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METHODS AND STANDARDS OF SETTING PAYMENT RATES FOR INPATIENT SERVICES PROVIDED BY HOSPITALS OPERATED BY THE NEW YORK STATE OFFICE OF MENTAL HEALTH

In accordance with the Mental Hygiene Law the office of Mental Health (OMH) establishes Medicaid inpatient rates of reimbursement, subject to the approval of the Director of the State Division of the Budget, for the psychiatric hospitals it operates. Statewide average payment rates shall be established for each of the rate categories outlined below under section I. The rates shall be established on a prospective basis in advance of the payment year.

I. [GENERAL] RATE CATEGORIES

[A separate rate is established for each of the following categories:]

[1] A. Adult Services

This rate category includes all inpatient units located at OMH Medicare and Medicaid certified Psychiatric Centers with the exception of Forensic Psychiatric Centers and discrete specialized unit for children and youth for which separate rate categories are established.

[2] B. Children's Services

This rate category applies to those separate and distinct Children's Units operated by the OMH. The Children's Units provide psychiatric care and treatment exclusively to children and/or adolescents. These Children's Units are located both within OMH Medicare and Medicaid certified psychiatric centers as well as in separately accredited Children's Psychiatric Centers certified only under the Medicaid Program.

[3] C. Forensic Psychiatric Centers

This rate category applies to those separate and distinct inpatient facilities that provide services to clients involved with the criminal justice system. These facilities provide a highly secure treatment environment for patients who are too dangerous to be treated in State civil psychiatric centers.

[Medicaid inpatient rates for each category are established prospectively on a statewide basis by averaging together each of the per diem rate components outlined below for all Medicaid certified facilities.]

II. BASE YEAR [OPERATING] PER DIEM

[The operating per diem of the inpatient Medicaid rates is developed by averaging together the following:] Allowable base year costs shall be determined as follows:

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**A. Medicare Certified Psychiatric Centers (including Forensic Psychiatric Centers)**

1. [Inpatient routine and ancillary per diem cost shall be obtained from the Medicare final settled cost reports for the fiscal year ended March 31, 2002.] The inpatient rates effective on and after April 1, 2019 will use the inpatient routine and ancillary per diem costs obtained from the Medicare final settled cost reports (CMS 2552) for the fiscal year ended March 31, 2016. The inpatient rates will be rebased no less frequently than every six years using the most currently available Medicare final settled cost reports. The next such rebasing will occur no later than the state fiscal year beginning April 1, 2025. [Medicare final settlements are issued by OMH's Medicare Fiscal Intermediary following their review and audit of the Medicare cost reports submitted by OMH for each of the Medicare participating providers it operates.]
2. Medicare final settlements are issued by the Centers for Medicare and Medicaid Services' Medicare Administrative Contractor (MAC) responsible for New York State following their review and audit of the Medicare cost reports submitted by OMH for each of the Medicare participating providers it operates.
3. [2.] Allowable inpatient cost [shall] will be inclusive of capital cost and [shall] will be determined without consideration of the Medicare facility-specific target rate limits or the Medicare national 75<sup>th</sup> percentile caps under 42 CFR § 413.40.
4. [3.] Allowable cost [shall] will include the professional services of hospital-based physicians. The allowable cost of physicians services [shall] will be determined subject to the Medicare reasonable compensation equivalent (RCE) limits under 42 CFR § 415.70. For purposes of applying this limitation the most recently issued RCE limits [shall] will be trended to the applicable rate year based upon the increase in the Consumer Price Index for All Urban Consumers (CPI-U).

**B. Children's Psychiatric Centers**

Since the Children's Psychiatric Centers are not Medicare participating providers Medicare final settlements are not processed for these providers. As such, the allowable inpatient cost for these facilities [shall] will be determined in accordance with the cost reporting and cost-finding methods developed by the Hospital industry as adopted by the Medicare (Title XVIII) and Medicaid (Title XIX) Programs. In determining those items of cost that [shall] will be determined to be allowable, Medicaid (Title XIX) laws, rules and regulations [shall] will be applied in accordance with paragraph III.A. below. Children's Psychiatric Center base year per diems will be updated in accordance with the same schedule and methodology as Medicare Certified Psychiatric Centers referenced under paragraph II. A. above.

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**III. ADJUSTMENTS FOR MEDICAID PURPOSES**

In determining the allowable base year operating per diem outlined under paragraph II above adjustments [shall] will be made to reflect the following:

**A. Differences in Medicare vs. Medicaid Covered Services**

The final Medicare inpatient payment rates as referenced under paragraphs II.A. and II.B. above [shall] will be adjusted to exclude the costs of any services included therein which have been determined to be non-reimbursable under the Medicaid Program. In addition the costs associated with any services covered under New York State's Medicaid Program but not reimbursable under the Medicare program (e.g. dental services) [shall] will be added to determine Medicaid allowable costs.

