

New York**1****Reserved**

[Methods and Standards for Establishing Payment Rates]

Out of State Services

I. Inpatient Hospital Care

New York reimburses out of state hospitals at the facility's Medicaid rate established by the State in which the institution is located; or when no such rate exists, at the lowest of the following charges:

1. the Medicare rate set for the hospital; or
2. the hospital's customary charge for public beneficiaries; or
3. the maximum New York State Title XIX rate for similar inpatient care.

Reimbursement for those days where recipients are awaiting placement to an alternate level of care (ALC) while they are inpatients at out of state hospitals will be at the facility's approved Medicaid ALC rate.

II. 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.

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. 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.]

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[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.]

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 9426. 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.]

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