<u>740</u>	<u>4</u>	<u>Mental Illness Diagnosis w O.R. Procedure, SOI-4</u>	<u>1.1418</u>

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<u>750</u>	<u>1</u>	<u>Schizophrenia, SOI-1</u>	<u>0.9444</u>
<u>750</u>	<u>2</u>	<u>Schizophrenia, SOI-2</u>	<u>0.9938</u>
<u>750</u>	<u>3</u>	<u>Schizophrenia, SOI-3</u>	<u>1.0527</u>
<u>750</u>	<u>4</u>	<u>Schizophrenia, SOI-4</u>	<u>1.0703</u>
<u>751</u>	<u>1</u>	<u>Major Depressive Disorders & Other/Unspecified Psychoses, SOI-1</u>	<u>0.9887</u>
<u>751</u>	<u>2</u>	<u>Major Depressive Disorders & Other/Unspecified Psychoses, SOI-2</u>	<u>1.0492</u>
<u>751</u>	<u>3</u>	<u>Major Depressive Disorders & Other/Unspecified Psychoses, SOI-3</u>	<u>1.0666</u>
<u>751</u>	<u>4</u>	<u>Major Depressive Disorders & Other/Unspecified Psychoses, SOI-4</u>	<u>1.1208</u>
<u>752</u>	<u>1</u>	<u>Disorders of Personality & Impulse Control, SOI-1</u>	<u>0.9847</u>
<u>752</u>	<u>2</u>	<u>Disorders of Personality & Impulse Control, SOI-2</u>	<u>1.0223</u>
<u>752</u>	<u>3</u>	<u>Disorders of Personality & Impulse Control, SOI-3</u>	<u>1.0223</u>
<u>752</u>	<u>4</u>	<u>Disorders of Personality & Impulse Control, SOI-4</u>	<u>1.0223</u>
<u>753</u>	<u>1</u>	<u>Bipolar Disorders, SOI-1</u>	<u>0.9714</u>
<u>753</u>	<u>2</u>	<u>Bipolar Disorders, SOI-2</u>	<u>1.0109</u>
<u>753</u>	<u>3</u>	<u>Bipolar Disorders, SOI-3</u>	<u>1.0576</u>
<u>753</u>	<u>4</u>	<u>Bipolar Disorders, SOI-4</u>	<u>1.1495</u>
<u>754</u>	<u>1</u>	<u>Depression Except Major Depressive Disorder, SOI-1</u>	<u>1.0225</u>
<u>754</u>	<u>2</u>	<u>Depression Except Major Depressive Disorder, SOI-2</u>	<u>1.0611</u>
<u>754</u>	<u>3</u>	<u>Depression Except Major Depressive Disorder, SOI-3</u>	<u>1.0864</u>
<u>754</u>	<u>4</u>	<u>Depression Except Major Depressive Disorder, SOI-4</u>	<u>1.0864</u>

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<u>755</u>	<u>1</u>	<u>Adjustment Disorders & Neuroses Except Depressive Diagnoses, SOI-1</u>	<u>1.0464</u>
<u>755</u>	<u>2</u>	<u>Adjustment Disorders & Neuroses Except Depressive Diagnoses, SOI-2</u>	<u>1.0464</u>
<u>755</u>	<u>3</u>	<u>Adjustment Disorders & Neuroses Except Depressive Diagnoses, SOI-3</u>	<u>1.0464</u>
<u>755</u>	<u>4</u>	<u>Adjustment Disorders & Neuroses Except Depressive Diagnoses, SOI-4</u>	<u>1.0464</u>
<u>756</u>	<u>1</u>	<u>Acute Anxiety & Delirium States, SOI-1</u>	<u>1.1144</u>
<u>756</u>	<u>2</u>	<u>Acute Anxiety & Delirium States, SOI-2</u>	<u>1.1558</u>
<u>756</u>	<u>3</u>	<u>Acute Anxiety & Delirium States, SOI-3</u>	<u>1.1558</u>
<u>756</u>	<u>4</u>	<u>Acute Anxiety & Delirium States, SOI-4</u>	<u>1.1558</u>
<u>757</u>	<u>1</u>	<u>Organic Mental Health Disturbances, SOI-1</u>	<u>1.0142</u>
<u>757</u>	<u>2</u>	<u>Organic Mental Health Disturbances, SOI-2</u>	<u>1.0142</u>
<u>757</u>	<u>3</u>	<u>Organic Mental Health Disturbances, SOI-3</u>	<u>1.0451</u>
<u>757</u>	<u>4</u>	<u>Organic Mental Health Disturbances, SOI-4</u>	<u>1.0451</u>
<u>758</u>	<u>1</u>	<u>Childhood Behavioral Disorders, SOI-1</u>	<u>0.9635</u>
<u>758</u>	<u>2</u>	<u>Childhood Behavioral Disorders, SOI-2</u>	<u>1.0365</u>
<u>758</u>	<u>3</u>	<u>Childhood Behavioral Disorders, SOI-3</u>	<u>1.0365</u>
<u>758</u>	<u>4</u>	<u>Childhood Behavioral Disorders, SOI-4</u>	<u>1.0365</u>
<u>759</u>	<u>1</u>	<u>Eating Disorders, SOI-1</u>	<u>0.8626</u>
<u>759</u>	<u>2</u>	<u>Eating Disorders, SOI-2</u>	<u>0.9256</u>
<u>759</u>	<u>3</u>	<u>Eating Disorders, SOI-3</u>	<u>0.9256</u>
<u>759</u>	<u>4</u>	<u>Eating Disorders, SOI-4</u>	<u>0.9256</u>
<u>760</u>	<u>1</u>	<u>Other Mental Health Disorders, SOI-1</u>	<u>0.9918</u>
<u>760</u>	<u>2</u>	<u>Other Mental Health Disorders, SOI-2</u>	<u>0.9918</u>
<u>760</u>	<u>3</u>	<u>Other Mental Health Disorders, SOI-3</u>	<u>0.9918</u>
<u>760</u>	<u>4</u>	<u>Other Mental Health Disorders, SOI-4</u>	<u>0.9918</u>
<u>770</u>	<u>1</u>	<u>Drug & Alcohol Abuse or Dependence, Left Against Medical Advice, SOI-1</u>	<u>0.9775</u>
<u>770</u>	<u>2</u>	<u>Drug & Alcohol Abuse or Dependence, Left Against Medical Advice, SOI-2</u>	<u>0.9775</u>
<u>770</u>	<u>3</u>	<u>Drug & Alcohol Abuse or Dependence, Left Against Medical Advice, SOI-3</u>	<u>0.9775</u>
<u>770</u>	<u>4</u>	<u>Drug & Alcohol Abuse or Dependence, Left Against Medical Advice, SOI-4</u>	<u>0.9775</u>

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772	1	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-1	0.8373
772	2	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-2	0.8373
772	3	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-3	0.8373
772	4	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-4	0.8373
773	1	Opioid Abuse & Dependence, SOI-1	1.0204
773	2	Opioid Abuse & Dependence, SOI-2	1.0204
773	3	Opioid Abuse & Dependence, SOI-3	1.0361
773	4	Opioid Abuse & Dependence, SOI-4	1.0361
774	1	Cocaine Abuse & Dependence, SOI-1	0.9807
774	2	Cocaine Abuse & Dependence, SOI-2	1.0360
774	3	Cocaine Abuse & Dependence, SOI-3	1.0513
774	4	Cocaine Abuse & Dependence, SOI-4	1.0513
775	1	Alcohol Abuse & Dependence, SOI-1	1.0196
775	2	Alcohol Abuse & Dependence, SOI-2	1.0709
775	3	Alcohol Abuse & Dependence, SOI-3	1.0709
775	4	Alcohol Abuse & Dependence, SOI-4	1.0709
776	1	Other Drug Abuse & Dependence, SOI-1	0.9363
776	2	Other Drug Abuse & Dependence, SOI-2	1.0926
776	3	Other Drug Abuse & Dependence, SOI-3	1.0926
776	4	Other Drug Abuse & Dependence, SOI-4	1.0926

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- iii. A rural adjustment factor of 1.2309 will be applied to the operating per diem for those hospitals designated as rural hospitals. A rural facility is a general hospital with a service area which has an average population of less than 175 persons per square mile, or a general hospital with a service area which has an average population of less than 200 persons per square mile measured as population density by zip code. For dates of service beginning on or after July 1, 2014, rural designation will be applicable to hospitals located in an upstate region, as defined in subparagraph (I) of this section, and with population densities of 225 persons or fewer per square mile as determined based on the New York State 2010 Vital Statistics table of estimated population, land area, and population density. For dates of service beginning on or after January 1, 2022, rural designation will be applicable to hospitals located in an upstate region, as defined in subparagraph (I) of this section, and with population densities of 300 persons or fewer per square mile as determined based on the New York State 2020 Vital Statistics table of estimated population, land area, and population density.
- iv. An age adjustment payment factor of 1.3597 will be applied to the per diem operating component for adolescents ages 17 and under. For ages 18 and over, an adjustment payment factor of 1 will be applied.

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- v. A payment adjustment factor of 1.0599 will be applied to the operating component for the presence of a mental retardation diagnosis.
- vi. The payment methodology will include one comorbidity factor per stay and if more than one comorbidity is present during a patient's stay, the comorbidity that reflects the highest payment factor will be used to adjust the per diem operating component.

<u>Comorbidity Categories</u>	<u>Adjustment Factor</u>
<u>Cancers</u>	<u>1.0942</u>
<u>Protein-Calorie Malnutrition</u>	<u>1.0848</u>
<u>Disorders of Fluid/Electrolyte/Acid-Base Balance</u>	<u>1.0630</u>
<u>Other Endocrine/Metabolic/Nutritional Disorders</u>	<u>1.1405</u>
<u>Other Hepatitis and Liver Disease</u>	<u>1.0856</u>
<u>Peptic Ulcer, Hemorrhage, Other Specified Gastrointestinal Disorders</u>	<u>1.1032</u>
<u>Other Musculoskeletal and Connective Tissue Disorders</u>	<u>1.0638</u>
<u>Blood Disorders</u>	<u>1.1056</u>
<u>Other Developmental Disability</u>	<u>1.2014</u>
<u>Brain/Head Injury</u>	<u>1.1361</u>
<u>Cardiorespiratory Failure and Shock</u>	<u>1.1608</u>
<u>Acute Coronary Syndrome</u>	<u>1.4046</u>
<u>Stroke/Occlusion/Cerebral Ischemia</u>	<u>1.2109</u>
<u>Respiratory Illness</u>	<u>1.0662</u>
<u>Other Eye Disorders</u>	<u>1.1224</u>
<u>Renal Disease</u>	<u>1.0954</u>
<u>Complications of Medical Care and Trauma</u>	<u>1.1297</u>
<u>Major Organ Transplant Status</u>	<u>1.1762</u>

- vii. A variable payment factor will be applied to the operating per diem for each day of the stay, with the factor for days 1 through 4 established at 1.2, the factor for days 5 through 11 established at 1.0, the factor for days 12 through 22 established at 0.96 and the factor for stays longer than 22 days established at 0.92.
- viii. An annual adjustment for inflation will be applied as determined in accordance with the trend factor provisions of this Attachment.

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- ix. For dates of service beginning on or after July 1, 2014, an additional ten percent increase will be applied for hospitals located in an upstate region as defined in subdivision (l) of this section.
- e. The first day of a patient's readmissions to the same hospital within 30 days of discharge will be treated as day four for purposes of the variable payment factor computed as aforementioned, with subsequent days treated in a conforming manner with the provisions.
- f. Reimbursement for physician services will not be included in rates and such services may be billed on a fee-for-services basis pursuant to the Hospital Physician Billing Section in Attachment 4.19-B.
- g. Reimbursement for electroconvulsive therapy will be established at a statewide fee of \$281, as adjusted for each facility's WEF, for each treatment during a patient's stay.
- h. New inpatient psychiatric exempt hospitals or units established pursuant to Article 28 of the Public Health Law will be reimbursed at the statewide price plus budgeted capital and Direct GME. Budgeted capital will be adjusted as described in this section and will be adjusted to actual costs in future years. Direct GME will be adjusted to actual costs based upon the first twelve months reporting following the calendar year after the opening of the new unit.
- i. The base period costs and statistics used for inpatient psychiatric per diem rate setting operating cost components including the weights assigned to diagnostic related groups (DRG) designated as psychiatric DRGs for per diem reimbursement, will be updated [no less frequently than every four years and the new base period will be no more than four years prior to the first applicable rate period that utilized such new base period.] as soon as is practical at which time the State will submit a state plan amendment for the implementation of rebasing. The payment factors for rural designation, age, certain defined comorbidities, and the presence of mental retardation may also be updated to reflect more current data.
- j. For rate periods through December 31, 2014, reimbursement will include transition payments of \$25 million on an annualized basis, which will be distributed as follows:

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- i. Fifty percent of the payments will be allocated to facilities that experience a reduction in Medicaid operating revenue relative to payments prior to this new methodology in excess of threshold percentage set forth in this paragraph as a result of the implementation of rates set pursuant to this section. The payments will be allocated proportionally, calculated utilizing each eligible facility's relative Medicaid operating revenue reduction in excess of the threshold, as determined by the Commissioner. The threshold percentage described in this paragraph will be 6.02%. Therefore, 50% of the \$25 million will be allocated to hospitals such that they will not lose more than 6.02% of revenue from the existing payment to the new payments in year 1.
- ii. Fifty percent of the payments will be allocated to facilities whose rates otherwise set pursuant to this section result in Medicaid revenue that is less than the facility's calculated Medicaid costs by a threshold percentage in excess of 1.20%. The payments will be allocated proportionally, utilizing the degree by which each facility's Medicaid operating revenue shortfall exceeds such threshold percentage. Therefore, with the utilization of 2006 data, 50% of the \$25 million will be allocated to hospitals whose costs are above their revenues.
- iii. In 2010-11, the \$25 million investment will be allocated to a transition fund pool. In future years through December 31, 2014, the \$25 million transition fund pool will be reduced, and the excess funds will be reinvested into the statewide base price as follows:

<u>Period</u>	<u>Transition</u>	<u>Statewide Rate</u>
<u>10/20/2010 – 12/31/2011</u>	<u>\$25 million</u>	<u>\$0</u>
<u>1/1/2012 – 12/31/2012</u>	<u>\$17 million</u>	<u>\$8 million</u>
<u>1/1/2013 – 12/31/2013</u>	<u>\$8 million</u>	<u>\$17 million</u>
<u>1/1/2014 – 12/31/2014</u>	<u>\$0</u>	<u>\$25 million</u>

- k. For the rate period October 20, 2010 through March 31, 2011, reimbursement will include transition payments totaling, in aggregate, \$12 million and will be distributed to eligible hospitals as described below, provided, however, that if less than \$12 million is distributed in such rate period then additional distributions of the \$12 million will be made in subsequent rate periods as follows:

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- i. Eligible hospitals will be those general hospitals which receive approval for certificate of need applications submitted to the Department of Health between April 1, 2010 and March 31, 2011 for adding new behavioral health inpatient beds in response to the decertification of other general hospital behavioral health inpatient beds in the same service area, or which the Commissioner of Health, in consultation with the Commissioner of Mental Health, has determined to have complied with Department of Health requests to adjust behavioral health service delivery in order to ensure access.
- ii. Eligible hospitals will, as a condition of their receipt of the rate adjustments, submit to the Department of Health proposed budgets for the expenditure of the additional Medicaid payments for the purpose of providing inpatient behavioral health services to Medicaid eligible individuals. The budgets must be approved by the Department of Health, in consultation with the Office of Mental Health, prior to the rate adjustments being issued.
- iii. Distributions will be made as add-ons to each eligible facility's inpatient Medicaid rate and will be allocated proportionally, utilizing the proportion of each approved hospital budget to the total amount of all approved hospital budgets. Distributions will be subsequently reconciled to ensure that actual aggregate expenditures are within available aggregate funding.
- l. For purposes of this section, the downstate region of New York State will consist of the following counties of: Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess; and the upstate region of New York State will consist of all other New York counties.
- m. Reimbursement equivalent to the inpatient hospital per diem rate of reimbursement will be made for extended observation bed (EOB) services in hospital-based comprehensive psychiatric emergency programs (CPEP), subsequent to a CPEP full or triage and referral visit and where the beneficiary remains in the CPEP for longer than 24 hours. Such reimbursement will be limited to 72 hours. Effective April 1, 2023, inpatient hospital rates for EOB services are available at the following Office of Mental Health website link:

https://omh.ny.gov/omhweb/mcicaid_reimbursement/excel/cpep.xlsx

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Effective Date April 1, 2023

- [8] 9. Hospitals or distinct units of hospitals that fail to maintain qualifying criteria for exempt status for reimbursement purposes, as set forth in this Attachment, shall continue to be reimbursed in accordance with such exempt status until the commencement of the next rate period, as determined by the Department.
- [9] 10. Rates of payment for inpatient services described in paragraphs (1) and (2) above, which utilize regional averages for determining a cost ceiling shall utilize regions of the State set forth below, except that if the otherwise applicable region has less than five exempt hospitals or units in the service, facilities located in the nearest regions will be used to establish a minimum of five hospital or units for the purpose of determining ceilings. Such regions are as follows:
- a. New York City, consisting of the counties of Bronx, New York, Kings, Queens and Richmond;
 - b. Long Island, consisting of the counties of Nassau and Suffolk;
 - c. Northern Metropolitan, consisting of the counties of Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester;
 - d. Northeast, consisting of the counties of Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington;
 - e. Utica / Watertown, consisting of the counties of Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida;
 - f. Central, consisting of the counties of Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga and Tompkins;
 - g. Rochester, consisting of the counties of Monroe, Ontario, Livingston, Wayne and Yates; and
 - h. Western, consisting of the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.
- [10] 11. Capital cost components of per diem rates determined pursuant to this Section shall be computed on the basis of budgeted capital costs allocated to the exempt hospital or distinct unit of a hospital pursuant to the capital cost provisions of this Attachment divided by exempt hospital or unit patient days reconciled to actual total expense.

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12. *New hospitals and new hospital units.* The operating cost component of rates of payment for new hospitals, or hospital units, without adequate cost experience will be computed based on either budgeted cost projections, subsequently reconciled to actual reported cost data, or the regional ceiling calculated in accordance with paragraph (10) of this section, whichever is lower. The capital cost component of such rates will be calculated in accordance with the capital cost provisions of this Attachment.

13. Effective July 1, 2018, Hospitals that have been approved by the Office of Mental Health to operate distinct units to provide specialized inpatient psychiatric care to stabilize adults with co-morbid mental illness and intellectual developmental disability diagnoses as defined in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, will be reimbursed a flat per diem operating rate of \$1,177.11, and the rate-setting methodology provided in paragraph 8 of this section will not apply to services furnished in such units. Capital costs will be reimbursed on a per diem basis for the cost of capital in accordance with paragraph 11 of this section. Specialized inpatient psychiatric units are a new approach to treating dually-diagnosed individuals. The units are physically distinct and have been approved by the State to provide such care and services based on a review of the unit's physical plant specifications, enhanced staffing, and adherence to specialized clinical protocols, which demonstrate sufficient specialization in the assessment and treatment of adults with co-occurring intellectual or developmental disability, including autism spectrum disorder, and mental illness diagnoses, who exhibit destructive behaviors, or an acute safety risk or decrease in functioning.

14. Effective August 1, 2019, Hospitals that have been approved by the Office of Mental Health to operate distinct units to provide specialized inpatient psychiatric care to stabilize children with co-morbid mental illness and intellectual developmental disability diagnoses as defined in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, will be reimbursed a flat per diem operating rate of \$1,792.50, and the rate-setting methodology provided in paragraph 8 of this section will not apply to services furnished in such units. Capital costs will be reimbursed on a per diem basis for the cost of capital in accordance with paragraph 11 of this section. Specialized inpatient psychiatric units are a new approach to treating dually-diagnosed individuals. The units are physically distinct and have been approved by the State to provide such care and services based on a review of the unit's physical plant specifications, enhanced staffing, and adherence to specialized clinical protocols, which demonstrate sufficient specialization in the assessment and treatment of children with co-occurring intellectual or developmental disability, including autism spectrum disorder, and mental illness diagnoses, who exhibit destructive behaviors, or an acute safety risk or decrease in functioning.

TN **#19-0045**

Supersedes TN **#18-0001**

Approval Date **October 22, 2019**

Effective Date **August 1, 2019**

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Trend factor.

1. The trend factor terms used in this section will be used to develop rates of payments on or after December 1, 2009.
2. The Commissioner shall establish trend factors for hospitals to project the effects of price movements on historical operating costs. Rates of payment excluding capital, as calculated pursuant to the provisions of this Attachment, shall be trended to the applicable rate year by the trend factors developed in accordance with the provision of this section for rate periods through March 31, 2000.
3. The methodology for establishing the trend factors shall be developed by a panel of four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the Commissioner.
4. The methodology shall include the appropriate external price indicators and the data from major collective bargaining agreements as reported quarterly by the Federal Department of Labor, Bureau of Labor Statistics, for non-supervisory employees. For 1996 through December 31, 1999, the Commissioner shall apply the 1995 trend factor methodology.
5. The Commissioner shall implement one interim adjustment to the trend factors, based on recommendations of the panel, and one final adjustment to the trend factors. Such adjustment shall reflect the price movement in the labor and non labor components of the trend factor. At the same time adjustments are made to the trend factors in accordance with this subdivision, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factor.
6. Trend factors used to project reimbursable operating costs to the rate period April 1, 1995 to December 31, 1995 shall not be applied in the development of the rates of payment. This section shall not apply to trend factors, adjusted trend factors or final trend factors used for the January 1, 1995 through December 31, 1995, rate period for purposes of projecting allowable operating costs to subsequent rate periods.
7. Trend factors used to project reimbursable operating costs to the rate period commencing April 1, 1996 through March 31, 1997, shall not be applied in the development of the rates of payment. This section shall not apply to trend factors or final trend factors used for the January 1, 1995 through December 31, 1995 or January 1, 1996 to March 31, 1996, rate period for purposes of projecting allowable operating costs to subsequent rates periods.