**IV. TREND FACTOR**

A trend factor [shall] will be utilized in order to project the base year operating per diems as developed under paragraphs II and III above to the applicable rate year. This trend factor will be developed by compounding the applicable increases in the Medicare [RPL (rehabilitation, psychiatric and long-term care)] Inpatient Psychiatric Facilities (IPF) market basket index between the base year and the rate year. In calculating the current year's rates the OMH [shall] will utilize estimates in instances where the actual increase in the [RPL] IPF market basket has

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not yet been determined for any particular years between the base year and the rate year. Once the actual increases in the [RPL] IPF have been determined the OMH will include an adjustment in the subsequent year's rate to compensate for any difference between the estimated and actual increases in the [RPL] IPF market basket. For purposes of this section the Medicare [RPL] IPF market basket index is that published by the Federal Centers for Medicare and Medicaid Services (CMS) for determining Medicare reimbursement to psychiatric hospitals under the inpatient psychiatric facilities prospective payment system (IPFs PPS).

**[V. ACCREDITATION ADJUSTMENT**

A per diem adjustment shall be incorporated in the inpatient Medicaid rates for OMH facilities to account for additional costs incurred subsequent to the base year used to develop the operating per diem pursuant to paragraph II above in order to meet minimum Medicaid and Medicare facility accreditation requirements. In addition, this adjustment may include additional accreditation costs expected to be incurred during the year for which the payment rates are being computed. For purposes of determining expected accreditation costs to be incurred during the rate year the Governor's Executive Budget submission to the legislature shall be utilized.]

**[VII]V. VOLUME ADJUSTMENT**

A per diem adjustment will be incorporated in the inpatient Medicaid rates for OMH facilities to account for

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An estimated volume adjustment will be calculated and included in the rate calculation. The estimated volume adjustment will be calculated based upon the projected patient days for the upcoming rate year vs. the actual patient days for the base year used to calculate the rates. Following the close of the rate year a comparison would be made between the projected days used in calculating the estimated volume adjustment and the actual days incurred for the rate year. The volume adjustment will then be recalculated to reflect the actual days for the rate year. The difference, if [in] any, between the estimated volume adjustment and the final actual volume adjustment will be included as an [retroactive] adjustment in the rate for the following year.

If it is determined by a utilization review committee that a Medicaid recipient no longer requires psychiatric hospital services but must remain in the hospital because a medically necessary skilled nursing facility or intermediate care facility bed is not available in the community ("alternate care day") and it is determined that the statewide rate of occupancy

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of operational beds at OMH hospitals is less than 80%, the hospital will be reimbursed at the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate. Operational beds are defined as the projected census for the upcoming year for the Office of Mental Health psychiatric hospital system as derived from the Executive Budget. In determining whether the statewide occupancy rates meets the 80% requirement, for purposes of determining the applicable reimbursement rate, alternate care days will not be counted as occupied beds.

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5(b)**

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

**VII. ADDITIONAL INPATIENT STATE PUBLIC HOSPITAL UPPER PAYMENT LIMIT  
(UPL) ADJUSTMENTS**

1. Effective for State UPL demonstrations for calendar year 2020 and after, if CMS determines that payments for inpatient hospital services provided by State government-owned hospitals exceed the UPL, the State will remit such amount in excess of the UPL as follows: The State will process a lump sum reduction equivalent to the value of the UPL excess upon approval of the UPL.
2. For the period beginning January 1, 2020, and each calendar year thereafter, the State will provide a supplemental payment for all inpatient services provided by State government-owned hospitals. The amount of the supplemental payment, when 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 State government-owned hospitals. Such a supplemental payment will be allocated and paid to OMH-operated hospitals based on the proportionate share of total base year Medicaid days used for the inpatient rate calculation and will be factored into facility-specific Disproportionate Share (DSH) limit calculations.

For the period January 1, 2022, through December 31, 2022, the supplemental payment will be \$24,622,791 and will be payable as a one-time lump sum.

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IX. DISPROPORTIONATE SHARE ADJUSTMENT

The Medicaid payment rates for OMH facilities will be adjusted in accordance with Sections 1902 (a)(13)(A) and 1923 of the Social Security Act to account for the situation of OMH facilities which serve a disproportionate number of low income patients with special needs. The adjustment will be made if either the Medicaid inpatient utilization rate for OMH hospitals is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or if the low income utilization rate for OMH hospitals exceeds 25 percent.