TN #09-34 Supersedes TN NEW Approval Date January 20, 2010 Effective Date December 1, 2009

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120(a)**

8. Trend factors used to project reimbursable operating costs to rate periods commencing July, 1, 1999 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.
9. For rate periods on and after April 1, 2000, the Commissioner shall establish trend factors for rates of payment for hospitals to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs calculated pursuant to this Attachment.
 - a. In developing trend factors for such rates of payment, the Commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all Urban Consumers published in the Congressional Budget Office Economic and Budget Outlook after June first of the rate year prior to the year for which rates are being developed.
 - b. After the final U.S. Consumer Price Index (CPI) for all Urban Consumers is published by the United States Department of Labor, Bureau of Labor Statistics, for a particular rate year, the Commissioner shall reconcile such final CPI to the projection used in subparagraph (a) and any difference will be included in the prospective trend factor for the current year.
 - c. At the time adjustments are made to the trend factors in accordance with this section, adjustments shall be made to all inpatient rates of payment affected by the trend factor adjustment.
10. The final 2006 trend factor shall be the U.S. CPI for all Urban Consumers, as published in the U.S. Department Labor Statistics, minus 0.25%.
11. The final 2007 trend factor shall equal 75% of the final trend factor determined in paragraph (b) above.
12. The applicable trend factor for the 2008 and 2009 calendar year periods shall be zero.
13. The applicable trend factor for the 2010 calendar year shall be zero for inpatient services provided by general hospitals [services provided] on and after January 1, 2010.

TN #10-11

Supersedes TN #09-34

Approval Date February 2, 2011

Effective Date April 1, 2010

**New York
120(a)(i)**

14. Effective for services provided on and after April 1, 2011, the applicable trend factor for the 2011 calendar year period will be no greater than zero.
15. Effective for services provided on and after January 1, 2012, the applicable trend factor for the 2012 calendar year period will be no greater than zero.
16. The applicable trend factor for the 2013 calendar year will be no greater than zero for services provided on and after January 1, 2013.
17. The applicable trend factor for the 2014 calendar year period will be no greater than zero for services provided on and after January 1, 2014.
18. The applicable trend factor for the 2015 calendar year period will be no greater than zero for services provided on and after January 1, 2015 through March 31, 2015 and April 23, 2015 through December 31, 2015.
19. The applicable trend factor for the 2016 calendar year period will be no greater than zero for services provided on and after January 1, 2016.
20. The applicable trend factor for the 2017 calendar year period will be no greater than zero for services provided on and after January 1, 2017 through March 31, 2017 and April 1, 2017 through December 31, 2017.
21. The applicable trend factor for the 2018 calendar year period will be no greater than zero for services provided on and after January 1, 2018.
22. The applicable trend factor for the 2019 calendar year period will be no greater than zero for services provided on and after January 1, 2019 through March 31, 2019[.]and April 1, 2019 through December 31, 2019.
23. The applicable trend factor for the period on and after January 1, 2020 will be no greater than zero.

TN #19-0041
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**New York
120(a)(ii)**

Potentially Preventable Negative Outcomes (PPNOs)

Potentially Preventable Complications (PPC)

For discharges occurring on and after July 1, 2011 through March 31, 2012 Medicaid rates of payment to hospitals that have higher than expected Medicaid payments related to potentially preventable complications, based on the criteria set forth in the Complication Criteria section, as determined by a risk adjusted comparison of the actual and expected Medicaid payments per case for each hospital as described by the Methodology section, will be reduced in accordance with the PPC Adjustment Factor section. Such rate adjustments for this period will result in an aggregate reduction in Medicaid payments of \$31,257,000. For discharges occurring on and after April 1, 2013 through March 31, 2014, such rate adjustments will result in an aggregate reduction in Medicaid payments of \$41,000,000. For discharges beginning April 1, 2014 through March 31, 2015, such rate adjustments will result in an aggregate reduction in Medicaid payments of \$20,500,000.

Definitions. As used in this Section, the following definitions will apply:

1. **Potentially Preventable Complications** will mean harmful events or negative outcomes that develop after hospital admission and may result from processes of care and treatment rather than from natural progression of the underlying illness, as defined under version [28] 30 of the Potentially Preventable Complication grouping logic software developed and published by 3M Health Information Systems, Inc. (3M). The software identifies 1,450 ICD-9-CM diagnosis codes as a PPC diagnoses. Each ICD-9-CM code designated as a PPC diagnosis was assigned to one of 64 mutually exclusive complication groups called PPCs. A list of such PPCs, [are] effective for periods on and after July 1, 2011, are available on the following Department of Health website link:

www.health.ny.gov/health_care/medicaid/quality/ppo/complications
2. **Hospital** will mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.
3. **Observed case** will mean all non-Medicare acute care cases.
4. **PPC Coefficient** will mean a dollar amount, the result of an indirect standardization, equal to the statewide average incremental Medicaid payment attributable to each of the 64 PPCs.
5. **Adjusted Admission APR-DRG** will be defined as the assigned hospital admission APR-DRG SOI for each observed case using version [28] 30 of the APR-DRG grouper and results from 3M's PPC grouping logic software. The software results identify each PPC per admission, which has been adjusted to reassign all secondary diagnosis, not identified as a PPC or the direct cause of a PPC, as present on admission.

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**New York
120(a)(iii)**

Complication Criteria.

A complication is a condition that develops after admission to the hospital. Complications may or may not be preventable. For a complication to qualify as a PPC, the secondary diagnosis must meet the following criteria:

- a. Shall not be redundant with the diagnosis that was the reason for hospital admission;
- b. Shall not be an inevitable, natural, or expected consequence or manifestation of the reason for hospital admission;
- c. Shall be expected to have a significant impact on short or long-term debility, mortality, patient suffering, or resource use; and
- d. Shall have a relatively narrow spectrum of manifestations, meaning that the impact of the diagnosis on the clinical course or on the resource use must not be significant for some patients but trivial for others.

Methodology.

1. The actual Medicaid payment will be computed as the aggregate Medicaid payment for each hospital observed case assigned using version 28 of the APR-DRG grouper. The discharge APR-DRG severity of illness (SOI) service intensity weight (SIW) is multiplied by the Medicaid statewide base price for the applicable rate period.
2. The expected Medicaid payment will be computed as the aggregate Medicaid payment for each adjusted admission APR-DRG. The expected Medicaid payment will equal the adjusted admission APR-DRG SIW multiplied by the Medicaid statewide base price for the applicable rate period. The expected Medicaid payment will then be reduced by the sum of the PPC coefficient for the particular observed case.
3. For each hospital, a hospital-specific coefficient will be computed and equal to the aggregate actual Medicaid payment minus the aggregate expected Medicaid payment of all observed cases, divided by the total number of observed cases. In the event the hospital-specific coefficient is less than zero, the hospital coefficient shall be set to zero.

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**New York
120(a)(iv)**

PPC Adjustment Factor.

1. Effective for the period July 1, 2011 through March 31, 2012, and for periods April 1, 2013 through March 31, [2014] 2015, rate adjustments for each hospital will be calculated using 2009 Medicaid claims data for discharges that occurred between January 1, 2009 and December 31, 2009.
2. The hospital-specific coefficient is multiplied by the total number of non-behavioral health Medicaid discharges to compute the PPC penalty. The PPC penalty is then multiplied by the hospital's wage equalization factor (WEF) and, for teaching hospitals, the indirect graduate medical education (IME) factor.
3. The Medicaid case payment rate for the applicable rate period shall be used to compute the total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital.
4. For each hospital, a PPC adjustment factor will be computed as the ratio of the hospital's PPC penalty and the hospital's total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital as determined pursuant to this section.

Adjustment for Hospitals With Unreliable Present On Admission (POA) Data.

Each hospital will be evaluated on five criteria for the reliability of the POA indicator in Medicaid discharge data. POA data was evaluated using 2009 Statewide Planning and Research Cooperative System (SPARCS) data. Two levels of POA quality will be established for each of the criteria, "red" and "grey" zones. The criteria and levels will be as follows:

1. The percent of pre-existing diagnoses that are coded as not present on admission: "red" will be greater than or equal to 7.5%, "grey" will be greater than or equal to 5%, but less than 7.5%.
2. Excluding pre-existing and exempt diagnoses, the percent of remaining diagnoses coded as uncertain: "red" will be greater than or equal to 10%, "grey" will be greater than or equal to 5%, but less than 10%.
3. Excluding pre-existing, exempt, and perinatal diagnoses, a high percentage of remaining diagnoses coded as present on admission: "red" will be greater than or equal to 96%, "grey" will be greater than or equal to 93%, but less than 96%.
4. Excluding pre-existing, exempt, and perinatal diagnoses, a low percentage of remaining diagnoses coded as present on admission: "red" will be less than or equal to 70%, "grey" will be greater than or equal to 70%, but less than 77%; and

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120(a)(v)**

5. For surgical cases only, the percent of secondary diagnoses coded as present on admission: "red" will be greater than or equal to 40%, "grey" will be greater than or equal to 30%, but less than 40%.
6. Hospitals are determined to have unreliable POA data if any of the five criteria are in the "red" zone, or if two or more of the five criteria are in the "grey" zone.
7. An upstate and downstate average PPC [adjustment factor] penalty will be [applied to each hospital deemed to have unreliable] calculated by computing a weighted average of the hospital-specific coefficients of all hospitals with reliable POA data located in each designated region using the total number of non-behavioral health Medicaid discharges of such hospitals. For each hospital deemed to have unreliable POA data the upstate and downstate average PPC penalty will be multiplied by the hospital's WEF, and, for teaching hospitals, the IME factor. The [upstate and downstate] PPC adjustment factor will be [calculated using a weighted average of all hospitals with reliable POA data located in each designated region] computed pursuant to the PPC Adjustment Factor section.
8. For purposes of this section, the downstate region of New York State will consist of the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess. The upstate region of New York State will consist of all other New York counties.

TN #13-0041

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**New York
120(b)**

Potentially Preventable Hospital Readmissions (PPR)

For discharges occurring on and after July 1, 2010 through March 31, 2012, Medicaid rates of payment to hospitals that have an excess number of readmissions based on the criteria set forth in the Readmission Criteria Section, as determined by a risk adjusted comparison of the actual and expected number of readmissions in a hospital as described by the Methodology Section, will be reduced in accordance with the Payment Calculation Section. Such rate adjustments will result in an aggregate reduction in Medicaid payments of \$27.8 million for the period July 1, 2010 through March 31, 2011 and \$12 million for the period April 1, 2011 through March 31, 2012. For discharges occurring on and after April 1, 2013 through March 31, 2014, rate adjustments will result in an aggregate reduction in Medicaid payments of \$27.4 million and \$13.7 million for the period April 1, 2014 through March 31, 2015.

Definitions. As used in this Section, the following definitions will apply:

1. **Potentially Preventable Readmissions (PPR)** will mean a readmission to a hospital that follows a prior admission from a hospital within 14 days, and that is clinically-related to the prior hospital admission, as defined under the PPR grouping logic software developed and published by 3M Health Information Systems, Inc. (3M), version 26.1 for the period July 1, 2010 through March 31, 2011; version 28 for the period April 1, 2011 through March 31, 2012; [and] version 29 for the period April 1, 2013 through March 31, 2014; version 30 for the period April 1, 2014 through June 30, 2014; version 31 for the period July 1, 2014 through December 31, 2014; and version 32 for the period January 1, 2015 through March 31, 2015.
2. **Hospital** will mean a general hospital as defined pursuant to the Hospital Inpatient Reimbursement – Effective December 1, 2009 Section, excluding, effective July 1, 2011, those hospitals exempt from the APR-DRG reimbursement methodology and critical access hospitals.
3. **Expected Potentially Preventable Readmissions**, for the period July 1, 2010 through June 30, 2011, are derived using a logistic regression analysis that produces a predicted probability (a number ranging from zero to one) that a hospital admission would be followed by at least one PPR. The total number of expected PPRs shall equal the sum of the expected probabilities of a PPR for all admissions at each hospital. Effective for the period July 1, 2011, through March 31, 2012; and April 1, 2013 through March 31, [2014] 2015, the Expected Potentially Preventable Readmissions will be derived using 2009 SPARCS Medicaid data through an indirect standardization. A statewide PPR rate, the number of at-risk admissions followed by at least one PPR divided by the total number of at-risk admissions, for every APR-DRG severity of illness (SOI) combination will be multiplied by the number of at-risk admissions in that APR-DRG SOI at each hospital. The sum of all APR-DRG SOI combinations will be the Expected PPRs.
4. **Observed Rate of Readmission** will mean the number of admissions in each hospital that were actually followed by at least one PPR divided by the total number of admissions.

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120(b)(i)**

5. **Expected Rate of Readmission** shall mean a risk adjusted rate for each hospital that accounts for the severity of illness, APR-DRG, and age of patients at the time of discharge preceding the readmission. It shall equal the number of expected PPRs divided by the total number of at risk hospital admissions at that hospital.
6. **Excess Rate of Readmission** shall mean the difference between the observed rate of readmission and the expected rate of readmission for each hospital.
7. **Behavioral Health**, for the period July 1, 2010 through June 30, 2011, shall mean an admission that includes a primary or secondary diagnosis of a major mental health related condition. Effective for the period July 1, 2011 through March 31, 2012, and for periods April 1, 2013 through March 31, [2014] 2015, Behavioral Health shall mean an admission that is assigned to a Major Diagnostic Category of 19-Mental Diseases and Disorders or 20-Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders.
8. **Average Hospital Specific Payment** shall equal the Medicaid operating payment, using the applicable Medicaid rates for such period, of the total number of PPRs identified for each hospital divided by the total number of PPRs identified for each hospital.

Readmission Criteria.

1. A readmission is a return hospitalization following a prior discharge that meets all of the following criteria:
 - a. The readmission could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period.
 - b. The readmission is for a condition or procedure related to the care during the prior discharge or the care during the period immediately following the prior discharge and including, but not limited to:
 - i. the same or closely related condition or procedure as the prior discharge;
 - ii. an infection or other complication of care;
 - iii. a condition or procedure indicative of a failed surgical intervention; or
 - iv. an acute decompensation of a coexisting chronic disease.
 - c. The readmission is back to the same or to any other hospital.
2. Readmissions, for the purposes of determining PPRs, excludes the following circumstances:

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120(b)(ii)**

- a. The original discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of such discharge and readmission are documented in the patient's medical record.
- b. For the period July 1, 2010 through June 30, 2011, the original discharge was for the purpose of securing treatment of a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions. Effective for the period July 1, 2011 through March 31, 2012, and for periods April 1, 2013 through March 31, [2014] 2015, the original discharge was for the purpose of securing treatments of the admissions listed on the following Department of Health website link:

www.health.ny.gov/health_care/medicaid/quality/ppo/outcomes
- c. The readmission was a planned readmission that occurred on or after 15 days following an initial admission.
- d. For readmissions occurring during the period up through March 31, 2012, and for periods April 1, 2013 through March 31, [2014] 2015, the readmissions involve a discharge determined to be behavioral health related.

Methodology.

1. For the period July 1, 2010 through June 30, 2011, rate adjustments for each hospital shall be calculated using 2007 Medicaid paid claims data for discharges that occurred between January 1, 2007 and December 31, 2007. Effective for the period July 1, 2011 through March 31, 2012, and for periods April 1, 2013 through March 31, [2014] 2015, rate adjustments for each hospital will be calculated using 2009 Medicaid claims data for discharges that occurred between January 1, 2009 and December 31, 2009.
2. The expected rate of readmission shall be reduced by:
 - (a) 24% for periods prior to September 30, 2010;
 - (b) 38.5% for the period October 1, 2010 through December 31, 2010;
 - (c) 33.3% for the period January 1, 2011 through June 30, 2011.
 - (d) 11.4% for periods on and after July 1, 2011.
3. The excess rate of readmission is multiplied by the total number of at risk hospital admissions at each hospital to determine the total number of risk adjusted excess readmissions.
4. In the event the observed rate of readmission for a hospital is lower than the expected rate of readmission, after the expected rate of readmission has been reduced by the applicable percentage in accordance with this section, the risk adjusted excess readmissions shall be set at zero.

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**New York
120(b)(iii)****Payment Calculation.**

1. An average hospital specific payment will be used to compute the total Medicaid operating payments, excluding behavioral health, associated with the risk adjusted excess readmissions in each hospital.
2. The Medicaid case payment rate for the applicable rate period shall be used to compute the total Medicaid operating payments for all non-behavioral health Medicaid discharges in each hospital.
3. For each hospital, a hospital specific readmission adjustment factor shall be computed as the ratio of the hospital's total Medicaid operating payments for the applicable rate period associated with the risk adjusted excess readmissions identified in the Methodology Section and the hospital's total Medicaid operating payments for the same rate period for all non-behavioral health Medicaid discharges in each hospital as determined pursuant to this Section.

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120(b)(3)

4. Non-behavioral health related Medicaid operating payments to hospitals shall be reduced by applying the hospital specific readmission adjustment factor from this Section to the applicable case payment or per-diem payment amount for all non-behavioral health related Medicaid discharges for each hospital.

TN #10-21

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Capital Expense Reimbursement.

1. The allowable costs of fixed capital, including but not limited to depreciation, rentals, interest on capital debt, and major movable equipment [shall] will be reimbursed based on budgeted data and [shall] will be reconciled to total actual expense for the rate year and [shall] will be determined and computed in accordance with the provisions of this section.
 - a. The allowable capital expense will be adjusted to exclude such expenses related to the following:
 - i. 44% of major moveable equipment;
 - ii. staff housing costs.
2. General hospitals [shall] will submit a budgeted schedule of anticipated inpatient capital-related expenses for the forthcoming year to the Commissioner at least 120 days prior to the beginning of the rate year.
 - a. The budgeted inpatient capital-related expense pertaining to the rate year will be decreased to reflect the percentage amount by which the budget for the applicable base year's capital-related expense exceeded the actual capital-related expense of that base year.
 - i. The base year used in the budget to actual capital cost comparison will be 2-years prior to the rate year.
3. The following principles [shall] will apply to budgets for inpatient capital-related expenses:
 - a. The basis for determining capital-related inpatient expenses [shall] will be the lesser of actual cost or the final amount specifically approved for construction of the capital asset.
 - b. Any capital-related inpatient expense generated by a capital expenditure which requires or required approval pursuant to the Hospitals section of the Public Health Law, must have received such approval for the capital-related expense to be included in the rate calculation.

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- c. The submitted budget may include the capital-related inpatient expense of all existing capital assets, as well as estimates of capital-related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the rate year.
 - d. Any capital-related expense generated by a capital expenditure acquired or placed in use during a rate year shall be carried forward to the subsequent rate year, provided all required approvals have been obtained. In instances where such approvals have been obtained or where approval is not required and such assets are acquired or placed in use during a rate year, the budget may include estimates for capital-related expenses relating to these assets.
4. *Allocation of budgeted capital costs.* In each rate year budgeted capital costs shall be allocated to exempt units and hospitals (including certified substance abuse detoxification services) and DRG case payment rates based on reported capital statistics for the year two years prior to the rate year.

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5. *Payment for budgeted allocated capital costs.*

- a. Capital per diems for exempt units and hospitals will be calculated by dividing the budgeted capital costs allocated to such rates pursuant to paragraph (4) above by budgeted exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital-approved capital expense. Effective on or after April 2, 2020, the budgeted and actual capital per diem rates will be reduced by five percent (5%). Effective on or after October 1, 2021, the budgeted and actual capital per diem rates will be reduced by an additional five percent (5%), resulting in a ten percent (10%) reduction. Additionally, for capital per diem rates reconciled on or after April 2, 2020, if the difference between the budgeted and actual capital per diem rate results in a positive rate adjustment, that rate adjustment will be reduced by ten percent (10%). Conversely, if the difference between the budgeted and actual capital per diem rate results in a negative rate adjustment, that rate adjustment will be increased by ten percent (10%).
- b. Capital payments for APR-DRG case rates will be determined by dividing the budgeted capital allocated to such rates pursuant to paragraph (4) above by the hospital's budgeted, nonexempt unit discharges, reconciled to rate year discharges and actual rate year nonexempt unit or hospital-approved capital expense. Effective on or after April 2, 2020, the budgeted and actual capital per APR-DRG case rates will be reduced by five percent (5%). Effective on or after October 1, 2021, the budgeted and actual capital per APR-DRG case rates will be reduced by an additional five percent (5%), resulting in a ten percent (10%) reduction. Additionally, for capital per APR-DRG case rates reconciled on or after April 2, 2020, if the difference between the budgeted and actual capital per APR-DRG case rate results in a positive rate adjustment, that rate adjustment will be reduced by ten percent (10%). Conversely, if the difference between the budgeted and actual capital per APR-DRG case rate results in a negative rate adjustment, that rate adjustment will be increased by ten percent (10%).
- c. Capital payments for transferred patients will be determined by dividing the budgeted capital allocated to the APR-DRG case rate by the hospital's budgeted non-exempt unit days, reconciled to rate year days and actual rate year non-exempt unit or hospital approved capital expense.

6. *Depreciation.*

- a. Reported depreciation based on historical cost is recognized as a proper element of cost. Useful lives will be the higher of the reported useful life or those useful lives from the Estimated Useful Lives of Depreciable Hospital Assets, American Hospital Association, consistent with title XVIII provisions. Copies of this publication are available from the American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611, and a copy is available for inspection and copying at the offices of the Records Access Officer of the Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237.
- b. In the computation of rates for voluntary facilities, depreciation will be included on a straight line method on plant and non-movable equipment.

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- Depreciation on movable equipment may be computed on a straight line method, or accelerated under a double declining balance, or sum-of-the-years' digit method. Depreciation [shall] will be funded unless the Commissioner determines, upon application by the facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required for the amortization of capital indebtedness. Funding for plant and fixed equipment [shall] will mean that the transfer of monies to the funded accounts [shall] will occur by the end of the fiscal period in which the depreciation is recorded. Board-designated funds and the accrual of liabilities to the funded depreciation accounts (due to/from accounts) [shall] will not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts to be considered as valid funding transactions unless expended for the purpose for which it was funded. Failure to meet the funding requirements will result in a reduction amount reimbursed for depreciation equal to the unfunded amount.
- c. In the computation of rates for public facilities, depreciation is to be included on a straight-line method on plant and non-movable equipment. Depreciation on movable equipment may be computed on a straight-line method, or accelerated under a double declining balance or sum-of-the-years' digits method.
- d. Medical facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law [shall] will conform to the requirements of this Subpart. In lieu of depreciation and interest, on the loan-financed portion of the facilities, the Commissioner [shall] will allow level debt service on the mortgage loan, for all loans approved for financing prior to January 1, 1990, together with such required fixed charges, sinking funds and reserves as may be determined by the Commissioner as necessary to assure repayment of the mortgage indebtedness. For loans approved for financing on or after January 1, 1990, medical facilities [shall] will receive reimbursement in the form of interest and depreciation in accordance with the remainder of this Attachment.

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7. Interest

- a. Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities.
- b. To be considered as an allowable cost, interest shall be incurred to satisfy a financial need, be at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made, and exclude costs and fes incurred as a result of an interest rate swap agreement. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner has been obtained. Financial need for capital indebtedness relating to a special project shall exist when all available restricted funds designated for capital acquisitions of that type have been considered for equity purposes.
- c. Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trustee malpractice insurance funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense. Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss shall not be allowable. Rate year investment income shall reduce rate year interest expense allowed for reimbursement as follows:
 - i. for all medical facilities, investment income shall first be used to reduce operating interest expense for that year;
 - ii. any remaining amount of investment income, after application of paragraph (i), shall be used to reduce capital interest expense reimbursed that year for medical facilities; and

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- iii. any remaining amount of investment income after application of paragraph (ii) shall not be considered in the determination of allowable costs.
- d. Interest on current indebtedness shall be treated and reported as an operating, administrative expense.
- e. Interest on capital indebtedness is an allowable cost if the debt generating the interest is approved by the Commissioner, incurred for authorized purposes, and the principal of the debt is the lesser of the approval of the Commissioner or the cost of the authorized purposes. Capital indebtedness shall mean all debt obligations of a facility that are:
 - i. evidenced by a mortgage note or bond and secured by a mortgage on the land, building or non-movable equipment; a note payable secured by the non-movable equipment of a facility; a capital lease;
 - ii. incurred for the purpose of financing the acquisition, construction or renovation of land, building or non-movable equipment;
 - iii. found by the Commissioner to be reasonable, necessary and in the public interest with respect to the facility. Interest related to refinancing indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness then being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable on acceptable demonstration to the Commissioner that such refinancing will result in a debt service savings over the life of the indebtedness; or
 - iv. incurred for the purpose of advance refunding of debt. Gains and losses resulting from the advanced refunding of debt shall be treated and reported as a deferred charge or asset. This deferred charge or asset is to be amortized on a straight-line basis over the period to the scheduled maturity date of the refunding debt.
- f. Where a public finance authority has established a mortgage rate of interest such that sufficient cash flows exist to retire the mortgage prior to the stated maturity, the amount of the mortgage to be forgiven, at the time of such forgiveness, shall be capitalized as a deferred asset and amortized over the remaining mortgage life, as a reduction to the facility's capital expense.

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g. Voluntary facilities shall report mortgage obligations financed by public finance authorities for their benefit and which they are responsible to repay, as liabilities in the general fund, when such mortgage obligations are incurred.

8. Sales, leases and realty transactions.

a. If a medical facility is sold, leased, or is the subject of any other realty transaction before a rate for the facility has been determined and certified by the Commissioner, the capital cost component for such rate shall be determined in accordance with the provisions of this Section.

b. If a medical facility is sold, leased, or is the subject of any other realty transaction after a rate for the facility has been determined and certified by the Commissioner, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction had not occurred. This paragraph shall not be construed as limiting the powers and rights of the Commissioner to change rate computations generally or specifically when based upon previous error, deceit or any other misrepresentation or misstatement that has led the commissioner to determine and certify a rate which he would otherwise not have determined or certified. Further, this paragraph shall not be construed as limiting the powers and rights of the commissioner to reduce rates when one or more of the original property right aspects related to such a facility is terminated.

c. An arms length lease purchase agreement with a non-related lessor involving plant facilities or equipment which meets any one of the four following conditions, establishes the lease is a virtual purchase.

i. The lease transfers a title of the facilities or equipment to the lessee during the lease term.

ii. The lease contains a bargain purchase option.

iii. The lease term is at least 75 percent of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment.

iv. The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. Present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is

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less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.

- d. If a lease is established as a virtual purchase under paragraph (c), the rental charge may be included in capital-related costs to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership shall be limited to depreciation and interest. Further, the amounts to be included in capital-related costs are determined as follows:
- i. The difference between the amount of rent paid and the amount of rent allowed as capital-related costs is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.
 - ii. If an asset is returned to the owner instead of being purchased, the deferred charge may be included in capital-related costs in the year the asset is returned.
 - iii. If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership.
 - iv. If the term of the lease is extended for an additional period of time at a reduced Lease cost and the option to purchase no longer exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to a fair rental value.
 - v. If the lessee becomes the owner of the leased asset (either by operation of the lease or by other means), the amount considered as depreciation for the purpose of having computed the limitation on rental charges under this paragraph, must be used in calculating the limitation on adjustments for the purpose of determining any gain or less upon disposal of an asset.
 - vi. In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs had the provider legal title to the asset.

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- e. If a facility enters into a sale and leaseback agreement involving plant facilities or equipment, the amounts to be included in capital-related costs both on an annual basis and over the useful life of the asset shall not exceed the costs of ownership which shall be limited to depreciation and interest, and shall be determined as follows:
- i. If the annual rental or lease costs in the early years of the lease are less than the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are more than the annual costs of ownership, in the years that the annual rental or lease costs are more than the annual costs of ownership, the facility may include in capital-related costs annually the actual amount of rental or lease costs, except that in any given year, the amount included in capital related costs is limited to an amount which would not cause the aggregate rental or lease costs included up to that year in capital-related costs to exceed the costs of ownership that would have been included in capital-related costs up to that year if the provider had retained legal title to the asset.
 - ii. If the annual rental or lease costs in the early years of the lease exceed the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are less than the annual costs of ownership, the facility may carry forward amounts of rental or lease costs that were not included in capital-related costs in the early years of the lease due to the costs of ownership limitation, and include these amounts in capital-related costs in the years of the lease when the annual rental or lease costs are less than the annual costs of ownership, provided, however, in any given year the amount of actual annual rental or lease costs plus the amount carried forward to that year may not exceed the amount of the costs of ownership for that year.
 - iii. In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs if the provider had retained legal title to the asset.
 - iv. If a facility enters into a sale and leaseback agreement involving land, the incurred rental for the cost of land may not be included in allowable costs.

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Reimbursable Assessment for Statewide Planning and Research Cooperative System (SPARCS).

The Commissioner will inform each such hospital of its actual fee to support the statewide planning and research cooperative system and each hospital will submit such fee on a quarterly basis to be received by the Commissioner no later than the 15th of February, May, August and November of each year. Failure to submit such fees in accordance with this schedule will result in a [one]two-percent reduction in the affected hospital's rate beginning on the first day following the due date and continuing until the last day of the calendar month in which said fees are submitted.

TN #10-33-B

Supersedes TN #09-34

Approval Date October 28, 2011

Effective Date July 1, 2011

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Federal upper limit compliance.

1. In the event the State cannot provide assurances satisfactory to the Secretary of the Department of Health and Human Services related to a comparison of rates of payment for general hospital inpatient services to beneficiaries of the Title XIX program in the aggregate to maximum reimbursement payments provided in Federal law and regulation for purposes of securing Federal financial participation in such payments, such rates of payments shall be adjusted proportionally as necessary to meet Federal requirements for securing Federal financial participation.

TN #09-34

Supersedes TN NEW

Approval Date January 20, 2010

Effective Date December 1, 2009

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Adding or deleting hospital services or units.

1. Notification of the elimination of a general hospital inpatient service or identifiable unit of such a service in instances in which the costs of such service are reflected in the rate calculated pursuant to this Section shall be submitted in writing by the facility to the Department within 60 days of the elimination of such service or unit. If a rate is modified by the Department as a result of such service or unit elimination, such rate shall be effective as of the date of the elimination of the service or unit.
2. Notification of the establishment of a new hospital or of a new exempt unit of an existing hospital shall be submitted in writing by the facility to the Department within 60 days of the establishment of such new hospital or such new unit. Thereafter the Department shall establish inpatient rates for such new hospital or such new exempt unit in accordance with the provisions of this Attachment. Such rates shall be effective the first day of the month following 30 days after such a notification or the date of the approved certificate of need (CON) certification, whichever is later.

TN #09-34 Supersedes TN NEW Approval Date January 20, 2010 Effective Date December 1, 2009

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New hospitals and hospitals on budgeted rates.

1. *New hospitals.* Payments to new hospitals without adequate cost experience for inpatient acute care services that are not exempt from DRG case-based rates of payment shall be computed in accordance with this Attachment except as follows:
 - a. Rates of payment shall be computed on the basis of 100 percent of the statewide base price multiplied by the service intensity weight for each DRG as determined and set forth with the provisions of this Attachment.
 - b. The WEF used to adjust the statewide base price shall be equal to 1.0 until adequate data becomes available.
 - c. The non-comparable operating costs of new facilities as defined by the Definitions Section and direct graduate medical education costs shall consist of the hospital's budgeted operating costs for these services.
2. *Hospitals on Budgeted Rates.* Payments to hospitals without adequate cost experience whose rates are based on budgeted cost projections for inpatient acute care services that are not exempt from DRG case-based rates of payment shall be computed in accordance with this Subpart except as follows:
 - a. Reimbursement for the costs of graduate medical education and non-comparable services shall be calculated pursuant to the provisions of paragraph(1)(c) above.
 - b. The WEF used shall be calculated for the facility based on available historical data.

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Swing bed reimbursement.**1. Definitions.**

- a. For purposes of this Section, a swing bed program operated by a rural hospital that has an approval from the Centers for Medicare and Medicaid Services (CMS) to provide post-hospital skilled nursing facility (SNF) care, shall mean beds used interchangeably as either general hospital or nursing home beds with reimbursement based on the specific type of care provided so that use of beds in this manner provides small hospitals with greater flexibility in meeting fluctuating demands for inpatient general hospital and nursing home care.
- b. Rate shall mean the aggregate governmental payment made to eligible facilities per patient day as defined in Attachment 4.19-D for the care of patients receiving care pursuant to Title XIX of the federal Social Security Act (Medicaid).

2. Rates of payment.

Payments to eligible hospitals for patient days resulting from usage of swing beds in caring for patients for whom it has been determined that inpatient hospital care is not medically necessary, but that skilled nursing or health related care is required, shall be determined as follows:

- a. The operating component of the rate shall consist of the following:
 - i. a direct component which shall be equivalent to the 1988 statewide average direct case mix neutral cost per day for hospital-based residential health care facilities, after application of the Regional Direct Input Price Adjustment Factor (RDIPAF) as determined pursuant to Attachment 4.19-D, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A;
 - ii. an indirect component which shall be equivalent to the 1988 statewide average indirect cost per day for hospital-based residential health care facilities, after application of the RDIPAF pursuant to Attachment 4.19-D, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A; and
 - iii. a non-comparable component which shall be equivalent to the 1988 statewide average non-comparable cost per day for hospital-based residential health care facilities, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A.

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- b. For general hospitals with more than 49 beds, the maximum number of days for which the operating component of the rate as defined in this Attachment shall be paid shall be equivalent to fifteen (15) percent of a hospital's total annual patient days for acute, exempt unit, and alternate level of care services, excluding swing bed days.
- c. The operating component of the rate as defined in this Attachment shall be paid for the first sixty (60) days per year during which a patient is receiving care as a participant in the swing bed program. Any patient stay in excess of sixty (60) days per year shall be reimbursed at the prevailing average rate paid for the care of Alternate Level of Care (ALC) patients pursuant to the Alternate Level of Care Payments provisions of this Attachment. The sixty-day period shall begin the first day on which the patient receives care as a participant in the swing bed program.
- d. A capital cost per diem shall be paid on the basis of budgeted capital costs allocated to the swing bed program, pursuant to the capital cost provisions of this Attachment, divided by patient days associated with the swing bed program, reconciled to actual total capital expense.

Mergers, acquisitions, consolidations, restructurings and closures.

1. *Rates of Payment.* [As used in this Section, t]The terms merger, acquisition, [and] consolidation, and restructuring, for the purpose of calculating a combined reimbursement rate, [shall]will mean the combining of two or more general hospitals where such combination is a full asset merger or a full asset acquisition (hereinafter referred to as full asset merger) and is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery and approved through the Department's Certificate of Need process. Payments for hospitals subject to a full asset merger[, acquisition or consolidation] for inpatient acute care services that are not otherwise exempt from DRG case-based rates of payment will be effective on the date the full asset merger transaction is effected and [shall]will be computed in accordance with this Section except as follows:
- a. The WEF used to adjust the statewide base price [shall]will be calculated by combining all components used in the calculation pursuant to the WEF Section for all hospitals subject to the full asset merger[, acquisition or consolidation].
 - b. The direct GME payment per discharge added to the case payment rates of teaching hospitals [shall]will be calculated by dividing the total reported Medicaid direct GME costs for all teaching hospitals subject to the full asset merger[, acquisition, or consolidation] by the total reported Medicaid discharges reported by such hospitals in the applicable base period.
 - c. The indirect GME payment per discharge added to the case payment rates of teaching hospitals [shall]will be calculated in accordance with the Add-ons to the Case Payment Rate Per Discharge Section, except the ratio of residents to beds used in the calculation [shall]will be based on the total residents and beds of all such hospitals subject to the full asset merger[, acquisition, or consolidation].
 - d. The non-comparable payment per discharge added to the case payment rates [shall]will be calculated by dividing the total reported Medicaid costs for qualifying non-comparable cost categories for all hospitals subject to the full asset merger[, acquisition, or consolidation] by the total reported Medicaid discharges reported by such hospitals in the applicable base period.
 - e. Rates calculated for exempt units where the hospitals merging provide the same exempt service will not be merged until such time that the base used for the exempt service is updated. At the time of the base rate update, combined costs and utilization will be used to develop the exempt service rate. Until that time, each hospital will continue to be reimbursed their facility specific exempt unit rate based on the method approved for the exempt service.

TN #16-0044Approval Date November 30, 2016Supersedes TN #11-0024-AEffective Date September 01, 2016

**New York
136.1**

1. A. Temporary rate change for full asset mergers and acquisitions.

- a. For the period April 1, 2012 through August 31, 2016, the Commissioner may grant approval of a temporary change to rates calculated pursuant to this Section for hospitals that complete a merger, acquisition or consolidation provided such hospitals demonstrate through submission of a written proposal that the merger, acquisition or consolidation will result in an improvement to (i) cost effectiveness of service delivery, (ii) quality of care, and (iii) factors deemed appropriate by the Commissioner. Such written proposal shall be submitted to the Department sixty days prior to the requested effective date of the temporary rate change. The temporary rate change shall be in effect for no longer than such time as base year costs are updated for the development of these temporary rates or such time as statewide base year costs are updated for the development of rates, whichever is earlier, and shall consist of the various operating rate components of the surviving entity. At the end of the specified timeframe, the hospital will be reimbursed in accordance with the statewide methodology set forth in this Attachment. The Commissioner may establish, as a condition of receiving such a temporary rate change, benchmarks and goals to be achieved as a result of the ongoing consolidation efforts and may also require that the hospital submit such periodic reports concerning the achievement of such benchmarks and goals as the Commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the Commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the hospital's temporary rate change prior to the end of the specified timeframe.
- b. The Commissioner shall withdraw approval of a temporary rate change for hospitals which (i) fail to demonstrate compliance with and continual improvement on the approved proposal or (ii) an update to the base year is made by the Department.
- c. For the period beginning September 1, 2016 and thereafter, the Commissioner may grant approval of a temporary change to the non-capital components of acute rates calculated pursuant to this Section for hospitals that have undergone a full asset merger:
 - i. The acute operating rate of all hospitals merged which represents the highest payment will be paid to all hospitals in the merged entity. The acute rates used in the development of the payment calculation to determine the highest payment will be based on all operating components of a hospital's acute rate and not determined on an individual operating acute rate component basis.

TN #16-0044

Supersedes TN #11-0024-D

Approval Date November 30, 2016

Effective Date September 01, 2016

**New York
136.2**

- ii. Facilities seeking a rate change under this section will submit an appeal and demonstrate that the additional resources provided by a temporary rate change will achieve one or more of the following:
- (1) protect or enhance access to care;
 - (2) protect or enhance quality of care; or
 - (3) improve the cost effectiveness of the delivery of health care services.
- iii. The temporary rate change issued pursuant to this section will be effective as of the date the full asset merger transaction is effected and will be in effect for three years. At the expiration of the temporary rate change period, the facility will be reimbursed in accordance with the otherwise applicable rate-setting methodology as stated in this section and will be effective the first day of the month following the expiration of the three year period.
- iv. During the temporary rate change period each provider will continue to be reimbursed their facility specific acute capital rate payment.

TN #16-0044Supersedes TN NEWApproval Date November 30, 2016Effective Date September 01, 2016

**New York
136(a)**

2. *Temporary rate adjustment for Vital Access Provider (VAP) Programs*

- a. A temporary rate adjustment will be provided to eligible hospital providers that are subject to or impacted by the closure, merger, and acquisition, consolidation or restructuring of a health care provider. The rate adjustment is intended to:
- Protect or enhance access to care;
 - Protect or enhance quality of care; or
 - Improve the cost effectiveness.

Eligible hospital providers, the [annual] amount of the temporary rate adjustment, and the duration of [the] each rate adjustment period [shall] will be listed in the table which follows. The total [annual] adjustment amount for each period shown will be paid quarterly during each period in equal installments [with the amount of each quarterly payment being equal to one fourth of the total annual amount established for each provider.] The [quarterly] temporary payment made under this section will be an add-on to services payments made under this Attachment to such facilities during the quarter.

To remain eligible, providers must submit benchmarks and goals acceptable to the Commissioner and must submit periodic reports, as requested by the Commissioner, concerning the achievement of such benchmarks and goals. Failure to achieve satisfactory progress in accomplishing such benchmarks and goals will result in termination of the provider's temporary rate adjustment prior to the end of the specified timeframe. Once a provider's temporary rate adjustment ends, the provider will be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in this Attachment.

TN #13-0068

Supersedes TN #11-0024-A

Approval Date May 10, 2016

Effective Date January 1, 2014

**New York
136(b)**

1905(a)(1) Inpatient Hospital Services

- b. Temporary rate adjustments have been approved for the following hospital providers in the amounts and for the effective periods listed:

Hospitals:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Eastern Niagara Hospital	\$666,667	08/19/2021 – 09/30/2021
	\$666,667	10/01/2021 – 12/31/2021
	\$666,667	01/01/2022 – 03/31/2022
	\$1,000,000	04/01/2022 – 06/30/2022
	\$1,000,000	07/01/2022 – 09/30/2022

*Denotes this provider is a Critical Access Hospital (CAH).

TN #21-0056

Supersedes TN #18-0054

Approval Date October 24, 2023

Effective Date August 19, 2021

**New York
136(b.1)**

Hospitals Continued:

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Carthage Hospital	\$250,000	01/01/2013 – 03/31/2013
<u>Long Island Jewish Medical Center</u>	<u>\$500,000</u>	<u>01/01/2017 – 03/31/2017</u>
Woodhull Medical Center	\$1,929,877	01/01/2013 – 03/31/2013
	\$1,499,996	04/01/2013 – 03/31/2014
	\$878,996	04/01/2014 – 03/31/2015

TN #17-0019Approval Date April 04, 2017Supersedes TN #11-0024-CEffective Date January 01, 2017

**New York
136(b.1.1)**

Hospitals Continued:

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
<u>Buffalo General Medical Center</u>	<u>\$2,181,085</u>	<u>06/01/2016 – 03/31/2017</u>
	<u>\$2,655,860</u>	<u>04/01/2017 – 03/31/2018</u>
	<u>\$2,709,867</u>	<u>04/01/2018 – 03/31/2019</u>
	<u>\$ 453,188</u>	<u>04/01/2019 - 05/31/2019</u>
<u>Mary Imogene Bassett Hospital</u>	<u>\$1,563,900</u>	<u>11/01/2014 – 03/31/2015</u>
	<u>\$2,050,438</u>	<u>04/01/2015 – 03/31/2016</u>
	<u>\$1,104,187</u>	<u>04/01/2016 – 03/31/2017</u>
	<u>\$281,250</u>	<u>04/01/2017 – 03/31/2018</u>

TN #16-0005 Approval Date: Aug 09, 2016

Supersedes TN #14-0022 Effective Date: June 01, 2016

**New York
136(b.2)**

Hospitals (Continued):

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Bassett Medical Center	\$861,356	04/01/2018 – 03/31/2019
	\$861,356	04/01/2019 – 03/31/2020
	\$861,360	04/01/2020 – 03/31/2021
Claxton Hepburn Medical Center	\$ 250,000	01/01/2020 – 03/31/2020
	\$1,000,000	04/01/2020 – 03/31/2021
	\$1,000,000	04/01/2021 – 03/31/2022
	\$ 750,000	04/01/2022 – 12/31/2022
Oswego Hospital	\$250,000	02/01/2015 - 03/31/2015
	\$1,000,000	04/01/2015 - 03/31/2016
	\$1,000,000	04/01/2016 – 03/31/2017
	\$750,000	04/01/2017 - 06/30/2017
	\$387,520	04/12/2018 – 03/31/2019
	\$737,626	04/01/2019 – 03/31/2020
	\$374,854	04/01/2020 – 03/31/2021
Arnot Health, Inc/St. Joseph's Hospital Elmira	\$1,553,578	09/11/2014 – 03/31/2015
	\$1,773,128	04/01/2015 – 03/31/2016
	\$1,710,279	04/01/2016 – 03/31/2017
	\$ 301,744	12/01/2017 – 03/31/2018
	\$ 618,290	04/01/2018 – 03/31/2019
	\$ 590,069	04/01/2019 – 03/31/2020
	\$ 289,897	04/01/2020 – 03/31/2021
SUNY Upstate Medical University	\$ 200,000	09/01/2021 – 12/31/2021
	\$ 52,500	01/01/2022 – 03/31/2022
	\$1,208,552	04/01/2022 – 12/31/2022
	\$402,851	01/01/2023 – 03/31/2023
	\$1,000,352	04/01/2023 – 12/31/2023
	\$333,451	01/01/2024 – 03/31/2024
	\$751,721	04/01/2024 – 12/31/2024
	\$250,573	01/01/2025 – 03/31/2025

TN #21-0020 Supersedes TN #20-0004 Approval Date December 22, 2021 Effective Date September 1, 2021

**New York
136(b.3)**

Hospitals (Continued):