The Medicaid inpatient utilization rate is defined as the total number of Medicaid inpatient days in a cost reporting period divided by the total number of hospitals inpatient days in that same period.

The low income utilization rate is defined as the sum (expressed as a percentage) of the fraction calculated as follows:

- Total Medicaid patient revenues paid to the hospital, plus the amount of cash subsidies received directly from State and local governments for the latest available cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and
- The total amount of the hospital's charge for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period less the portion of cash subsidies reasonably attributable to inpatient hospital services, divided by the total amount of the hospital's charges for inpatient service in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third-party payers, such as HMO's, Medicare and Blue Cross.

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Those OMH hospitals that qualify as a disproportionate share hospital will receive a payment adjustment to [fully] reimburse the hospital for the unreimbursed costs incurred in providing services to individuals who are either eligible for medical assistance or who have no health insurance or other source of third party coverage for the services provided. The OMH hospitals, in aggregate, will be paid DSH equal to 100% of the federal mental health facility DSH allotment.

For OMH hospitals, the State Plan rate year shall be defined as running from April 1 of a calendar year through March 31 of the subsequent calendar year. The four-digit State Plan rate year will be the year that contains the end date of period. For example, State Plan rate year 2011 will be the period from April 1, 2010 through March 31, 2011.

Due to State's reliance on Section 1923(e) of the Social Security Act, OMH hospitals will be deemed disproportionate share hospitals without regard to the requirements of Section 1923(d)(1) of the Social Security Act.

**X. DISPROPORTIONATE SHARE LIMITATIONS**

Effective April 1, 1994, and thereafter, for OMH facilities, disproportionate share payment distributions made pursuant to this Part of this Attachment shall be limited in accordance with the provisions of this section.

Effective April 1, [2]1994, OMH facilities whose inpatient Medicaid eligible patient days are less than one percent of total inpatient days shall not be eligible to receive disproportionate share distributions.

[Effective for the state fiscal year beginning April 1, 1994, disproportionate share payments to OMH facilities with inpatient Medicaid eligible patient days, as a percentage of total inpatient days, of at least one standard deviation above the statewide mean Medicaid patient day percentage shall be increased to 200 percent of the disproportionate share limit determined in accordance with this section. This increase shall be contingent upon acceptance by the Secretary of the federal Department of Health and Human Services of the Governor's certification that the hospital's applicable minimum amount is used for health services during the year. Federal funds associated with payments to OMH facilities in excess of 100 percent of unreimbursed costs shall not be distributed unless OMH submits to the Commissioner a written certification stating that all distributions in excess of the 100 percent limit will be used for health services.]

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No OMH facility shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred for furnishing inpatient and ambulatory hospital services to individuals who are eligible for Medicaid benefits pursuant to [t]Title XIX of the federal Social Security Act or to individuals who have no health insurance or other source of third party coverage, reduced by medical assistance payments made pursuant to Title XIX of the federal Social Security Act, other than disproportionate share payments, and payments by uninsured patients. For purposes of this section, payments to OMH facilities for services provided to indigent patients made by the State [of] or a unit of local government within the State shall not be considered a source of third party payment.

[For purposes of calculating disproportionate share (DSH) distributions pursuant to this section, if the hospital receiving the distribution is a public hospital (operated by the State, a city, county or other municipal subdivision), then the payments determined hereunder are further limited. Unless the hospital qualifies as a "high DSH" facility (as defined below), payments made during a distribution period shall not exceed the cost incurred by the hospital for furnishing hospital services to Medicaid recipients less non-DSH reimbursement and to uninsured patients less patient payments. In the case of a hospital defined as "high DSH", payments made during a distribution period shall equal 200 percent of the amount described in the previous sentence. To be considered a "high DSH" facility, a hospital must have a Medicaid inpatient utilization rate of at least one standard deviation above the mean Medicaid inpatient utilization rate for hospital receiving Medicaid payments in the State, or have the largest number of Medicaid inpatient days of any hospital in the State in the previous distribution period.]

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Previous years' data for both uninsured and Medicaid cost and payments shall be used to estimate the limitation. A cost determination of both the uninsured and the Medicaid inpatient cost shall be made upon receipt of an appropriate report.