<u>Provider Name</u>	<u>Gross Medicaid Rate Adjustment</u>	<u>Rate Period Effective</u>
St. Joseph's Hospital Health Center-Syracuse	\$ 14,735	02/01-2016 – 03/31/2016
	\$1,621,031	04/01/2016 – 03/31/2017
	\$2,512,304	04/01/2017 – 03/31/2018
	\$1,287,472	04/01/2018 – 03/31/2019
	\$ 245,297	04/01/2019 – 06/30/2019
United Health Services, Inc. [Binghamton]	\$3,427,931	02/01/2016 – 03/31/2016
	\$4,247,865	04/01/2016 – 03/31/2017
	\$3,196,083	04/01/2017 – 12/31/2017
	\$ 452,987	01/01/2018 – 03/31/2018
	\$1,811,948	04/01/2018 – 03/31/2019
	\$1,811,948	04/01/2019 – 03/31/2020
	\$1,358,965	04/01/2020 – 12/31/2020

TN #18-0010Supersedes TN #16-0012Approval Date April 19, 2018Effective Date January 01, 2018

**New York
136(c)**

1905(a)(1) Inpatient Hospital Services**Hospitals (Continued):**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Interfaith Medical Center	\$13,384,525	04/01/2020 – 03/31/2021
Long Island Jewish Medical Center	\$1,000,000	04/01/2020 – 03/31/2021
Mercy Hospital of Buffalo	\$1,800,000	08/19/2021 – 09/30/2021
	\$1,800,000	10/01/2021 – 12/31/2021
	\$1,800,000	01/01/2022 – 03/31/2022
	\$1,350,000	04/01/2022 – 06/30/2022
	\$1,350,000	07/01/2022 – 09/30/2022
	\$1,350,000	10/01/2022 – 12/31/2022
	\$1,350,000	01/01/2023 – 03/31/2023

*Denotes this provider is a Critical Access Hospital (CAH)

TN #21-0056

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Supersedes TN #20-0031

Effective Date August 19, 2021

**New York
136(c.1)**

1905(a)(1) Inpatient Hospital Services**Hospitals (Continued):**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Mount St. Mary's Hospital and Health Center	\$533,333	08/19/2021 – 09/30/2021
	\$533,333	10/01/2021 – 12/31/2021
	\$533,334	01/01/2022 – 03/31/2022
	\$400,000	04/01/2022 – 06/30/2022
	\$400,000	07/01/2022 – 09/30/2022
	\$400,000	10/01/2022 – 12/31/2022
	\$400,000	01/01/2023 – 03/31/2023

*Denotes this provider is a Critical Access Hospital (CAH)

TN #21-0056

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Supersedes TN #21-0025

Effective Date August 19, 2021

**New York
136(c.2)**

1905(a)(1) Inpatient Hospital Services**Hospitals (Continued):**

Provider Name	Gross Medicaid Rate Adjustment	Rate Period Effective
Richmond University Medical Center	\$9,711,500	04/01/2020 – 03/31/2021
St. Barnabas Hospital	\$12,000,000	04/01/2020 – 03/31/2021
	\$12,000,000	04/01/2021 – 03/31/2022
St. John's Riverside-St. John's Division	\$ 500,000	04/01/2020 – 03/31/2021
	\$1,500,000	04/01/2021 – 03/31/2022
St. Joseph's Hospital Health Center	\$4,000,000	04/01/2020 – 03/31/2021
St. Joseph's Medical Center	\$1,500,000	04/01/2021 – 03/31/2022
South Nassau Communities Hospital	\$4,000,000	04/01/2020 – 03/31/2021
Strong Memorial Hospital	\$2,588,381	04/01/2020 – 03/31/2021
	\$2,235,555	04/01/2021 – 03/31/2022

*Denotes this provider is a Critical Access Hospital (CAH).

TN #21-0056

Approval Date October 24, 2023

Supersedes TN #NEW

Effective Date August 19, 2021

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Administrative rate appeals

1. Administrative rate appeals of rates of payment issued pursuant to this Attachment must be submitted to the Department in writing within 120 days of the date such rates are issued by the Department to the facility. Such rate appeals must set forth in detail the basis for such appeal and be accompanied by any relevant documentation. Thereafter the Department shall respond to such rate appeals in writing and shall either affirm the original rates, revise such rates or request additional information. A failure to respond to the Department's request for additional information within 30 days shall be deemed to constitute the withdrawal, with prejudice, of the facility's rate appeal, provided, however, that the Department may extend that time period upon a request by the facility and for good cause shown. Upon its receipt of the requested additional information the Department shall issue a written determination of such rate appeal.
2. The Department's written determination of a facility's rate appeal shall be deemed final unless the facility submits a written request for further consideration of the rate appeal within 30 days of the date the Department issued such written determination, provided, however, that if such written determination advises the facility that its rate appeal is being denied on the ground that the appeal constitutes a challenge to the rate-setting methodology set forth in this Attachment, such denial shall be deemed to be the Department's final administrative determination with regard to such appeal and there shall be no further administrative review available. The Department shall otherwise respond in writing to such further appeal and either affirm or revise its original rate appeal determination and this response by the Department shall be deemed its final administrative determination with regard to such rate appeal.
3. Rate appeals which are rejected or precluded on the grounds of being untimely may be considered in connection with subsequent audits conducted pursuant to the audit provisions of this Attachment.
4. The Department shall consider only those rate appeals that reflect one or more of the following bases.
 - a. Mathematical or clerical errors in the financial and/or statistical data originally submitted by the medical facility, including information reported to the New York State Statewide Planning and Research Cooperative System (SPARCS), or mathematical or clerical errors made by the Department. Revised data submitted by a facility must meet the same certification requirements as the original data and the Department may require verification of revised SPARCS data by an independent review agent at the cost of the facility; and

TN #09-34Supersedes TN NEWApproval Date January 20, 2010Effective Date December 1, 2009

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- b. Any errors regarding a medical facility's capital cost reimbursement.
- [5. The Department may refuse to accept or consider a rate appeal from a facility that:
- a. is providing an unacceptable level of care as determined after review by the State Hospital review and Planning Council; or
 - b. is operated by the same management that operates a facility with regard to which a determination of an unacceptable level of care has been made in accordance with paragraph (a) of this subdivision; or
 - c. has been determined by the Department as being operated by a person or persons not properly established or licensed pursuant to the Public Health Law; or
 - d. is delinquent in the payment of a fine or penalty imposed on the facility pursuant to the Public Health Law.
6. Any hospital whose Medicaid inpatient rates are subject to this Subpart and which is determined by the federal Department of Health and Human Services to be no longer eligible for reimbursement pursuant to Title XVIII (Medicare) of the federal social security act shall not be eligible for reimbursement by Medicaid until re-certification of the facility by the federal Department of Health and Human Services as eligible for reimbursement pursuant to Title XVIII of the federal Social Security Act.]
- c.
 - i. Beginning on and after January 1, 2014, direct graduate medical education (DGME) and indirect graduate medical education (IME) costs, as defined under the Definitions Section of this Attachment for Graduate Medical Education, for hospitals where the teaching status has changed from non-teaching to teaching.
 - ii. Rate appeals and rate adjustments for new teaching hospitals.
 - 1. Eligible for reimbursement.
 - a. New teaching hospital (from non-teaching to teaching status)
 - b. New residency programs which are started by the new teaching hospital during the 5-year ramp-up period as defined in subparagraph 4(c)(ii)(3)(d).
 - 2. Not Eligible for reimbursement.

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- a. New teaching program in an already existing teaching hospital.
 - b. Residency programs transferred to the new teaching hospital from an existing teaching hospital.
 - c. Affiliated existing teaching hospital training additional residents 'based at' the new teaching hospital. Affiliated hospital will not receive a rate adjustment.
3. Appeal requirements.
- a. A hospital is required to submit a written request to the Department of Health (Department) for additional reimbursement due to the new teaching status.
 - b. An initial rate adjustment will be calculated for Program Year 1 (PGY 1) provided the Department has received the appeal request and all supporting documentation required 30 days prior to the start of the first teaching program. If an appeal is received subsequent to the start of PGY 1, the rate adjustment will be calculated based on the ramp-up period that the provider is in at the time of the appeal request.
 - c. Ramp-up schedules 1 and 2 are determined based on the Department's receipt of the appeal request pursuant to subparagraph 4(c)(ii)(3)(b). Ramp-up appeal requests will only be accepted during the hospital's determined schedule. The appropriate schedule will be noted in the Department's response to the appeal request. A chart of the potential appeal schedules has been provided below:

Program Year	Appeal Deadline	Effective Date of Rate Adj.	Rate Year / Resident counts	Ramp- Up Schedule
1	30 days prior to July 1st	July 1st	Program	Initial Year
2	30 days prior to Jan 1st	Jan 1st	January – Calendar Year	Schedule 1
	After Jan 1st but 30 days prior to July 1st	July 1st	July - PGY residents	Schedule 2
3	30 days prior to Jan 1st	Jan 1st	January – Calendar Year	Schedule 1
	After Jan 1st but 30 days prior to July 1st	July 1st	July - PGY residents	Schedule 2
4	30 days prior to Jan 1st	Jan 1st	January – Calendar Year	Schedule 1
	After Jan 1st but 30 days prior to July 1st	July 1st	July - PGY residents	Schedule 2
Final	30 days prior to Jan 1st	Jan 1st	January – Calendar Year	Schedule 1
	After Jan 1st but 30 days prior to July 1st	July 1st	July - PGY residents	Schedule 2

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- d. Hospitals have 5 years to establish new programs. This time period is viewed as a 'ramp-up' period and year 1 of the program is defined as the first approved program year that the hospital received teaching status. Appeals for new teaching costs will only be accepted during this ramp-up period.
 - e. The hospital will provide the following data:
 - i. Documentation from the accrediting organization demonstrating the maximum number of approved positions eligible for the associated programs.
 - ii. Documentation from the new teaching hospital demonstrating the projected filled slots for the associated programs for the upcoming PGY. Documentation must include the resident name, residency program, program year, start date, and expected graduation date.
 - iii. Documentation from the new teaching hospital demonstrating the actual filled slots for the associated programs from the prior PGY if applicable. This includes resident name, residency program, program year, start date, and expected graduation date.
 - iv. Completion of the Department's New Teaching Hospital - Form (A), as of June 26, 2017, found on the APR-DRG website below:

<https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/>
 - v. Budgeted DGME costs must be included in the New Teaching Hospital Form (A) and must reflect calendar year costs based on the effective date of the rate adjustment. Budgeted DGME Costs must be discretely reported consistent with the standard cost centers provided for interns and residents, and supervising physicians within the annual institutional cost report.
4. Additional reimbursement will be received based on:
- a. The initial effective date for a rate increase due to an appeal will be in accordance with subparagraph 4 (c)(ii)(3)(b). This provides for reimbursement effective July 1st.
 - b. Subsequent appeals after the initial effective date will be accepted during the ramp-up period and in accordance with subparagraph 4(c)(ii)(3)(c).
 - c. A Direct Graduate Medical Education (DGME) payment [per discharge]will be added [to the acute per discharge rate as stated in the Add-ons to the case payment rate per discharge section of this attachment]as follows.

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- i. For new teaching hospitals budgeted DGME costs will be submitted by the hospital and used until the first full year of actual DGME costs are available in a provider's Institutional Cost Report (ICR). The first full year of actual DGME costs for this purpose will be the first full year after the last ramp-up year. DGME budgeted costs can be submitted by a hospital for a rate revision each year during the ramp-up period.
 - 1. If an appeal is not submitted with updated budgeted DGME costs, the budgeted DGME costs currently in the rate will continue.
- ii. The DGME budgeted costs will be allocated between inpatient and outpatient services, however, there is no rate increase in the outpatient services for new teaching hospitals. Appeals for an initial rate adjustment are required to report the percentage of costs allocated to Inpatient and Outpatient services in section 6 of the New Teaching Hospital - (Form A). Once a full year of program costs have been included in an ICR submitted to the Department during the ramp up period, the total inpatient DGME traceback percentages for that year will be utilized for the remainder of the ramp-up period.
- iii. At the time the Department updates the base year utilized for the DGME add-ons to the rate, if the provider is still in their ramp-up period, the new teaching costs will remain on budgeted costs.
- iv. The DGME add-on to the Acute rate per discharge will be calculated by dividing the total inpatient DGME budgeted costs by the total reported Medicaid discharges as defined in [paragraph 3 (b of the Statewide base price section)] the Definitions Section of this Attachment.
- v. The DGME payment will be included in the exempt hospital rates for hospitals that are exempt from the Acute per discharge rate method, reimbursed in accordance with the Exempt units and hospitals section of this Attachment and the DGME costs are not included in the ceiling or price development. These DGME costs will be added to the base year total exempt hospital costs and reimbursed in accordance with the Exempt units and hospital section of this Attachment.
- d. An Indirect Medical Education (IME) payment will be added to the acute per discharge rate as stated in the Add-ons to the case payment rate per discharge section of this attachment.
 - i. An IME percentage will be calculated for new teaching hospitals as follows and applied to the adjusted statewide base price to determine the per case add-on payment.
 - 1. For IME rate adjustments, effective July 1st for program year, the IME Payment percentage will be calculated based on the formula $[1.03 * (((1+r)) ^{0.405}) - 1]$ where "r" equals the ratio of residents for the upcoming PGY, as provided with the appeal, to inpatient acute staff beds as reported in the base [period]year defined in [paragraph 3 of the statewide base price section] the Definitions Section of this Attachment.
 - 2. For IME rate adjustments, effective January 1st for calendar year, the IME Payment percentage will be calculated based on the formula $[1.03 * (((1+r)) ^{0.405}) - 1]$ where "r" equals the ratio of calendar year residents as defined in paragraph 3 of this section to]

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2. For IME rate adjustments, effective January 1st for calendar year, the IME Payment percentage will be calculated based on the formula $[1.03 * (((1 + (r))^{0.405} - 1)]$ where "r" equals the ratio of calendar year residents as defined in paragraph 3 of this section to inpatient acute staff beds as reported in the base [period]year defined in [paragraph 3 of the Statewide base price section] the Definitions Section of this Attachment.
3. Calendar year residents are calculated as follows:
- i. Upcoming PGY Resident counts as provided in paragraph 4(c)(ii)(3)(e)(ii) are multiplied by six months
 - ii. Prior PGY Resident counts as provided in 4(c)(ii)(3)(e)(iii) are multiplied by six months
 - iii. The calendar year residents equal the sum of i and ii divided by twelve months.
- ii. IME residents will be calculated each ramp-up year until the final year ramp-up.
- [5. The Department may refuse to accept or consider a rate appeal from a facility that:
- a. is providing an unacceptable level of care as determined after review by the State Hospital review and Planning Council; or
 - b. is operated by the same management that operates a facility with regard to which a determination of an unacceptable level of care has been made in accordance with paragraph (a) of this subdivision; or
 - c. has been determined by the Department as being operated by a person or persons not properly established or licensed pursuant to the Public Health Law; or
 - d. is delinquent in the payment of a fine or penalty imposed on the facility pursuant to the Public Health Law.
6. Any hospital whose Medicaid inpatient rates are subject to this Subpart and which is determined by the federal Department of Health and Human Services to be no longer eligible for reimbursement pursuant to Title XVIII (Medicare) of the federal social security act shall not be eligible for reimbursement by Medicaid until re-certification of the facility by the federal Department of Health and Human Services as eligible for reimbursement pursuant to Title XVIII of the federal Social Security Act.]

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d. i. Beginning on and after July 1, 2014, direct graduate medical education (DGME) and indirect medical education (IME) costs, as defined in the Definitions Section of this Attachment, for Graduate Medical Education for displaced residents due to the closure of a teaching hospital.

ii. Rate appeals for rate adjustments may be submitted for displaced residents subsumed by a hospital that is approved as a teaching facility and receiving a payment in their rate for DGME and IME. If the displaced residents are subsumed by a new teaching hospital, as described in paragraph (4)(c) of this section, the rate adjustments are in accordance with paragraph (4)(c) of this section.

1. Eligible for reimbursement.

a. Displaced residents due to the closing of a teaching hospital.

i. Hospitals that take in residents from a closed hospital after Jan 1st of the base year, as defined in the Definitions Section, and before the subsequent rebasing effective date, and

ii. The hospital takes in the residents for 6 months or more of needed training to complete the program from which they were displaced.

b. A facility is not limited to a one-time receipt of a displaced residents rate adjustment and is eligible to submit appeals for future hospital closures if they meet the appeal requirements. However, only one rate adjustment will be approved for each closure.

2. Not eligible for reimbursement:

a. Displaced residents due to the closing of a residency program in a teaching hospital that has remained open.

b. Displaced residents, due to a teaching hospital closing, requiring less than six months of training to complete the program from which they were displaced.

3. Appeal requirements:

a. A hospital is required to submit a written request to the Department for additional reimbursement due to displaced residents.

i. The rate adjustment will be effective the first day of the month following the later of:

1. The Department's receipt of the written notification and documentation requesting a rate adjustment, or

2. The date the hospital has taken in the displaced residents.

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- b. The hospital will provide the following data:
 - i. Completion of the Department's standardized template - Form (B), as of June 26, 2017, found on the APR-DRG website below:

<https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/>
 - c. The Department will obtain information from the closing hospital pertaining to placement of the displaced residents.
4. Additional reimbursement will be received based on:
- a. The revised FTE count based on the added displaced residents.
 - b. The maximum resident count will be filled slots at the time the existing resident program closed limited by the number of filled slots actually entering the program at the time the hospital takes in the residents from the closed teaching hospital. No additional adjustment will be received if slots are subsequently filled after the hospital takes in the displaced residents.
 - c. Direct Graduate Medical Education (DGME) Acute rate cost calculation:
 - i. Using the receiving hospital's Institutional Cost Report (ICR), a cost per resident will be calculated as follows:
 - 1. DGME costs from the base year, as defined in the Definitions Section of this Attachment, that are used in the DGME add-on calculated per the Add-On to the Acute Rate Per Discharge Section of this Attachment.
 - 2. Total Acute Residents used in the Indirect Medical Education (IME) calculation per the Add-On to the Acute Rate Per Discharge Section of this Attachment.
 - 3. The DGME costs will be divided by the Total Acute Residents to determine a cost per resident.
 - ii. The cost per resident will be applied to the maximum allowed additional FTE displaced resident count, as described in paragraph (4)(d)(ii)(4)(b), to determine the additional DGME costs. These additional costs will be added to the DGME costs, described in paragraph (4)(d)(ii)(4)(c)(i)(1) of this section, for the development of the DGME add-on that is developed per the Acute Rate Per Discharge section of this Attachment.

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- d. The DGME payment will be included in the exempt hospital rates for hospitals that are exempt from the Acute per discharge rate method, reimbursed in accordance with the Exempt units and hospitals section of this Attachment and the DGME costs are not included in the ceiling or price development.
 - i. Using the receiving hospital's ICR, a cost per resident will be calculated as follows:
 - 1. A DGME cost per resident will be developed by dividing the total DGME costs from the base year, per the Exempt units and hospitals section of this Attachment, by the total residents as reported in the same base year.
 - 2. The cost per resident will be applied to the maximum allowed additional FTE displaced resident count, as described in paragraph (4)(d)(ii)(4)(b), to determine the additional DGME costs. These additional costs will be added to the base year total exempt hospital costs and reimbursed in accordance with the Exempt units and hospital section of this Attachment.
 - e. Indirect Medical Education (IME) for the Acute rate per discharge:
 - i. The maximum allowed additional FTE displaced resident count, as described in paragraph (4)(d)(ii)(4)(b), will be added to the receiving hospital's Total Acute Residents, described in paragraph (4)(d)(ii)(4)(c)(i)(2) of this section, for the development of the IME payment per discharge calculation per the Add-On to the Acute Rate Per Discharge section of this Attachment.
 - f. The receiving hospital will receive no further adjustment for this specific hospital closure until the time the base year, as defined in the Definitions Section, is subsequently updated.
 - g. Receiving a Medicare cap increase is not a requirement for submitting a Medicaid rate appeal.
5. The Department may refuse to accept or consider a rate appeal from a facility that:
- a. is providing an unacceptable level of care as determined after review by the State Hospital review and Planning Council; or
 - b. is operated by the same management that operates a facility with regard to which a determination of an unacceptable level of care has been made in accordance with paragraph (a) of this subdivision; or
 - c. has been determined by the Department as being operated by a person or persons not properly established or licensed pursuant to the Public Health Law; or
 - d. is delinquent in the payment of a fine or penalty imposed on the facility pursuant to the Public Health Law.

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6. Any hospital whose Medicaid inpatient rates are subject to this Subpart and which is determined by the federal Department of Health and Human Services to be no longer eligible for reimbursement pursuant to Title XVIII (Medicare) of the federal social security act will not be eligible for reimbursement by Medicaid until re-certification of the facility by the federal Department of Health and Human Services as eligible for reimbursement pursuant to Title XVIII of the federal Social Security Act.

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Out-of-state providers.

1. For discharges occurring on and after December 1, 2009, rates of payment for inpatient hospital services provided by out-of-state providers in accordance with the prior approval requirements shall be as follows:
 - a. the weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the downstate region of New York State shall apply with regard to services provided by out-of-state providers located in the New Jersey counties of Sussex, Passaic, Bergen, Hudson, Essex, Union, Middlesex and Monmouth, in the Pennsylvania county of Pike, and in the Connecticut counties of Fairfield and Litchfield;
 - b. For rates effective beginning March 5, 2014, the weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the downstate region of New York State shall also apply with regard to services provided by out-of-state providers located in cities where the city's population census is 500,000 or greater based on the U. S. Department of Commerce, United States Census Bureau. This population test will be updated when the acute inpatient rates are updated to a new cost base and will remain constant while the cost base is in effect. For implementing the census population test, the latest census data that is available at that time will be used;
 - c. the weighted average of inpatient rates, including a teaching adjustment where applicable, in effect for similar services for hospitals located in the upstate region of New York State shall apply with regard to all other out-of-state providers;
 - d. high cost outlier rates of payment shall be calculated in accordance with the Outlier and Transfer Cases Rates of Payment section of this Attachment, with the exception of the wage equalization factor (WEF) being based upon the weighted average of the upstate or downstate region; and
 - e. the weighted average of the capital component of the inpatient rates in effect for similar services for hospitals located in New York State shall apply with regard to services provided by out-of-state providers.
2. Notwithstanding any inconsistent provision of this Section, in the event the Department determines that an out-of-state provider is providing services that are not available within New York State, the Department may negotiate payment rates and conditions with such provider; provided however, such payments shall not exceed the provider's usual and customary charges for such services.
3. For purposes of this Section, the downstate region of New York State shall consist of the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess, and the upstate region of New York State shall consist of all other New York counties.

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Supplemental indigent care distributions.

The methodology described in this section sunsets on December 31, 2012. The new methodology effective January 1, 2013 is described in the Indigent Care Pool Reform section of this Attachment.

1. From funds in the pool for each year, except as otherwise provided for in this section, \$27 million shall be reserved on an annual basis for the periods January 1, 2000 through May 1, 2009, to be distributed to each hospital based on each hospital's proportional annual reduction to their projected distribution from the New York State Health Care Reform Act Profession Education Pool, relative to the statewide annual reduction to said pool, as authorized by State law, up to the hospital specific disproportionate share (DSH) payment limits.
2. Effective May 1, 2009 through December 31, 2009:
 - a. Each hospital eligible for supplemental indigent care distributions in 2008 shall receive 90% of its 2008 annual award amount as Medicaid DSH payment.
 - b. \$307 million shall be distributed to facilities designated by the Department as teaching hospitals as of December 31, 2008, to compensate such facilities for Medicaid and self-pay losses. The payment amounts apply consistently to all teaching hospitals, and are reasonably related to costs, based on Medicare GME payments as a proxy, and are pursuant to the following schedule of payments:

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<u>Hospital</u>	<u>Calendar Year 2009</u>
	<u>\$307,000,000</u>
	<u>Uninsured Distribution to Teaching Hospitals</u>
ALBANY MEDICAL CENTER HOSPITAL	\$ 7,207,099
ST PETERS HOSPITAL	\$ 1,001,662
ALBANY MEDICAL CENTER SOUTH CLINICAL CAMPUS	\$ 3,880
UNITED HEALTH SERVICES, INC	\$ 1,140,730
OLEAN GENERAL HOSPITAL	\$ 24,817
ERIE COUNTY MEDICAL CENTER	\$ 597,922
MERCY HOSPITAL OF BUFFALO	\$ 319,739
ROSWELL PARK MEMORIAL INSTITUTE	\$ 1,652,987
KALEIDA HEALTH	\$ 4,938,527
HIGHLAND HOSPITAL OF ROCHESTER	\$ 2,845,852
ROCHESTER GENERAL HOSPITAL	\$ 3,553,825
STRONG MEMORIAL HOSPITAL	\$ 11,695,895
THE UNITY HOSPITAL OF ROCHESTER	\$ 572,019
GLEN COVE HOSPITAL	\$ 471,540
WINTHROP UNIVERSITY HOSPITAL	\$ 6,071,885
SOUTH NASSAU COMMUNITIES HOSPITAL	\$ 530,429
NASSAU UNIVERSITY MEDICAL CENTER	\$ 1,783,090
NORTH SHORE UNIVERSITY HOSPITAL	\$ 13,118,952
ST FRANCIS HOSPITAL OF ROSLYN	\$ 425,667
ST ELIZABETH MEDICAL CENTER	\$ 7,889
FAXTON- ST LUKE'S HEALTHCARE	\$ 23,436
COMMUNITY-GENERAL HOSPITAL OF GREATER SYRACUSE	\$ 196,351
UNIVERSITY HOSPITAL SUNY HEALTH SCIENCE CENTER	\$ 6,987,635
CROUSE HOSPITAL	\$ 958,865
MARY IMOGENE BASSETT HOSPITAL	\$ 472,619
ELLIS HOSPITAL	\$ 960,657
ST CHARLES HOSPITAL	\$ 249,445
UNIVERSITY HOSPITAL AT STONY BROOK	\$ 13,197,922
HUNTINGTON HOSPITAL	\$ 64,200
GOOD SAMARITAN HOSPITAL OF WEST ISLIP	\$ 589,318

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<u>BENEDICTINE HOSPITAL</u>	\$ 459,898
<u>KINGSTON HOSPITAL</u>	\$ 430,512
<u>MOUNT VERNON HOSPITAL</u>	\$ 115,045
<u>SOUND SHORE MEDICAL CENTER</u>	\$ 155,810
<u>WESTCHESTER MEDICAL CENTER</u>	\$ 16,611,342
<u>BRONX-LEBANON HOSPITAL CENTER</u>	\$ 37,193
<u>JACOBI MEDICAL CENTER</u>	\$ 2,082,896
<u>MONTEFIORE HOSPITAL & MEDICAL CENTER</u>	\$ 24,605,332
<u>LINCOLN MEDICAL & MENTAL HEALTH CENTER</u>	\$ 3,019,391
<u>NORTH CENTRAL BRONX HOSPITAL</u>	\$ 754,891
<u>BROOKLYN HOSPITAL</u>	\$ 5,938,856
<u>CONEY ISLAND HOSPITAL</u>	\$ 995,496
<u>KINGS COUNTY HOSPITAL CENTER</u>	\$ 3,882,475
<u>LONG ISLAND COLLEGE HOSPITAL</u>	\$ 3,448,174
<u>NY METHODIST HOSPITAL OF BROOKLYN</u>	\$ 3,807,310
<u>KINGSBROOK JEWISH MEDICAL CENTER</u>	\$ 121,313
<u>WYCKOFF HEIGHTS HOSPITAL</u>	\$ 1,230,117
<u>STATE UNIVERSITY HOSPITAL DOWNSTATE MEDICAL CENTER</u>	\$ 4,116,253
<u>WOODHULL MEDICAL AND MENTAL HEALTH CENTER</u>	\$ 876,601
<u>INTERFAITH MEDICAL CENTER</u>	\$ 831,511
<u>BELLEVUE HOSPITAL CENTER</u>	\$ 2,636,659
<u>BETH ISRAEL MEDICAL CENTER</u>	\$ 12,615,285
<u>HARLEM HOSPITAL CENTER</u>	\$ 2,002,465
<u>HOSPITAL FOR SPECIAL SURGERY</u>	\$ 3,247,177
<u>LENOX HILL HOSPITAL</u>	\$ 12,658,212
<u>MANHATTAN EYE EAR AND THROAT</u>	\$ 416,294
<u>MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES</u>	\$ 5,831,787
<u>METROPOLITAN HOSPITAL CENTER</u>	\$ 1,570,125
<u>MOUNT SINAI HOSPITAL</u>	\$ 18,689,832
<u>NY EYE AND EAR INFIRMARY</u>	\$ 407,797
<u>ST LUKES – ROOSEVELT HOSPITAL CENTER</u>	\$ 8,823,583
<u>SVCMC ST VINCENTS-MANHATTAN</u>	\$ 5,342,595
<u>GOLDWATER MEMORIAL HOSPITAL</u>	\$ 10,006
<u>COLER MEMORIAL HOSPITAL</u>	\$ 639
<u>NYU HOSPITALS CENTER</u>	\$ 13,483,008

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<u>NEW YORK PRESBYTERIAN HOSPITAL</u>	\$ 27,337,202
<u>ELMHURST HOSPITAL</u>	\$ 2,226,463
<u>JAMAICA HOSPITAL</u>	\$ 1,185,404
<u>LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER</u>	\$ 18,206,316
<u>QUEENS HOSPITAL CENTER</u>	\$ 554,077
<u>NY MED CTR OF QUEENS</u>	\$ 3,178,354
<u>FOREST HILLS HOSPITAL</u>	\$ 1,334,742
<u>STATEN ISLAND UNIVERSITY HOSPITAL</u>	\$ 5,084,762
<u>RICHMOND UNIVERSITY MEDICAL CENTER</u>	\$ 2,274,908

- c. Effective May 1, 2009 through December 31, 2009, \$16 million shall be proportionally distributed to non-teaching hospitals based on their proportion of uninsured losses as determined according to the methodology contained in the High Need Indigent Care Adjustment Pool of this Attachment.
- d. Effective December 1, 2009, \$25 million shall be distributed to non-major public hospitals having Medicaid discharges of 40% or greater from data reported in each hospital's 2007 annual cost report, based on each hospital's decrease in Medicaid revenues resulting from the reductions in trend factors for 2008 and 2009 as contained in this Attachment and the inpatient and outpatient reimbursement methodology changes effective December 1, 2009.

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3. For annual periods beginning on and after January 1, 2010 through December 31, 2012:
- a. From regional allotments specified below, \$269.5 million shall be distributed to non-major public teaching hospitals on a regional basis to cover each eligible facility's proportional regional share of 2007 uncompensated care, as defined in the disproportionate share payment calculation provisions of this Attachment and offset by disproportionate share payments received by each facility during calendar year 2010 in accordance with the disproportionate share payment calculations provisions of this Attachment.

<u>Region</u>	<u>Revised Regional Distribution</u>
<u>Long Island</u>	<u>\$ 31,171,915</u>
<u>New York City</u>	<u>\$ 181,778,400</u>
<u>Northern Metropolitan</u>	<u>\$ 14,526,351</u>
<u>Northeast</u>	<u>\$ 8,130,067</u>
<u>Utica/Watertown</u>	<u>\$ 502,271</u>
<u>Central</u>	<u>\$ 10,052,989</u>
<u>Rochester</u>	<u>\$ 16,615,910</u>
<u>Western</u>	<u>\$ 6,722,096</u>
<u>Statewide</u>	<u>\$269,500,000</u>

- b. \$25 million shall be distributed to non-major public hospitals having eligible for payments based upon each facility's proportion of uninsured losses as determined according to the methodology in the High Need Indigent Care Adjustment Pool of this Attachment.
- c. \$16 million shall continue to be proportionally distributed to non-teaching hospitals based on their proportion of uninsured losses as determined according to the methodology contained in the High Need Indigent Care Adjustment Pool of this Attachment.
- d. \$25 million shall be distributed to non-major public hospitals having Medicaid discharges of 40% or greater from data reported in each hospital's 2007 annual cost report, based on each hospital's decrease in Medicaid revenues resulting from the reductions in trend factors for 2008 and 2009 as contained in this Attachment and the inpatient and outpatient reimbursement methodology changes effective December 1, 2009.

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- (l) High Need Indigent Care Adjustment Pool. Funds will be deposited as authorized and used for the purpose of making Medicaid disproportionate share payments within the limits established on an annualized basis pursuant to disproportionate share limitations, except as otherwise provided for in this section, for the period January 1, 2000 through December 31, [2014] 2012, in accordance with the following:

(1) From the funds in the pool each year:

- (i) Each eligible rural hospital will receive a payment of \$140,000 on an annualized basis for the period January 1, 2000 through September 30, 2009. Effective on and after October 1, 2009 through December 31, 2012, each eligible rural hospital will receive a payment of \$126,000 on an annualized basis, provided as a disproportionate share payment; provided, however, that if such payment pursuant to this clause exceeds a hospital's applicable disproportionate share limit, then the total amount in excess of such limit will be provided as a nondisproportionate share payment in the form of a grant directly from this pool without federal financial participation;
- (ii) Each such hospital will also receive an amount calculated by multiplying the facility's uncompensated care need by the appropriate percentage from the following scale based on hospital rankings developed in accordance with each eligible rural hospital's weight as defined by this section:

Rank	Percentage Coverage of Uncompensated Care Need
1-9	60.0%
10-17	52.5%
18-25	45.0%
26-33	37.5%
34-41	30.0%
42-49	22.5%
50-57	15.0%
58+	7.5%

- (iii) "Eligible rural hospital", as used in paragraph (1), will mean a general hospital classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (Medicare) or under state regulations, or a general hospital with a service area which has an average population of less than 175 persons per square mile, or a general hospital which has a service area which has an average population of less than two hundred persons per square mile measured as population density by zip code.

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**New York
144(b)**

The average population of the service area is calculated by multiplying annual patient discharges by the population density per square mile of the county of origin or zip code as applicable for each patient discharge and dividing by total discharges. Annual patient discharges shall be determined using discharge data for the 1997 rate year, as reported to the commissioner by October 1, 1998. Population density shall be determined utilizing United States census bureau data for 1997.

- (iv) "Eligible rural hospital weight", as used in paragraph (1), shall mean the result of adding, for each eligible rural hospital:
 - (a) The eligible rural hospital's targeted need, as defined in subparagraph (ii) of this section, minus the mean targeted need for all eligible rural hospitals, divided by the standard deviation of the targeted need of all eligible rural hospitals; and
 - (b) The mean number of beds of all eligible rural hospitals minus the number of beds for an individual hospital, divided by the standard deviation of the number of beds for all eligible rural hospitals.
- (2) From the funds in the pool each year, except as otherwise provided for in this section, \$36 million on an annualized basis for the periods January 1, 2000 through September 30, 2009, and for the periods on and after October 1, 2009 through December 31, 2012, \$32.4 million on an annualized basis, of the funds not distributed in accordance with paragraph (1), shall be distributed in accordance with the formula set forth in paragraph (12) of the Medicaid disproportionate share payments section of this Attachment.
- (3) From the funds in the pool each year, any funds not distributed in accordance with paragraphs (1) or (2), shall be distributed in accordance with the formula set forth in subparagraph (d) of paragraph (10) of the Medicaid disproportionate share payments section.

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**New York
144(c)**

For annual periods beginning January 1, 2009 through December 31, 2012, disproportionate share hospital (DSH) payments shall be reduced to 90 percent of the amount otherwise payable. In addition, DSH payments to each general hospital will be distributed in accordance with the following:

- (a) \$13.93 million will be distributed to major government hospitals and will be allocated proportionally, based on each facility's relative uncompensated care need as determined in accordance with (c);
- (b) \$70.77 million will be distributed to general hospitals other than major government general hospitals and will be allocated proportionally, based on each facility's relative uncompensated care need as determined in accordance with (c);
- (c) each facility's relative uncompensated care need amount will be determined by multiplying inpatient units of services for all uninsured patients from the calendar year two years prior to the distribution year, excluding referred ambulatory units of services, by the applicable Medicaid inpatient rates in effect for such prior year, but not including prospective rate adjustments and rate add-ons, provided, however, that for distributions on and after January 1, 2010 through December 31, 2012, the uncompensated amount for inpatient services shall utilize the inpatient rates in effect as of July 1 of the prior year; and:

by multiplying outpatient units of service for all uninsured patients from the calendar year two years prior to the distribution year, including emergency department services and ambulatory surgery services, but excluding referred ambulatory services units of service, by Medicaid outpatient rates that reflect the exclusive utilization of the ambulatory patient groups (APG) rate-setting methodology, however, for those services for which APG rates are not available the applicable Medicaid outpatient rate shall be the rate in effect for the calendar year two years prior to the distribution year.

For distributions on and after January 1, 2010 through December 31, 2012, each facility's uncompensated need amount will be reduced by the sum of all payment amounts collected from such patients. The total uncompensated care need for each facility will then be adjusted by application of the existing nominal need scale.

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144(d)**

- (d) (i) Continuing annually for periods on and after January 1, 2009 through December 31, 2012, no general hospital will receive DSH payment distributions that exceed the costs incurred by such hospital during the distribution period for providing inpatient and outpatient hospital services to Medicaid eligible patients or, uninsured patients. Such costs will be net of monies received from non-DSH related Medicaid payments and collections from uninsured patients.
- (ii) DSH payment reductions will first be made from the public general hospital indigent care adjustment payments pursuant to this Attachment, and then from payments from this section.
- (e) Distributions to voluntary sector general hospitals, excluding government general hospitals, made in accordance with the Medicaid Disproportionate Share Section, the Supplemental Indigent Care Distributions Section, and the High Need Indigent Care Adjustment Pool Section will be reduced proportionally by the final payment amounts paid to eligible voluntary sector general hospitals, excluding government general hospitals, made in accordance with the Additional Inpatient Hospitals Payments Section for the period commencing July 1, 2010, and annually thereafter through December 31, 2012.
- (f) In addition to reductions noted in paragraph (e), distributions to voluntary sector general hospitals, made in accordance with the Medicaid Disproportionate Share Section, the Supplemental Indigent Care Distributions Section, and the High Need Indigent Care Adjustment Pool Section will be reduced proportionally by \$69.4M for the period commencing July 1, 2010 through December 31, 2010 and by \$73.2M annually for rate periods commencing January 1, 2011 [and thereafter] through December 31, 2012 excluding distributions made in accordance with subparagraphs (b), (c), and (d) of paragraph (3) of the Supplemental Indigent Care Distributions Section.

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Hospital physician billing.

1. With the exception of hospitals designated under the Medicare program as meeting the criteria set forth in §1861(b)(7) of the federal Social Security Act, for discharges occurring on and after February 1, 2010, hospitals may bill for physician services in accordance with the applicable Medicaid physician fee schedule in addition to billing the applicable DRG.

TN #09-34

Supersedes TN NEW

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New York
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Serious Adverse Events.

Effective October 1, 2008, through June 30, 2011, the New York State Medicaid program shall deny reimbursement or reduce payment for the higher DRG arising from the following three serious adverse events, defined as avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients: foreign object left in patient after surgery, air embolism, and blood incompatibility. On and after November 1, 2009, hospitals will be required to bill all claims associated with one of the remaining ten (10) serious adverse events using the following procedures:

- a. For those cases where a serious adverse event occurs and the hospital elects to receive no payment for the admission (i.e., it is expected that Medicaid will deny the entire payment based on the type of event), the hospital will notify Medicaid of this case by submitting a claim using a new rate code 2590 (non-reimbursable with serious adverse events), along with the requisite billing information submitted with a claim.

Department of Health will identify claims billed with rate code 2590 and instruct the Island Peer Review Organization (IPRO), the New York State Medicaid review agent, to request the medical record for the admission and conduct a case review.

- b. For those cases where a serious adverse event occurs and the hospital anticipates at least partial payment for the admission, the hospital will follow a two-step process for billing the admission:
 - i. The hospital will first submit their claim for the entire stay in the usual manner, using the appropriate rate code (i.e., rate code 2946 for DRG claims or the appropriate exempt unit per diem rate code such as 2852 for psychiatric care, etc.). That claim will be processed in the normal manner and the provider will receive full payment for the case.

TN #11-46-A Supersedes TN #09-34 Approval Date May 25, 2012 Effective Date July 1, 2011

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ii. Once remittance for the initial claim is received, it will be necessary for the hospital to then submit an adjustment transaction to the original paid claim using one of the following two new rate codes associated with identification of claims with serious adverse events:

- 2591 (DRG with serious adverse events), or
- 2592 (Per Diem with serious adverse events)

The adjusted claim will then pend to the Department and will be forwarded to Island Peer Review Organization (IPRO) for further review. IPRO will review the medical record for the case to determine appropriate payment. Once IPRO has completed its review of the medical record, a preliminary notification indicating their findings will be issued. Hospitals will be required to respond to this preliminary finding within thirty days indicating whether it agrees or disagrees with the finding. If the provider disagrees with this preliminary finding, they may appeal by submitting additional rationale and supporting documentation to the IPRO. IPRO will then re-review the case taking into account the provider's rationale and supporting documentation. A final determination will be made at the conclusion of this process.

The thirteen serious adverse events are as follows:

- (1) Surgery performed on the wrong body part
- (2) Surgery performed on the wrong patient
- (3) Wrong surgical procedure on a patient
- (4) Foreign object inadvertently left in patient after surgery
- (5) Medication error
- (6) Air embolism
- (7) Blood incompatibility
- (8) Patient disability from electric shock

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- (9) Patient disability from use of contaminated drugs
- (10) Patient disability from wrong function of a device
- (11) Incidents whereby a line designated for oxygen intended for patient is wrong item or contaminated

- (12) Patient disability from burns

- (13) Patient disability from use of restraints or bedrails

Hospitals receiving payment under New York State Medicaid shall be required to provide information, through Present on Admission (POA) indicators, on each admission. These POA indicators shall designate which procedures or complications were present on admission, and which occurred during or as a result of hospital care.

This provision applies to all Medicaid supplemental or enhanced payments and Medicaid disproportionate share hospital payments.

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**New York
148(a)**

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19(A) of this State plan.

 X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19(A) of this State plan.

 X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

 X Additional Other Provider-Preventable Conditions identified below: [Not applicable.]

Effective July 1, 2011, reimbursement for inpatient hospital services shall be based on the Provider Preventable Conditions (PPC) policy defined in 42 CFR 447.26.

PPCs are defined as two distinct categories: Health Care-Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC).

For APR-DRG cases, the APR-DRG payable shall exclude the diagnoses not present on admission for any HCAC. For per diem payments, the number of covered days shall be reduced by the number of days associated with diagnoses not present on admission for any HCAC.

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148(b)**

For per diem payments, the number of covered days shall be reduced by the number of days associated with diagnoses not present on admission for any HCAC. Claims containing a diagnosis not present on admission will be subsequently reviewed by clinical review staff to determine if the diagnosis contributed to a longer length of stay. If the clinical review can reasonably isolate that portion of the actual length of stay that is directly related to the diagnosis not present on admission, payment will be denied for the directly related length of stay.

No payment shall be made for inpatient services for OPPCs. OPPCs are the three Medicare National Coverage Determinations:

1. Wrong surgical or other invasive procedure performed on a patient;
2. Surgical or other invasive procedure performed on the wrong body part; and
3. Surgical or other invasive procedure performed on the wrong patient.

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment will be limited to the extent that the following apply:

1. The identified PPCs would otherwise result in an increase in payment.
2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPCs.

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

TN #11-46-A

Approval Date May 25, 2012

Supersedes TN NEW

Effective Date July 1, 2011

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Graduate Medical Education – Medicaid Managed Care Reimbursement

Teaching hospitals shall receive direct reimbursement from the State Medicaid Agency for graduate medical education (GME) costs associated with inpatient services rendered to patients enrolled in Medicaid managed care or Family Health Plus plans.

GME payments for DRG based services shall include the following:

- a. A direct graduate medical education (GME) payment per discharge calculated for each teaching hospital by dividing the facility's total reported acute care Medicaid direct GME costs by its total Medicaid acute care discharges in the applicable base period. Direct GME costs shall be those costs defined in the Definitions Section, derived from the same base period used to calculate the statewide base price for the applicable rate period, and trended forward to such rate period in accordance with applicable provisions of this Attachment.
- b. An indirect GME payment per discharge calculated for each teaching hospital by applying the actual applicable Service Intensity Weight for the discharge, Wage Equalization Factor Adjustment, and indirect teaching cost percentage described in this Attachment to the statewide base price. Each of these variables will be for the applicable rate year in which the discharge occurs.