Facility specific limitations will be estimated before the beginning of each fiscal year. The estimate will be based on the most recently available actual cost and revenue information as adjusted for expected changes in cost and revenue. These estimated facility-specific limitations will be recalculated to reflect actual information after the year has been completed and the necessary information has been compiled. Once the actual limitations for the year are known, adjustments will be made as necessary to the disproportionate share amounts paid to the facility. If it is determined that disproportionate share payments to a particular facility exceeded the facility-specific calculation, a recoupment will be made. Alternatively, if it is determined that additional disproportionate share payments are due the facility, such additional payments will be made.

If it is determined that disproportionate share payments to a particular OMH facility exceeded the facility-specific calculation, such excess amounts will be recouped and reallocated to OMH facilities proportionally based on each facility's remaining unreimbursed Medicaid and uninsured costs. If after such reallocation there remain additional unallocated amounts, such amounts will be allocated to governmental facilities, 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, whose disproportionate share payments were less than their respective facility-specific calculations, in accordance with the Disproportionate Share Limitations section of this Attachment. Such payments will be made to each such individual hospital based on the relative share of each hospital's actual medical assistance and uninsured patient costs for that DSH state plan rate year (SPRY). The federal share of any remaining unallocated excess amounts above shall be promptly refunded to the federal government.

For any federal mental health facility DSH allotment that remains unused by OMH, the excess reallocated to those other non-state governmental facilities will occur in the same four-digit State Plan rate year.

**XI. TRANSFER OF OWNERSHIP**

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

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[XI. Additional Disproportionate Share Payment

The State's methodology used to take into account the situation of disproportionate share hospitals also includes additional payments to meet the needs of those facilities which serve a large number of Medicaid eligible, low income and uninsured patients, including those eligible for Home Relief, who other providers view as financially undesirable. These payments are available to hospitals on behalf of certain low-income persons who are described below and are made in addition to, and not as a substitute for, the disproportionate share adjustment described in section IX. However, the calculations of hospitals' bad debt and charity care costs which are partially covered by the disproportionate share adjustment described in section IX, does not include costs of services to any person for whom an additional disproportionate share payment has been made under this section.

These additional payment adjustments are made either by the Department or through an intermediary to disproportionate share hospitals which have provided services to persons determined to be low-income by reason of their having met the income and resource standards for the State's Home Relief program (except for their current residential status). These persons must have demonstrated to a local social services district or the Department that their household income and resources do not exceed the income and resources standard established by the Department, which standards vary by household size and take into account the household's regularly recurring monthly needs, shelter, fuel for heating, home energy needs, supplemental home energy needs and other relevant factors affecting household needs.

Each hospital, or an intermediary making a payment to a hospital, will determine which patients qualify as low-income persons eligible for additional payments by a verifiable process subject to the above eligibility conditions. Each hospital must maintain documentation of the patient's eligibility for additional payments and must document the amounts claimed for additional payments. The supporting documentation must include written verification from a local social services district or the Department attesting to the person's eligibility for Home Relief. Such supporting documentation may be in the form of a photocopy of the person's current valid official benefits card or a copy of an eligibility verification confirmation received from the Department's Electronic Medicaid Eligibility Verification System (EMEVS), which system includes information with respect to persons eligible for Home Relief and additional payments, or other verifiable documentation acceptable to the Department which establishes that the person has met the income and resource standards for Home Relief on the date the services were provided.]

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[A "disproportionate share hospital" for purposes of receiving additional disproportionate share payments under this provision is any hospital which furnishes medical or remedial care to a qualified low income person without expectation of payment from the person due to the patient's inability to pay as documented by his or her having met the income and resource standards for Home Relief benefits as set forth above, and meets the requirements of State Plan Amendment 94-26. In addition, a "disproportionate share hospital" (except hospitals serving an in-patient population predominantly comprised of persons under 18 years of age and hospitals which did not offer non-emergency obstetrical care on or before December 21, 1987) must have at least two obstetricians with staff privileges who have agreed to provide obstetrical care and services to Medicaid eligible patients on a non-emergency basis.

The amount of this disproportionate share adjustment will vary by hospital and reflect the dollar amount of payments either from the State directly, or through an intermediary, to the hospital for services provided to low income patients. For each hospital such adjustments shall be paid in the normal Medicaid payment process, or intermediary payment process; and according to established rates or fees, for fee-for-service program services or by the intermediary for its services. To receive payment of this adjustment each hospital must submit a claim in the form and manner specified by this Department, or the intermediary, as appropriate.

Disproportionate share payments under this plan cannot exceed the State disproportionate share allotment calculated in accordance with the provision of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (P.L. 102-234), as set forth at 42 CFR Sections 447.296 through 447.299, and cannot exceed the facility specific disproportionate share payment limits required by the Omnibus Budget Reconciliation Act of 1993.]

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