GME payments for exempt unit or hospital services shall include a direct GME and an indirect GME component calculated as follows:

- a. A direct GME payment per discharge for each exempt unit or hospital by dividing the facility's applicable exempt unit or hospital Medicaid direct GME costs by the total Medicaid discharges for that exempt unit or hospital in the applicable base period. Direct GME costs shall be those costs defined in the Definitions Section, derived from the same base period used to calculate the average operating cost per diem for the applicable rate period, and trended forward to such rate period in accordance with applicable provisions of this Attachment.

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- b. An indirect GME payment per discharge for each exempt unit or hospital by applying the indirect teaching cost percentage calculated in accordance with this Attachment to the hospital's operating cost per diem calculated in accordance with the provisions of this Attachment excluding the costs of direct GME calculated in (a) above, converted to a per diem basis, and trended forward to the rate period in accordance with the provisions of each applicable exempt unit or hospital's average length of stay based on the latest available data reported on the Institutional Cost Report for the reporting period two years prior to the rate year.

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New York
150(a)

Disproportionate Share Hospital (DSH) State Plan Rate Years

The State Plan Rate Year for Disproportionate Share Hospital payments made to general acute care and specialty hospitals in this Attachment and facility specific DSH caps shall be defined as running from January 1 through December 31 of the current calendar year and each subsequent calendar year thereafter.

TN #11-0016-B

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Supersedes TN # NEW

Effective Date 01/01/2011

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Disproportionate share limitations.

1. Disproportionate share payment distributions made to general hospitals pursuant to this Attachment shall be limited in accordance with the provisions of this Section. The latest available annual cost report submitted by a hospital prior to the disproportionate share distribution period shall be used to determine eligibility pursuant to paragraph (2) and for projected limits pursuant to paragraph (5). Annual cost reports having an end date in the applicable annual disproportionate share distribution period, or for certain state-operated general hospitals, annual cost reports having an end date in the subsequent annual disproportionate share distribution period, shall be used to reconcile limits pursuant to paragraph (6).
2. General hospitals must meet the following conditions to receive disproportionate share distributions:
 - a. The hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for obstetric services under a state plan. This requirement doesn't apply to a hospital if their inpatients are predominantly under 18 years old or if the hospital does not offer nonemergency obstetric services to the general population as of December 22, 1987. If the hospital is a rural hospital, an obstetrician is any physician with staff privileges to perform nonemergency obstetric procedures.
 - b. The hospital must have a Medicaid inpatient utilization rate of at least one percent.
3. No general hospital shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred during the periods described in paragraph (1) for furnishing inpatient and ambulatory hospital services to individuals who are eligible for medical assistance benefits pursuant to title XIX of the Federal Social Security Act (hereinafter referred to as "Medicaid cost") or to individuals who have no health insurance or other source of third party coverage (hereinafter referred to as "self-pay cost"), reduced by medical assistance payments made pursuant to title XIX of the Federal Social Security Act (hereinafter referred to as "Medicaid revenue"), other than disproportionate share payments, and payments by uninsured patients. For purposes of this Section, payments to a general hospital for services provided to indigent patients made by the State or a unit of local government within the State shall not be considered a source of third party payment.
4. In order to ensure the continued flow of disproportionate share payments to hospitals, the Commissioner shall make projections of each hospital's disproportionate share limitation based on the most current data available from the hospital's annual cost reports. The

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Commissioner shall use annual cost reports in accordance with the provisions of paragraph (5) to estimate Medicaid and self-pay costs in the projection methodology for a particular rate year. This shall be referred to as the "projection methodology". Subsequent to the receipt of a hospital's annual cost report having an end date in the applicable annual disproportionate share distribution period, or for certain state-operated general hospitals whose annual cost reports have an end date within the subsequent annual period, each hospital's disproportionate share limitation shall be reconciled to the actual rate year data. This shall be referred to as the "reconciliation methodology".

5. **Projection methodology.** Each hospital's projected disproportionate share limitation for each rate year shall be the sum of its inpatient and outpatient Medicaid and uninsured gains/(losses) as calculated using reported base year data and statistics from the year two years immediately preceding the rate year and as used for projection methodology purposes for that prior year. For the two thousand eleven calendar year, maximum disproportionate share payment distributions shall be determined initially based on each hospital's submission of a fully completed two thousand eight disproportionate share hospital data collection tool, and shall subsequently be revised to reflect each hospital's submission of a fully completed two thousand nine disproportionate share hospital data collection tool. For calendar years on or after January 1, 2012, inpatient and outpatient Medicaid and uninsured gains/(losses) based on data for the most recent calendar year available [2 years] prior to the DSH payment year submitted by hospitals as prescribed by the Commissioner shall be used to determine maximum disproportionate share payments. All such initial determinations shall subsequently be revised to reflect actual calendar year inpatient and outpatient Medicaid and uninsured gains/(losses) applicable to the DSH payment year.
6. **Reconciliation methodology.** The Commissioner shall revise the projected limitation based on actual audited and certified data reported to the Commissioner for such calendar year in accordance with the following and in accordance with final regulations issued by the federal Department of Health and Human Services implementing 42 USC §1396r-4. The Commissioner shall revise the projected limitations for each hospital within eight months from the date required reports are submitted to the Department, except if such reports are determined to be unacceptable by the Department. For hospitals which have submitted unacceptable reports, the Commissioner shall revise the projected limitations within eight months from the date acceptable reports have been resubmitted to the Department.

[a.]

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outpatient Medicaid and self-pay gains/(losses) during the cost reporting year. The disproportionate share limitation schedule shall be accompanied by a certification by the hospital's independent public accountant which provides the Commissioner sufficient assurance as to the accuracy of the information contained in such schedule.

- i. The final limit shall be calculated by excluding inpatient and outpatient Medicaid revenue impacts resulting from prospective adjustments to rates for periods prior to the implementation of the federal hospital specific disproportionate share payment limits from the inpatient and outpatient Medicaid and self-pay gains/(losses) reported on the disproportionate share payment limitation schedule.]

a. Failure of a hospital to submit the information required by this Section in a form acceptable to the Commissioner shall result in the immediate withholding of subsequent disproportionate share distributions. Such withholding shall continue until the hospital complies with the reporting requirements of this section.

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1905(a)(1): Inpatient Hospital Services**Government General Hospital Additional Disproportionate Share Payments**

Government general hospital disproportionate share payments will be made to increase reimbursement to hospitals operated by the State of New York, the State University of New York. To be eligible, hospitals must be operating at the time the payments are made. The payments are subject to the payment limits established in this Attachment of this plan.

1. Government general hospitals operated by the State of New York or the State University of New York shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007 and April 1, 2007 through March 31, 2009, for the state fiscal years beginning April 1, 2009 through March 31, 2011, for the state fiscal years beginning April 1, 2011 through March 31, 2013, for the state fiscal years beginning April 1, 2013 through March 31, 2016 and, for the state fiscal years beginning April 1, 2016 through March 31, 2019, and for state fiscal years beginning April 1, 2019 through March 31, 2022 and for state fiscal years beginning April 1, 2022 through March 31, 2025 subject to the limits established pursuant to this Attachment. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002 after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006.

TN #22-0034 Approval Date February 1, 2023Supersedes TN #19-0008 Effective Date April 1, 2022

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Such payments shall continue to be established for periods beginning on April 1, 2007, through March 31, 2008, based initially on 100% of reported 2000 reconciled data and further reconciled to 100% of actual reported data for 2007. For periods beginning April 1, 2008, through March 31, 2009, such payments shall be based initially on 100% of reported 2000 reconciled data and further reconciled to 100% of actual reported data for 2008. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For periods beginning April 1, 2009 through March 31, 2010 [2011], such payments shall be established based initially on reported 2007 reconciled data, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data for 2009[, and to actual reported data for each respective succeeding year]. For periods beginning on and after April 1, 2010, such payments shall be established based initially on reported reconciled data from the base year two years prior to the payment year, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data from such payment year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

TN #10-20-BApproval Date July 29, 2011Supersedes #09-34Effective Date April 1, 2010

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1905(a)(1) Inpatient Hospital Services

2. Government general hospitals operated by a county, which does not include a city with a population of over one million, shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007, and April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, for the state fiscal years beginning April 1, 2009 through March 31, 2011, for the state fiscal years beginning April 1, 2011 through March 31, 2013, for the state fiscal years beginning April 1, 2013 through March 31, 2016, for the state fiscal years beginning April 1, 2016 through March 31, 2019, for the state fiscal years beginning April 1, 2019 through March 31, 2022, and for state fiscal years beginning April 1, 2022 through March 31, 2025 subject to the limits established pursuant to this Attachment. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002, after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006.

TN #22-0034 Approval Date February 1, 2023Supersedes TN #19-0008 Effective Date April 1, 2022

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Such payments shall continue to be established for periods beginning on April 1, 2007, based initially on up to 100% of reported 2000 reconciled data as further reconciled to up to 100% of actual reported data for 2007, for state fiscal year beginning on April 1, 2008 through March 31, 2009, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2008. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For periods beginning April 1, 2009 through March 31, 2010 [2011], such payments shall be established based initially on reported 2007 reconciled data, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data for 2009[, and to actual reported data for each respective succeeding year]. For periods beginning on and after April 1, 2010, such payments shall be established based initially on reported reconciled data from the base year two years prior to the payment year, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data from such payment year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

TN #10-20-B Approval Date July 29, 2011 Supersedes #09-34 Effective Date April 1, 2010

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Government general hospitals operated by a county, which does not include city of over one million, or beginning April 1, 1997, government general hospitals located in the county of Erie, shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007, and April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, subject to the limits established in accordance with disproportionate share limitations. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002 after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006. Such payments shall continue to be established for periods beginning on April 1, 2007, based initially on up to 100% of reported 2000 reconciled data as further reconciled to up to 100% or actual reported data for 2007 and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

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Government general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million, shall receive 120 million dollars in additional disproportionate share payments effective January 1, 1997 and 120 million dollars in additional disproportionate share payments during each state fiscal year commencing April 1, 1997 and thereafter until March 31, 2000, 120 million dollars in initial additional disproportionate share payments each state fiscal year commencing April 1, 2000 and thereafter until March 31, 2003, \$120 million during the state fiscal year April 1, 2005 through March 31, 2006, \$120 million during the state fiscal year beginning April 1, 2006 through March 31, 2007, \$120 million beginning April 1, 2007 through March 31, 2008, \$120 million during the state fiscal year beginning April 1, 2008 through March 31, 2009, \$420 million [annually] for the state fiscal year[s] beginning April 1, 2009 through March 31, 2010[1], \$420 million for the state fiscal year beginning April 1, 2010 through March 31, 2011, and \$120 million for the state fiscal year beginning April 1, 2011 through March 31, 2012 and annually thereafter, subject to the maximum payment amounts permitted under sections 1923(f) and 1923(g) of the federal Social Security Act after application of all other disproportionate share hospital payments, \$120 million annually for the state fiscal year beginning April 1, 2011, and annually thereafter]. Such facilities will also receive payments equivalent to any undistributed disproportionate share payment amount, after all other statewide disproportionate share payments, pursuant to the states' allotment under 1923(f) and (g) of the federal Social Security Act. Such payments will be made to each qualified individual hospital based on the relative share of each such hospital's medical assistance and uninsured patient losses for 1997 after considering all other medical assistance payments to such government general hospitals based on 1994 reconciled data as further reconciled to actual reported 1997 reconciled data, for any payments made in 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 or 1998 reconciled data, for payments made during the state fiscal year beginning April 1, 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 or 1999 data, for payments made during the state fiscal year ending March 31, 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 or 2000 data, for payments made during the state fiscal year beginning April 1, 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 or 2001 data, for payments made during the state fiscal year beginning April 1, 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 or 2002 data, for payments made during the state fiscal year beginning April 1, 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 or 2003 data, for payments made for the state fiscal year beginning April 1, 2005 based initially on reported 2000 reconciled data, as further reconciled to actual reported 2005 or 2006 data, and for payments made for the state fiscal year beginning April 1, 2006, based initially on reported 2000 reconciled data, as further reconciled to actual reported 2006 or 2007 data.

TN #10-20-BApproval Date July 29, 2011Supersedes TN #09-34Effective Date April 1, 2010

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Such payments shall continue to be established for the state fiscal year beginning on April 1, 2007 based initially on reported 2000 reconciled data, as further reconciled to actual reported 2007 or 2008 data, for the state fiscal year beginning on April 1, 2008 through March 31, 2009, based initially on reported 2000 reconciled data, as further reconciled to actual reported 2008 or 2009 data. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For periods beginning April 1, 2009 through March 31, 2010 [2011], such payments shall be established based initially on reported 2007 reconciled data, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data for 2009[, and to actual reported data for each respective succeeding year]. For periods beginning on and after April 1, 2010, such payments shall be established based initially on reported reconciled data from the base year two years prior to the payment year, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data from such payment year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

Beginning April 1, 2000 government general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million are authorized to receive additional disproportionate share payments as projected or reconciled pursuant to this Attachment governing disproportionate share payments to hospitals, based on the relative share of each such non-state operated government general hospital of projected or reconciled medical assistance and uninsured patient losses after payment of all other medical assistance, including disproportionate share payments to such government general hospitals. For the period April 1, 2000 through March 31, 2001, an additional payment of \$103 million is authorized. Effective April 1, 2001 through March 31, 2002, additional payments of \$113 million are authorized. For the state fiscal years beginning April 1, 2002 and ending March 31, 2009, and each state fiscal year thereafter, additional annual payments of \$210 million are authorized. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

TN #10-20-B Approval Date July 29, 2011 Supersedes TN #09-34 Effective Date April 1, 2010

**New York
158(a)**

For state fiscal years beginning April 1, 2003 and ending March 31, 2005, the Department of Health is authorized to pay government general hospitals, operated by the State of New York or by the State University of New York additional payments for inpatient hospital services as medical assistance payments for patients eligible for federal financial participation under Title XIX of the federal social security act pursuant to the federal laws and regulations governing disproportionate share payments to hospitals 175 percent of each such government general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such government general hospital, based initially on reported 2000 reconciled data. Such payments for the periods ending March 31, 2004 and March 31, 2005, shall be further reconciled to actual reported 2003 and 2004 data respectively, provided, however, that such payments for all eligible hospitals shall be reduced to the extent such payments would result in the exceeding of the State's disproportionate share allotment limit, as determined in accordance with federal statute and regulations, provided, however, that such reduction shall be based on each such hospital's proportionate share of the sum of all such payments that would be made without regard to such allotment limit. Such payments may be added to rates of payment or made as aggregate payments to an eligible government general hospital.

TN #10-20-BApproval Date July 29, 2011Supersedes NewEffective Date April 1, 2010

New York
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Reimbursable Assessment on Hospital Inpatient Services

Effective January 1, 2006, and thereafter, an assessment on net patient services revenue for hospital inpatient services rendered to Medicaid beneficiaries shall be considered an allowable cost and reimbursed through an adjustment to Medicaid services rates of payment.

TN #09-34 _____

Approval Date January 20, 2010

Supersedes TN New _____

Effective Date December 1, 2009

New York
160

Government General Hospital Indigent Care Adjustment.

For rate periods commencing January 1, 1997 [and thereafter,] through December 31, 2012 each eligible government general hospital [shall] will receive an annual amount equal to the amount allocated to such government general hospitals as determined pursuant to this Attachment for the period January 1, 1996 through December 31, 1996. The adjustment may be made to rates of payment or as aggregate payments to an eligible government general hospital and is contingent upon all federal approvals necessary by federal law and rules for federal financial participation for medical assistance under Title XIX of the federal Social Security Act based upon the adjustment provided herein as a component of such payments being granted.

For calendar years effective January 1, 2013, and for each calendar year thereafter, eligible major government general hospitals will receive in aggregate \$412,000,000 proportionately allocated based on each eligible hospital's Medicaid and uninsured losses to the total of such losses for eligible hospitals. The Medicaid and uninsured losses will be determined based on the latest available audited annual data as of January 1 of the distribution year prepared in accordance with federal DSH Auditing and Reporting regulations 42 CFR Parts 447 and 455 and submitted annually to the Department of Health as required by the Commissioner of Health. Eligible major government hospitals are defined as all State operated general hospitals, all general hospitals operated by the New York City Health and Hospitals Corporation, and all other public general hospitals having annual inpatient operating costs in excess of \$25 million dollars. Medicaid and uninsured losses will be calculated in accordance with federal DSH Auditing and Reporting regulations 42 CFR Parts 447 and 455. Payments will be calculated on an annual basis and distributed in four quarterly installments.

TN #13-13Approval Date January 28, 2014Supersedes TN 09-34Effective Date January 1, 2013

**New York
161**

1905(a)(1) Inpatient Hospital Services

Additional Inpatient Governmental Hospital Payments

For the period beginning state fiscal year April 1, 2022, and ending March 31, 2023, the State will provide a supplemental payment for all inpatient services provided by eligible government general hospitals located in a city with a population over one million and not operated by the State of New York or the State University of New York. The amount of the supplemental payment will be \$395,836,204 and paid semi-annually in September and March. It will be distributed to hospitals proportionately using each hospital's proportionate share of total Medicaid days reported for the base year two years prior to the rate year. Such payments, aggregated with other medical assistance payments will not exceed 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state government owned or operated government general hospitals for the respective period.

TN #22-0039_____

Approval Date January 17, 2024_____

Supersedes TN #21-0033_____

Effective Date April 1, 2022_____

**New York
161(0)****Additional Inpatient Governmental Hospital Payments (Continued)**

For the state fiscal year beginning April 1, [2016] 2018 and ending March 31, [2017] 2019, the State will provide an additional supplemental payment for all inpatient services provided by eligible government general hospitals. To be eligible, hospitals must (1) be a government general hospital, (2) not be operated by the State of New York or the State University of New York, and (3) be located in a city with a population over one million. Also, all medical assistance payments when aggregated with both the supplemental payment and the additional supplemental payment will not exceed 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state government owned or operated government hospitals for this period.

The amount of the additional supplemental payment will be [the difference between the amount of \$393,987,995 and the previous supplemental payment amount of \$337,471,812 within the same year] \$64,814,765. Medical assistance payments will be made for all inpatient services for patients eligible for federal financial participation under Title XIX of the Federal Social Security Act and calculated using each such hospital's proportionate share of total Medicaid days of all eligible hospitals reported for the base period two years prior to the rate year.

TN **#18-0028-A**
Supersedes TN **#16-0035-A**

Approval Date **September 19, 2019**
Effective Date **April 1, 2018**

**New York
161(1)**

1905(a)(1) Inpatient Hospital Services

Voluntary Supplemental Inpatient Payments

Effective for the period July 1, 2010 through March 31, 2011, additional inpatient hospital payments are authorized to voluntary sector hospitals, excluding government general hospitals, for inpatient hospital services after all other medical assistance payments, of \$235,500,000 for the period July 1, 2010 through March 31, 2011; \$314,000,000 for the period April 1, 2011 through March 31, 2012; \$281,778,852 for the period April 1, 2012 through March 31, 2013; \$298,860,732 for the period April 1, 2013 through March 31, 2014; \$226,443,721 for the period April 1, 2014 through March 31, 2015; \$264,916,150 for the period April 1, 2015 through March 31, 2016; \$271,204,805 for the period of April 1, 2016 through March 31, 2017; \$319,459,509 for the period of April 1, 2017 through March 31, 2018; \$362,865,600 for the period of April 1, 2018 through March 31, 2019; \$182,541,796 for the period of April 1, 2019 through March 31, 2020; \$ 193,635,130 for the period of April 1, 2020 through March 31, 2021; \$275,082,185 for the period of April 1, 2021 through March 31, 2022; \$338,850,034 for the period of April 1, 2022 through March 31, 2023 subject to the requirements of 42 CFR 447.272 (upper payment limit) . Such payments are paid monthly to eligible voluntary sector owned or operated general hospitals, excluding government general hospitals.

Eligibility to receive such additional payments, and the allocation amount paid to each hospital, will be based on data from the period two years prior to the rate year, as reported on the Institutional Cost Report (ICR) submitted to the Department as of October 1 of the prior rate year.

- (a) Thirty percent of such payments will be allocated to safety net hospitals based on each eligible hospital's proportionate share of all eligible safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;
 - (i) Safety net hospitals are defined as non-government owned or operated hospitals which provide emergency room services having either: a Medicaid share of total inpatient hospital discharges of at least 35%, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least 30%, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services.
- (b) Seventy percent of such payments will be allocated to eligible general hospitals, which provide emergency room services, based on each such hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services;
- (c) No payment will be made to a hospital described in (i) and (ii). Payment amounts will be reduced as necessary not to exceed the limitations described in (iii).
 - (i) did not receive an Indigent Care Pool (ICP) payment;
 - (ii) the hospital's facility specific projected disproportionate share hospital payment ceiling is zero; or,
 - (iii) the annual payments amount to eligible hospitals exceeds the Medicaid customary charge limit at 42 CFR 447.271.
- (d) Any amounts calculated under paragraphs (a) and (b) but not paid to a hospital because of the requirements in paragraph (c) will be allocated proportionately to those eligible general hospitals that provide emergency room services and which would not be precluded by paragraph (c) from receiving such additional allocations.

TN **#22-0038**

Approval Date **January 17, 2024**

Supersedes TN **#21-0034**

Effective Date **April 1, 2022**

**New York
161(a)**

Medicaid disproportionate share payments.

1. For the rate periods commencing January 1, 1991 and thereafter, Medicaid disproportionate share payments shall be made to hospitals to reimburse a portion or all of the costs associated with serving those patients unable or unwilling to pay for services rendered.
2. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, uncompensated care need shall mean losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient services. The cost of services provided as an employment benefit or as a courtesy shall not be included.
3. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, targeted need shall be defined as the relationship of uncompensated care need to reported costs expressed as a percentage. Reported costs shall mean costs allocated as prescribed by the Commissioner to government general hospital inpatient services. Targeted need shall be determined based on base year data and statistics for the calendar year two years prior to the distribution period.
4. Nominal payment amount shall be defined as the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to the scale specified in this section. This paragraph sunsets on December 31, 2012.
5. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, targeted need share shall mean the relationship of each general hospital's nominal payment amount of uncompensated care need determined in accordance with the scale specified in this section to the nominal payment amounts of uncompensated care need for all eligible general hospitals applied to funds available for distribution pursuant to this section.
6. Major government general hospitals shall mean all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospital Corporation and all other government general hospitals having annual inpatient operating costs in excess of \$25 million. This paragraph sunsets on December 31, 2012.
7. Voluntary sector hospitals shall mean all voluntary non-profit, private proprietary and government general hospitals other than major government general hospitals. This paragraph sunsets on December 31, 2012.
8. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, uninsured care shall be defined as losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient services, which are not eligible for payment in whole or in part by a governmental agency, insurer or other third-party payor on behalf of a patient, including payment made

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**New York
161(b)**

directly to the government general hospital and indemnity or similar payments made to the person who is a payor of hospital services. The costs of services denied reimbursement, other than emergency room services, for lack of medical necessity or lack of compliance with prior authorization requirements, or provided as an employment benefit, or as a courtesy shall not be included.

9. In order to be eligible for distributions, a general hospital's targeted need must exceed one-half of one percent. This paragraph sunsets December 31, 2012.
10. For rate years commencing January 1, 1991 and prior to January 1, 1997, each eligible major government general hospital shall receive a portion of its bad debt and charity care need equal to 110 percent of the result of the application of the percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of Medicare, developed on the basis of 1985 financial and statistical reports, to the statewide resources for the rate year.
 - a. Statewide resources shall mean the sum of the result of multiplying a statewide average 5.48% by each general hospital's (including major government general hospitals and all other hospitals) rate year reimbursable inpatient costs used in the initial promulgation of rates, adjusted of case mix and volume changes, excluding inpatient costs related to services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare), and without consideration of inpatient uncollectible amounts, and including income from invested funds.
11. For rate periods commencing January 1, 1997 through December 31, [2014] 2012, each eligible major government general hospital shall receive an amount equal to the amount allocated to such major government general hospital for the period January 1, 1996 through December 31, 1996.
12. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, the balance of unallocated funds after the Medicaid disproportionate share payments are made in accordance with paragraph (11) of this section and funds are reserved for distribution as high need adjustments in accordance with paragraph (13) of this section and shall be distributed to eligible hospitals, excluding major government general hospitals, on the basis of targeted need share.
 - a. Need calculations shall be based on need data for the year two years prior to the rate year.

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**New York
161(b)(i)**

- b. For the rate periods commencing January 1, 1991 and prior to January 1, 1997, the scale specified in this section, and for rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, the scale specified in subparagraph (d) of this section shall be utilized to calculate individual hospital's nominal payment amounts on the basis of the percentage relationship between their need for the year two years prior to the rate year and their patient service revenues for the year two years prior to the rate year.
- c. The scale utilized for development of each hospital's nominal payment amount shall be as follows:

Targeted Need Percentage	Percentage of Reimbursement Attributable to the Portion of Targeted Need
0 – 1%	35%
1 - 2%	50%
2 – 3%	65%
3 – 4%	85%
4 – 5%	90%
5+ %	95%

- d. The scale utilized for development of each eligible government general hospital's nominal payment amount shall be as follows:

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161(c)**

Targeted Need Percentage	Percentage of Reimbursement Attributable to the Portion of Targeted Need
0 – 0.5%	60%
0.5+ % -2%	65%
2+ – 3%	70%
3+ – 4%	75%
4+ – 5%	80%
5+ – 6%	85%
6+ – 7%	90%
7+ – 8%	95%
8+ %	100%

13. Payments described in paragraph 2 of the High Need Indigent Care Pool subdivision shall be distributed as high need adjustments to general hospitals, excluding major government general hospitals, with nominal payment amount in excess of 4 percent of reported costs as follows: each general hospital's share shall be based on such hospital's aggregate share of nominal payment amount above 4 percent of reported costs compared to the total aggregate nominal payment amount above 4 percent of reported costs of all eligible hospitals. This paragraph sunsets on December 31, 2012.

TN #13-13

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Supersedes TN #10-26

Effective Date January 1, 2013

**New York
161(d)****1905(a)(1) Inpatient Hospital Services****Indigent Care Pool Reform – effective January 1, 2013**

The provisions of this section will be effective for the period January 1, 2013 through December 31, 2025.

(a) Indigent Care Pool Reform Methodology. Each hospital's uncompensated care nominal need will be calculated in accordance with the following:

- 1. Inpatient Uncompensated Care.** Inpatient units of service for uninsured (self-pay and charity) patients, as reported in Exhibit 32 of the Institutional Cost Report (ICR) for the calendar year two years prior to the distribution year for each inpatient service area which has a distinct reimbursement rate, excluding hospital-based residential health care facility (RHCF) and hospice units of service, will be multiplied by the applicable Medicaid inpatient rates in effect for January 1 of the distribution year.

Medicaid inpatient rates for acute and psychiatric services will be the statewide base price adjusted for hospital-specific factors including an average case mix adjustment plus all rate add-ons except the public goods surcharge. Medicaid inpatient rates for all other inpatient services will be the per diem rate, excluding the public goods surcharge add-on. Units of service for acute care services will be uninsured patient discharges; units of service for all other inpatient services will be uninsured patient days, not including alternate level of care (ALC) days.

- 2. Outpatient Uncompensated Care.** Outpatient units of service for those uninsured (self-pay and charity) patients reported in Exhibit 33 of the ICR for the calendar year two years prior to the distribution year, excluding referred ambulatory services and home health units of service, will be multiplied by the average paid Medicaid outpatient rates that reflect the exclusive utilization of the ambulatory patient groups (APG) rate-setting methodology; however, for those services for which APG rates are not available the applicable Medicaid rate in effect for January 1 of the distribution year will be utilized. The outpatient rates used are exclusive of the public goods surcharge.

Units of service for ambulatory surgery services will be uninsured procedures, not including those which result in inpatient admissions; units of service for all other outpatient services will be uninsured visits, not including those which result in inpatient admissions.

TN #23-0051

Approval Date September 18, 2023

Supersedes TN #20-0040

Effective Date April 1, 2023

**New York
161(e)**

- 3. Adjusted Inpatient Uncompensated Care.** The inpatient uncompensated care will be summed and adjusted by an inpatient statewide cost adjustment factor calculated as the statewide aggregate sum of the inpatient uninsured units multiplied by the step-down cost per unit for each applicable inpatient service, excluding hospital-based RHCF and hospice services, divided by the statewide aggregate sum of the inpatient uncompensated care.

Allowable step-down costs include the direct and indirect costs from the ICR for the calendar year two years prior to the distribution year. The direct costs are reported for each of the hospital's inpatient service areas on Exhibit 11, and adjusted for reclasses, adjustments to expenses, and post step-down adjustments as reported on Exhibits 12, 14, and 15 respectively. Indirect routine and ancillary costs for each inpatient service area are allocated to such based on the cost allocation statistics reported on Exhibits 19 and 20 of the ICR. The resulting direct and indirect allowable step-down costs are adjusted for transfers and converted to a per unit amount for each inpatient service, excluding hospital-based residential health care facility (RHCF) and hospice services, by dividing such costs by the total units for the service as reported in Exhibit 32 of the ICR for the calendar year two years prior to the distribution year.

- 4. Adjusted Outpatient Uncompensated Care.** The outpatient uncompensated care will be summed and adjusted by an outpatient statewide cost adjustment factor calculated as the statewide aggregate sum of the outpatient uninsured units of service multiplied by the step-down cost per unit for each applicable outpatient service, excluding referred ambulatory and home health services, divided by the statewide aggregate sum of the outpatient uncompensated care.

Allowable step-down costs include the direct and indirect costs from the ICR for the calendar year two years prior to the distribution year. The direct costs are reported for each of the hospital's outpatient service areas on Exhibit 11, and adjusted for reclasses, adjustments to expenses, and post step-down adjustments as reported on Exhibits 12, 14, and 15 respectively. Indirect routine and ancillary costs for each outpatient service area are allocated to such based on the cost allocation statistics reported on Exhibits 19 and 20 of the ICR. The resulting direct and indirect allowable step-down costs are adjusted for transfers and converted to a per unit amount for each outpatient service, excluding referred ambulatory and home health services, by dividing such costs by the total units for the service as reported in Exhibit 33 of the ICR for the calendar year two years prior to the distribution year.

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Supersedes TN NEW

Effective Date January 1, 2013

New York
161(f)

5. Total Net Adjusted Uncompensated Care. The adjusted inpatient and outpatient uncompensated care will be summed and reduced by the sum of all uncompensated care collections (cash payments) collected from inpatient and outpatient uninsured patients as reported in Exhibits 32 and 33 of the ICR for the calendar year two years prior to the distribution year to determine total net adjusted uncompensated care.

6. Nominal Need Factor. A nominal need factor will be calculated as the sum of:
a. 0.40; and
b. the Medicaid inpatient utilization rate multiplied by 0.60.

The Medicaid inpatient utilization rate will be calculated as the sum of Medicaid fee-for-service and Medicaid managed care discharges divided by the total inpatient discharges for the applicable inpatient services. The inpatient discharges used in this calculation will be from Exhibit 32 of the ICR for the cost reporting year two years prior to the distribution year.

7. Uncompensated Care Nominal Need. The total net adjusted uncompensated care will be multiplied by the nominal need factor to determine uncompensated care nominal need used to proportionally allocate the available indigent care pool funding described in paragraph (b) of the following Indigent Care Pool section.

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**New York
161(g)**

(b) Indigent Care Pool. Indigent care pool distributions will be made to eligible hospitals in the following amounts, as calculated on a calendar year basis which will be paid in twelve, approximately equal lump sum, monthly installments on a state fiscal year basis; except for distributions for Calendar year 2020 related to paragraph (5) which shall be made in ten approximately equal lump sum, monthly installments from June 2020 to March 2020:

- 1. Major Government General Hospital Pool Distributions.** \$139.4 million, less the amount allocated pursuant to the Financial Assistance Compliance Pool section in subparagraph 8) below, will be distributed as Medicaid disproportionate share hospital (DSH) payments to major government general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital's relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all major government general hospitals determined in accordance with the Indigent Care Pool Reform methodology described in [sub]paragraph [3] (a) of this section.

Major government general hospitals are defined as all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospital Corporation, and all other government general hospitals having annual inpatient operating costs in excess of \$25 million. Hospitals eligible for distributions from this pool will be all such major government general hospitals which are open for all or part of the distribution year. Hospitals open for a partial year will receive a pro-rated share based on the number of months open.

- 2. Voluntary General Hospital Pool Distributions.** \$994.9 million, less the amount allocated pursuant to the Financial Assistance Compliance Pool section in subparagraph (8) below and the Voluntary ICP Pool Reduction in subparagraph (4) below, plus the Enhanced Safety Net Transition Collar Pool in subparagraph (5) below will be distributed as Medicaid disproportionate share hospital (DHS) payments to eligible voluntary general hospitals, other than major public general hospitals, on the basis of each hospital's relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all eligible voluntary general hospitals as determined in accordance with the Indigent Care Pool Reform methodology described in paragraph (a) of this section. Distributions to voluntary general hospitals, other than major public general hospitals, relative to calendar year 2020 and calendar years thereafter made pursuant to this subparagraph shall not include transition pool distributions. Such reduced distributions shall not affect any hospital's relative share as determined in accordance with the Indigent Care Pool Reform methodology described in paragraph (a) of this section and shall reflect a reduction in the amount of the pool to \$969.9 million.

Voluntary general hospitals are defined as all voluntary non-profit, private proprietary, and government general hospitals other than major government general hospitals. Hospitals eligible for distributions from this pool will be all such voluntary hospitals which are open for all or part of the distribution year. Hospitals open for a partial year will receive a pro-rated share based on the number of months open.

TN #20-0040 _____

Approval Date September 11, 2020

Supersedes TN #13-0013 _____

Effective Date April 2, 2020

**New York
161(h)****1905(a)(1) Inpatient Hospital Services**

- 3. Transition Pool.** An eight-year transition pool utilizing a floor/ceiling model has been established to help hospitals avoid large funding swings. The transition pool funding will be generated through a redistribution of dollars from those hospitals which experience an increase in distributions using the new Indigent Care Reform Methodology to those that experience a decrease. Transition amounts will be determined based on a comparison of the distributions for the applicable calendar year 2013 through 2020 to an average of the annual distributions for the three year period January 1, 2010 through December 31, 2012.

A separate transition pool will be established for major government general hospitals and voluntary general hospitals. Individual hospital gains and losses in each pool will be capped by means of the following transition adjustments. Any adjustments provided pursuant to this subparagraph will not apply to distributions relative to calendar years beyond 2019.

TN #23-0051 Supersedes TN #20-0040 Approval Date September 18, 2023 Effective Date April 1, 2023

New York 161(i)

RESERVED

A	B	C	D	E	F	G	H	I	J	K	L	M
1	Sample Transition Period DSH Pool Payment Calculations											
2			Floor Pct.:	Ceiling Pct.:								
3	CY 2014		95.0%	109.9%								
4			(i)	(ii)								
5	Hospital Name	Indigent Care Pool Payment Before Transition Period Adjustment	Three Year Historical Average of Pool Payments (2010-2012)	Floor Amount	Ceiling Amount	Tentative Transition Period Payment	Financial Assistance Compliance Pool Carve-out (2014-2015)	Actual Transition Period Payment		Allocation Before Adjustment as Pct. of Three Year Avg	Tentative Transition Period Payment as Pct. of Three Year Avg	
6	(a)	(b)	(c)	(d)	(e)	(f)						
7												
8	Hospital A	\$25,000,000	\$18,000,000	\$17,100,000	\$19,782,000	\$19,782,000	\$454,106	\$19,327,894		138.9%	109.9%	
9	Hospital B	\$14,000,000	\$12,000,000	\$11,400,000	\$13,188,000	\$13,188,000	\$302,737	\$12,885,263		116.7%	109.9%	
10	Hospital C	\$20,000,000	\$19,600,000	\$18,620,000	\$21,540,400	\$20,000,000	\$459,110	\$19,540,890		102.0%	102.0%	
11	Hospital D	\$30,000,000	\$30,400,000	\$28,880,000	\$33,409,600	\$30,000,000	\$688,666	\$29,311,334		98.7%	98.7%	
12	Hospital E	\$27,000,000	\$31,000,000	\$29,450,000	\$34,069,000	\$29,450,000	\$676,040	\$28,773,960		87.1%	95.0%	
13	Hospital F	\$19,000,000	\$23,000,000	\$21,850,000	\$25,277,000	\$21,850,000	\$501,578	\$21,348,422		82.6%	95.0%	
14	Hospital G	\$4,400,000	\$5,400,000	\$5,130,000	\$5,934,600	\$5,130,000	\$117,762	\$5,012,238		81.5%	95.0%	
15	Statewide Totals	\$139,400,000	\$139,400,000	\$132,430,000	\$153,200,600	\$139,400,000	\$3,200,000	\$136,200,000				
16												
17												
18	✓	(1) Tentative Transition Period Payment:										
19		(a) Hospital name										
20		(b) The unadjusted amount that would otherwise be paid to each hospital under the new DSH pool allocation methodology beginning 1/1/2013										
21		(c) The actual average amount paid to each hospital under the prior DSH pool allocation methodology in CY's 2010 - 2012										
22		(d) The amount for each hospital in (c) multiplied by the Floor Percentage in (i)										
23		(e) The amount for each hospital in (c) multiplied by the Ceiling Percentage in (ii)										
24		(f) For each individual hospital, if the Indigent Care Pool Actual Transition Period Payment is:										
25		(1) < the Floor Amount, the Transition Period Payment is the Floor Amount										
26		(2) > the Ceiling Amount, the Transition Period Payment is the Ceiling Amount										
27		(3) Otherwise it is the amount in (b) calculated using the new DSH pool allocation methodology effective 1/1/2013.										
28		Using the formula =IF(Bn<Dn,Dn,IF(Bn>En,En,Bn))										
29												
30	✓	(2) Percentages:										
31		(i) The Floor Percentage equals 97.5% in 2013, 95.0% in 2014, and 92.5% in 2015										
32		(ii) A unique Ceiling Percentage is calculated using an iterative set of calculations where both:										
33		(1) the total transition payments equal the respective pool amounts, and										
34		(2) all the constraints in (f) are respected										
35		For instance, using the Excel Goal Seek data tool:										
36		Set Cell F15										
37		Equal to \$139,400,000										
38		By Changing Cell E2										
39												
40	✓	(3) Financial Assistance Compliance Pool Carve-out for 2014 & 2015:										
41		The carve out will be calculated by using each hospital's share of the \$139.4M allocation and										
42		applying that percentage to the \$3.2M in compliance pool funds.										
43												
44	✓	(4) This same process would apply to the Voluntary Allocations of \$994.9M										

TN #20-0040

Approval Date September 11, 2020

Supersedes TN #13-0013

Effective Date April 2, 2020

**New York
161(j)**

1905(a)(1) Inpatient Hospital Services

4. Voluntary ICP Pool Reduction. For calendar years 2020 through 2025, total distributions made to eligible voluntary general hospitals will reflect a reduction of one hundred fifty million dollars annually. For calendar years 2023 through 2025, total distributions made to eligible voluntary general hospitals will reflect an additional reduction of eighty five million four hundred thousand dollars annually. Hospitals that qualify as Enhanced Safety Net hospitals under §2807-c(34) of the Public Health Law in State Fiscal Year 2019-2020 are exempt from such reductions. The methodology to allocate the reduction will take into account the payor mix of each voluntary hospital, including the percentage of inpatient days paid by Medicaid. Such methodology will calculate the total public payor mix of each facility and calculate a statewide average public payor mix. For the purposes of this subparagraph, public payor mix means the percentage of total reported Medicaid and Medicare inpatient days, as reported in Exhibit 32 of the Institutional Cost Report (ICR) for the reporting period two years prior to the distribution year, where Medicaid and Medicare were the primary payors, out of total reported inpatient days which includes all inpatient services but excludes Alternate Level of Care days. Hospitals exceeding the calculated average of public payor mix will be exempt from reductions pursuant to this subparagraph. Hospitals that fall below the calculated average of public payor mix will be subject to a proportionate reduction pursuant to this subparagraph.

5. Enhanced Safety Net Transition Collar Pool. For calendar years 2020 through 2025, sixty-four million six hundred thousand dollars will be distributed to voluntary hospitals qualifying as Enhanced Safety Net Hospitals under §2807-c(34) of the Public Health Law in State Fiscal Year 2019-2020 that experience a reduction in their distribution year Indigent Care Pool payments when compared to their 2019 ICP payments. The methodology to allocate this funding will be proportional to the reduction received by the facility. The proportionate allocation will be equal to each qualifying Enhanced Safety Net Hospital's percentage share of total ICP losses when compared to CY 2019 distributions for all qualifying Enhanced Safety Net Hospitals.

6. Voluntary UPL Payment Reductions. The distributions in this section will be reduced by the final payment amounts paid to the eligible voluntary general hospitals, excluding government general hospitals, made in accordance with the Voluntary Supplemental Inpatient and Outpatient Payments section.

7. DSH Payment Limits. The distributions in this section are subject to the provisions of the Disproportionate share limitations section. Should a facility's total payments exceed its DSH cap, the facility will receive the State share only of any ICP award in excess of the hospital specific DSH limit as set out in paragraph 9 (Reconciliation and Redistribution of Overpayments) below.

8. Financial Assistance Compliance Pool. For calendar years 2014 through 2025, an amount equivalent to one percent of total DSH funds will be segregated into the Financial Assistance Compliance Pool (FACP) and allocated to all hospitals which prior to December 31, 2015 demonstrate substantial compliance with §2807-k(5-d)(b)(iv) of the Public Health Law (New York State Financial Aid Law) as in effect on January 1, 2013. There will be separate pool amounts for major governmental and voluntary hospitals. The DSH funds in the FACP will be proportionately allocated to all compliant hospitals using the Indigent Care Methodology described in paragraph (a) of this section. Compliance will be on a pass/fail basis. When a hospital is deemed compliant, one hundred percent of its share of the FACP funds will be released; there will be no partial payment for partial compliance. Any unallocated funds resulting from hospitals being non-compliant will be proportionally reallocated to compliant hospitals in each respective group based on their relative share of the distributions calculated in paragraph (a).

TN #23-0051

Approval Date September 18, 2023

Supersedes TN #20-0040

Effective Date April 1, 2023

**New York
161(j)(1)****1905(a)(1) Inpatient Hospital Services**

9. Reconciliation and Redistribution of Overpayments. The modeled distribution of hospital-specific ICP annual payments will be refreshed based on updated ICR and DSH Audit data. Any over or under payment will be reconciled and redistributed as soon as possible. The total pool amount is fixed; therefore, it is anticipated that any overpayments and underpayments will be balanced within the most recent schedule of hospital-specific ICP annual payments for the applicable State Plan Rate Year (SPRY) calculated pursuant to the approved State Plan and applicable State Law, calculated utilizing the most recently available data.

In the case of underpayments, the State will adjust the facility's payment going forward to ensure that the total amount received for each SPRY reflects the updated ICP Award Amount. In the case of overpayments, the State will immediately move any overpayment amount to a 100% State Share liability by adjusting ICP claiming. The State will then repay the liability by reducing future ICP dollars. When this is not possible, funds may be recouped by the State in order to resolve any overpayments which cannot be resolved by reducing or adjusting future Indigent Care Pool Payments. In all circumstances, the ICP payment amounts will be subject to a final reconciliation wherein it is ensured that no facility receives more than its individual model amount nor a Federal share in excess of its hospital specific DSH limit.

TN #23-0051 Supersedes TN NEW Approval Date September 18, 2023 Effective Date April 1, 2023

New York
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Additional disproportionate share payments.

Beginning April 10, 1997 and for annual periods beginning April 1, 1st 1998 and thereafter, 1998 through December 31, 2011, additional disproportionate share payments shall be paid to voluntary non-profit general hospitals. Such payments shall be limited to [not exceed] each such general hospital's cost of providing services to uninsured and Medicaid patients after taking into consideration all other medical assistance payments received, including disproportionate share hospital (DSH) payments made to such general hospitals and payments from and on behalf of such uninsured patients with the limitations based initially on reported data from the base year two years prior to the payment year and further reconciled to actual reported data from such payment year [and shall also not exceed the amount of state aid for which the hospital or its successor would have been eligible pursuant to the Funding for Substance Abuse Services and the Local Unified Services Sections of the Mental Hygiene Law (as described below) for fiscal year 1996-97, the Base Year. Such additional disproportionate share payments will be calculated by aggregating net approved operating costs for such mental health and/or alcoholism or substance abuse programs in each hospital. Net operating costs are defined as operating costs offset by revenues, other income, federal aid and fees. The payments may be made as quarterly aggregate payments to an eligible hospital]. Such payments shall not exceed the limit specified on the Disproportionate Share limitations section of this attachment.

[Payments beginning April 1, 1998 and thereafter will be related to the hospital's willingness to continue to provide services previously funded by state aid grants. The Commissioners of the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS), in consultation with county directors of community services, will annually designate to the Department of Health those general hospitals eligible for the additional disproportionate share payment, and the amount thereof. If a hospital does not continue to provide substantially the same level of program and/or services as in the Base Year, the local governmental unit can recommend to the Commissioner of OMH and/or the Commissioner of OASAS that the provider not be designated to receive disproportionate share payments for mental health and/or substance abuse and alcoholism services in the future. In addition, if a hospital reduces its deficit from that of the Base Year, either as a result of increased program revenues, or as a result of program or service cutbacks, or as a result of lower costs, the local governmental unit can recommend to OMH and/or OASAS that the additional disproportionate share payment be reduced commensurate with the decrease in the deficit.

Services funded under the Local and Unified Services Section of the Mental Hygiene Law include mental health services. Alcoholism services funded under the Local and Unified Services section of the Mental Hygiene Law include health and alcoholism treatment services. Substance abuse services funded under Funding for Substance Abuse Services Section of the Mental Hygiene Law include health and substance abuse services.]

Payments to voluntary general hospitals providing mental health services for the period April 1, 2010 – December 31, 2010 and January 1, 2011 – December 31, 2011. The payment amounts apply consistently to voluntary general hospitals providing mental health services, and are reasonably related to costs, and are pursuant to the following schedule:

TN	<u> #10-04 </u>	Approval Date	<u> September 29, 2011 </u>
Supersedes	<u> #09-34 </u>	Effective Date	<u> April 1, 2010 </u>

New York
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Hospital	<u>April 1, 2010 –December 31, 2010</u>	<u>January 1, 2011 –December 31, 2011</u>
	<u>\$ 26,462,568</u>	<u>\$ 29,290,399</u>
	<u>OMH DSH Distributions to the Voluntary Hospitals</u>	<u>OMH DSH Distributions to the Voluntary Hospitals</u>
Bassett Healthcare	943,686	1,248,400
Benedictine Hospital	62,163	4,160
Beth Israel Medical Center	1,212,066	1,604,850
Bronx-Lebanon Hospital Center	740,049	696,611
Brookdale Hospital Medical Center	1,083,018	1,422,646
Carthage Area Hospital	77,418	0
Clifton Springs Hospital	57,528	76,074
Cortland Memorial Hospital	83,631	108,283
Ellis Hospital	675,282	637,756
Episcopal Health Services, Inc	606,489	774,063
Flushing Hospital and Medical Center	123,372	82,248
Glens Falls Hospital	603,378	607,170
Good Samaritan Hospital Reg Med Ctr	169,419	123,085
Interfaith Medical Center	1,256,433	1,029,351
Kaleida Health	227,604	151,738
Kingsbrook Jewish Medical	197,184	253,051
Long Island Jewish Medical Center	624,630	814,626
Maimonides Medical Center	2,061,948	2,053,498
Mercy Medical Center	86,421	57,607
Mount Sinai Hospital	1,381,293	1,187,020
Mount Vernon Hospital	106,260	137,117
New York Presbyterian Hospital	1,893,480	2,233,985
Niagara Falls Comm MH Center	385,965	506,400
North Shore Univ Hospital	586,014	0
Olean General Hospital	91,296	117,162
Orange Regional Medical Center	54,924	72,629
Oswego Hospital Mental Health Div	260,232	0
Our Lady of Lourdes Memorial Hospital	34,002	0
Phelps Memorial Hospital Center	221,226	284,774
Putnam Hospital Center	97,749	129,255
Richmond University Medical Center	989,730	828,765
Rochester General Hospital	64,731	85,594
Samaritan Medical Center	154,836	103,224
Sound Shore Med Ctr of Westchester	54,861	42,307
South Nassau Com Hospital	170,037	113,375
St Barnabas Hospital	610,992	798,468
St Joseph's Hospital Health Center	1,221,312	1,567,059
St Joseph's Medical Center	313,698	2,842,434
St Luke's-Roosevelt Hospital Center	919,176	1,215,464
St Vincent's Catholic MC of NY	1,908,708	0
Strong Memorial Hospital	1,848,738	2,417,142
The Unity Hospital of Rochester	1,186,143	1,524,260
United Health Services Hospital	1,015,446	1,338,748
Total	<u>26,462,568</u>	<u>29,290,399</u>

TN #10-04Approval Date September 29, 2011Supersedes #09-34Effective Date April 1, 2010

New York
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Payments to voluntary general hospitals providing alcohol and substance abuse services for the period April 1, 2010 – December 31, 2010 and January 1, 2011 – December 31, 2011. The payment amounts apply consistently to voluntary general hospitals providing alcohol and substance abuse services, and are reasonably related to costs, and are pursuant to the following schedule:

<u>Hospital</u>	<u>April 1, 2010 – December 31, 2010</u>	<u>January 1, 2011 – December 31, 2011</u>
	<u>\$ 15,469,267</u>	<u>\$ 18,308,116</u>
	<u>OASAS DSH Distributions to the Voluntary Hospitals</u>	<u>OASAS DSH Distributions to the Voluntary Hospitals</u>
<u>Beth Israel Medical Center</u>	<u>9,243,739</u>	<u>12,334,244</u>
<u>Interfaith Medical Center</u>	<u>144,173</u>	<u>96,115</u>
<u>Montefiore Hospital & Medical Center</u>	<u>1,162,710</u>	<u>1,085,387</u>
<u>Mount Sinai Hospital</u>	<u>384,500</u>	<u>256,333</u>
<u>New York Presbyterian Hospital</u>	<u>335,471</u>	<u>447,294</u>
<u>Richmond University Medical Center</u>	<u>1,403,298</u>	<u>1,871,064</u>
<u>St Luke's – Roosevelt Hospital Center</u>	<u>897,294</u>	<u>1,196,392</u>
<u>St Vincent's Hospital & Medical Ctr of NY</u>	<u>1,507,819</u>	<u>500,937</u>
<u>Staten Island University Hospital</u>	<u>390,263</u>	<u>520,350</u>
<u>Total</u>	<u>15,469,267</u>	<u>18,308,116</u>

TN #10-04Approval Date September 29, 2011Supersedes #09-34Effective Date April 1, 2010

New York
165

Reimbursement for language assistance services in hospital inpatient settings:

Effective for hospital inpatient services provided on and after September 1, 2012, a Medicaid rate of payment for language interpretation services provided to patients with limited English proficiency (LEP) and communication services provided for patients who are deaf and hard of hearing will be established as follows:

- (1) Payment will be established on a per unit basis, with the unit of payment based on the number of minutes of language assistance services provided.
- (2) A maximum of two billable units of language assistance services will be allowable per patient per day with the billable units defined as follows:
 - i) 1st billable unit – for encounters providing one to 22 minutes of language assistance service.
 - ii) 2nd billable unit – for encounters providing additional minutes (23+) beyond the initial 22 minutes of language assistance services during the given patient day.
- (3) The rate of payment will be established at \$11.00 per unit of language assistance services, with a maximum payment per inpatient day of care of \$22.00. Such payment will be available on an "as provided only" basis via a separate and discretely billed rate, and will supplement the applicable DRG or exempt unit per diem payment for the given inpatient stay to account for the additional costs of inpatient services involving language assistance services.
- (4) To be reimbursable, the language assistance services must be provided by an independent third party, a dedicated hospital employee or a third party vendor (e.g., telephonic interpretation service) whose sole function is to provide interpretation services for individuals with LEP and communication services for patients who are deaf and hard of hearing.

TN #12-28

Approval Date March 27, 2013

Supersedes NEW

Effective Date September 1, 2012

Attachment A

Deleted Pages:

Pages 103, 104, 104(a), 105, 106, 106(a), 107, 108, 108(a), 109, 109(a), 110, 110(a), 111, 111(a), 112, 112(a), 112(b), 112(c), 112(d), 112(e), 112(f), 112(f)(1), 112(f)(2), 112(g), 112(h), 113, 113(a), 113(b), 113(b)(1), 113(b)(2), 113(b)(2)(i), 113(b)(2)(ii), 113(b)(3), 113(c), 114, 114(a), 114(b), 115, 116, 117, 117(a), 117(a)(1), 117(b), 117(c), 117(d), 117(e), 118, 118(a), 119, 120, 120(a), 121, 121(a), 122, 123, 124, 125, 126, 127, 127(a), 128, 129, 130, 131, 131(a), 131(b), 131(c), 131(c)(1), 131(d), 131(e), 131(f), 131(g), 131(h), 132, 132(a), 133, 134, 134(a), 135, 136, 136(a), 136(b), 136(b)(1), 136(b)(2), 136(b)(3), 136(c), 136(c)(1), 136(d), 136(e), 137, 137(a), 138, 139, 139(a), 140, 141, 141(a), 142, 142(a), 143, 143(a), 144, 144(a), 144(b), 144(b)(1), 144(c), 144(d), 144(e), 145, 145(a), 145(b), 145(c), 145(d), 146, 146(a), 146(a)(1), 147, 148, 148(a), 148(b), 149, 149(a), 149(a)(i), 149(a)(ii), 149(a)(1), 149(a)(2), 149(b), 149(c), 149(d), 149(e), 150, 150(a), 151, 151(a), 152, 152(a), 153, 153(a), 153(b), 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 165(a), 165(b), 165(c), 165(d), 165(e), 165(f), 165(g), 165(h), 165(i), 165(j), 165(k), 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 175(a), 175(b), 175(c), 175(d), 175(d)(1), 175(d)(2), 175(d)(3), 175(d)(4), 175(d)(5), 175(d)(6), 175(d)(7), 175(d)(8), 175(d)(9), 175(d)(10), 175(d)(11), 175(d)(12), 175(d)(13), 175(d)(14), 175(d)(15), 175(d)(16), 175(d)(17), 175(d)(18), 175(d)(19), 175(d)(20), 175(d)(21), 175(d)(22), 175(d)(23), 175(d)(24), 175(d)(25), 175(D)(26), 175(D)(27), 175(D)(28), 175(D)(29), 175(D)(30), 175(D)(31), 175(D)(32), 175(D)(33), 175(D)(34), 175(D)(35), 175(D)(36), 175(D)(37), 175(D)(38), 175(D)(39), 175(D)(40), 175(D)(41), 175(D)(42), 175(D)(43), 175(D)(44), 175(D)(45), 175(D)(46), 175(D)(47), 175(D)(48), 175(D)(49), 175(D)(50), 175(e), 176, 176(a), 176(b), 176(c), 176(c)(1), 176(d), 176(e), 176(f), 176(g), 176(h), 176(i), 176(j), 176(k), 176(l), 176(m), 176(n), 176(o), 176(p), 176(q), 176(r), 176(s), 176(t), 176(u), 176(v), 176(w), 176(x), 176(x)(1), 176(x)(2), 176(x)(3), 176(x)(4), 176(x)(5), 176(x)(6), 176(x)(7), 176(x)(8), 176(x)(9), 176(x)(10), 176(x)(11), 176(x)(12), 176(x)(13), 176(x)(14), 176(x)(15), 176(x)(16), 176(x)(17), 176(x)(18), 176(x)(19), 176(x)(20), 176(x)(21), 176(x)(22), 176(x)(23), 176(x)(24), 176(x)(25), 177, 177(a), 178, 179, 179(a), 180, 180(a), 180(b), 180(c), 180(d), 180(e), 180(f), 180(g), 180(g)(1), 180(h), 180(i), 181, 181(a), 181(b), 182, 182(a), 183, 183(a), 184, 184(a), 185, 185(a), 185(b), 186, 187, 188, 188(a), 188(a)(1), 188(b), 188(b)(A), 188(b)(B), 188(b)(C), 188(b)(D), 188(b)(E), 188(b)(1), 188(b)(2), 188(b)(3), 188(b)(4), 189, 189(a), 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 210(a), 210(b), 211, 211(a), 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 222(a), 223, 224, 225, 226, 226(a), 226(b), 227, 228, 229, 230, 230(a), 230(b), 230(c), 230(d), 231, 231(a), 232, 232(a), 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 246(a), 246(b), 246(c), 246(d), 246(e), 246(f), 247, 248, 248(a), 248(a)(1), 248(b), 248(b)(1), 249(a), 249, 249(a)(1), 249(a)(2), 249(a)(3), 249(b), 249(c), 249(d), 249(d)(1), 249(e), 250, 251, 252, 253, 253(a)

Note: The State does not have a Page 233

Attachment B

New Pages:

Pages 103, 104, 105, 105(a), 106, 107, 108, 109, 109(a), 110, 111, 112, 113, 114, 115, 116, 117, 117(a), 117(b), 117(c), 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 136(a), 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162

APPENDIX I

TN #88-6

Supersedes TN NEW

Approval Date August 1, 1991

Effective Date January 1, 1988

New York
1

ITEM	PROXY
<u>Labor</u>	
<u>Executive, Administrative and Managerial Personnel</u>	<u>ECI-Civilian-Compensation-Executive, Administrative and Managerial 1/</u>
<u>Professional and Technical Personnel</u>	<u>ECI-Civilian-Compensation-Professional and Technical 1/</u>
<u>All Other Personnel</u>	<u>1. ECI-Civilian-Compensation-Service Occupation 41.1% 1/</u> <u>2. ECI-Civilian-Compensation-Clerical 45.0% 1/</u> <u>3. ECI-Civilian-Compensation-Blue Collar 8.9% 1/</u> <u>4. ECI-Compensation-Private Industry-Workers-Union-Service Producing Industries 5.0% 1/</u>
<u>Regional Adjustment Factor</u>	<u>Average hourly earnings industry composite-New York and U.S. – 50% CPI-U-New York City Area, Buffalo Area, Northeast Size b, Northeast Size C., U.S. – 50%</u>
<u>Administrative and General</u>	
<u>Telephone</u>	<u>Telephone rate index</u>
<u>Postage</u>	<u>Consumer Price Index (CPI-W)</u>
<u>Insurance- malpractice and umbrella</u>	<u>Malpractice survey</u>
<u>Insurance-General liability and property</u>	<u>General Liability insurance rates</u>
<u>Insurance Automobile</u>	<u>Automobile insurance (ECI)</u>
<u>Insurance-Other</u>	<u>Insurance Composite</u>

TN #98-06Approval Date April 6, 2000Supersedes TN #95-06Effective Date January 1, 1998

New York
2

ITEM	PROXY
<u>Legal Fees</u>	<u>ECI-Compensation-Private Industry Workers- Professional Specialty & Technical 1/</u>
<u>Accounting Fees</u>	<u>ECI-Compensation-Private Industry Workers- Executive, Administrative and Managerial 1/</u>
<u>Office Supplies</u>	<ol style="list-style-type: none"> 1. <u>Office Supplies & Accessories (PPI) – 40%</u> 2. <u>Office Machines NEC – 12.5% (PPI)</u> 3. <u>Writing and Printing Papers – 20% (PPI)</u> 4. <u>Pens, Pencils and Marking Devices – 12.5% (PPI)</u> 5. <u>Classified Advertising – 7.5% (PPI)</u> 6. <u>Periodicals, Circulation – 7.5% (PPI)</u>
<u>Management Consulting Fees</u>	<u>Average hourly earnings – Management and Public Relation Services 2/</u> <ol style="list-style-type: none"> a. <u>ECI Private Industry Workers – Compensation – Executive, Administrative and Managerial 3/</u> b. <u>ECI – Private Industry Workers – Wages and Salaries – Executive, Administrative and Managerial 3/</u>
<u>Data Processing</u>	<u>Average Hourly Earnings – Computer and Data Processing Services 2/</u> <ol style="list-style-type: none"> a. <u>ECI- Private Industry Workers – Compensation-Professional Specialty and Technical 3/</u> b. <u>ECI-Private Industry Workers-Wages and Salaries-Professional Specialty and Technical 3/</u>
<u>Interest Expense – Working Capital</u>	<u>Predominant prime time</u>
<u>Real Estate Taxes</u>	<ol style="list-style-type: none"> 1. <u>NYC tax rates</u> 2. <u>Upstate overall tax rates</u>
<u>Dietary</u>	<ol style="list-style-type: none"> 1. <u>All Foods (PPI) – 40%</u> 2a. <u>Food at Home, U.S. City average (CPI) or</u> 2b. <u>Food at Home, NY-NENJ (CPI) – 40%</u> 3. <u>Cups and Liquid – Tight Containers (PPI) – 3%</u> 4. <u>Tableware, Serving Pieces, and Nonelectric Kitchenware (CPI) – 7%</u> 5a. <u>Food Away From Home, (CPI) U.S. City average or</u> 5b. <u>Food Away From Home, NY-NENJ (CPI) – 10%</u>

TN #98-06Approval Date April 6, 2000Supersedes TN #95-06Effective Date January 1, 1998

New York
3

ITEM	PROXY
<u>Operation and Maintenance of Plant</u>	
<u>Maintenance & Repairs</u>	<u>Maintenance & Repairs (CPI)</u>
• <u>#2 Fuel Oil</u>	<u>Price, Tank Car Reseller, NYC & Albany</u>
• <u>#6 Fuel Oil</u>	<u>Price, Tank Car Reseller, NYC & Albany</u>
• <u>Natural gas</u>	<u>NYSDPS data for Brooklyn Union, Central Hudson, Columbia Gas, Con-Ed, L.I. Lighting, National Fuel Dist., Niagara Mohawk, NYS Electric & Gas, Orange & Rockland, Rochester Gas & Electric</u>
• <u>Purchased Steam</u>	<u>NYSDOH Price Index for Con-Ed purchased steam</u>
• <u>Electric Power</u>	<u>NYSDPS price index for Con-Ed, L.I. Lighting, Orange & Rockland, Central Hudson, NYS Electric & Gas, Niagara Mohawk, Rochester Gas & Electric</u>
• <u>Water and Sewer</u>	<u>Water and Sewerage Maintenance (CPI)</u>
• <u>Waste Disposal</u>	<u>Refuse Collection (CPI)</u>
• <u>Laundry and Linen</u>	<u>Laundry and Dry Cleaning Other than Coin Operator (CPI)</u>
• <u>Housekeeping</u>	<u>1. Soap and Synthetic Detergents – 40% (PPI)</u> <u>2. Unsupported Plastic Film and Sheeting – 30% (PPI)</u> <u>3. Sanitary Papers and Health Products – 30% (PPI)</u>
• <u>Security</u>	<u>ECI-Private Industry Worker- Compensation-Service Occupation 1/</u>

TN #98-06Supersedes TN #95-06Approval Date April 6, 2000Effective Date January 1, 1998

New York
4

ITEM	PROXY
Professional Services	
• <u>Maintenance & Repairs</u>	<u>Equipment/ECI-Private Industry Workers-Compensation-Service Industry 1/</u>
• <u>Drugs</u>	<ol style="list-style-type: none"> 1. <u>Preparations, Ethical (Prescription) (PPI) – 72.0%</u> 2. <u>Preparation, Prop. (Over the Counter) (PPI) – 5.0%</u> 3. <u>Prescription Drugs (CPI) – 23.0%</u>
• <u>Medical Supplies</u>	<ol style="list-style-type: none"> 1. <u>Medical Instruments and Apparatus – 45% (PPI)</u> 2. <u>Surgical Appliances and Supplies – 55% (PPI)</u>
• <u>Non-Medical Supplies</u>	<ol style="list-style-type: none"> 1. <u>Office Supplies & Accessories (PPI) – 40%</u> 2. <u>Office Machines NEC – 12.5% (PPI)</u> 3. <u>Writing and Printing Papers – 20% (PPI)</u> 4. <u>Pens, Pencils and Marking Devices – 12.5% (PPI)</u> 5. <u>Classified Advertising – 7.5% (PPI)</u> 6. <u>Periodicals, Circulation – 7.5% (PPI)</u>
• <u>Physicians Fees</u>	<u>Physicians' Services (CPI) 4/</u>
• <u>Other Medical Professional</u>	<u>ECI-Compensation-Civilian-Professional Specialty and Technical 1/</u>
• <u>X-Ray Film</u>	<u>Change in manufacturer's list prices</u>
• <u>Reagents</u>	<u>Reagents (PPI)</u>
• <u>Travel and Conference</u>	<u>Private Transportation (CPI)</u>
• <u>Employment Agency Fees- Nursing</u>	<u>ECI-Private Industry Workers-Compensation-Professional Specialty and Technical 1/</u>
• <u>Employment Fees</u>	<u>ECI- Civilian - Compensation – Clerical 1/</u>

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Appendix II

TN #89-46

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New York

1

PHASE I HOSPITALS

Albany Medical Center
Auburn Memorial
Beth Israel Medical Center
Bronx-Lebanon
City Hospital at Elmhurst
Community Hospital Western Suffolk
Cortland Memorial
Ellis Hospital
Erie County Medical Center
Long Beach Memorial
Maimonides
Mercy Hospital, Rockville
Metropolitan Hospital
Nassau County Medical Center
Niagara Falls Memorial
St. Joseph's, Yonkers
St. Luke's Roosevelt
St. Vincent's, NYC
St. Vincent's, Richmond
Southside Hospital
State University- Upstate
Strong Memorial
Summit Park
SUNY Stony Brook
United Health Services
Westchester County MC
Women's Christian
Woodhull

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New York

2

PHASE II HOSPITALS

Bayley Seton Hospital
Buffalo General Hospital
Cabrini Medical Center
Central General Hospital
Champlain Valley Hospital
Clifton Springs Hospital
Coney Island Hospital
Eastern Long Island Hospital
Franklin General Hospital
Genesee Hospital
Glens Falls Hospital
Good Samaritan Hospital of Suffern
Harlem Hospital
Mary Imogene Bassett
Montefiore Medical Center
North Central Bronx Hospital
Presbyterian Hospital
Queens Hospital
Samaritan Hospital
Saratoga Hospital
St. Barnabas Hospital
St. Francis Hospital
St. James Mercy Hospital
St. Mary's Hospital
St. Vincent's Hospital- Westchester

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