

Hospital Indigent Care Pool Payment Methodology

Effective date: 9/1/17

Pursuant to the authority vested in the Commissioner of Health by section 2807-k (5-d) of the Public Health Law, Section 86-1.47 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon filing with the Secretary of State, to read as follows:

Subdivision (f) of section 86-1.47 is renumbered as subdivision (i) and amended to read as follows:

(i) (1) Funds reserved in the Financial Assistance Compliance Pool (“FACP”) pursuant to §2807-k(5-d)(b)(iv) of the Public Health Law for the calendar years 2014 [and 2015] through 2018 shall be distributed to hospitals which demonstrate substantial compliance, as determined by the Commissioner, with the provisions of §2807-k(9-a) of the Public Health Law (the “financial assistance law” or “FAL”).

(2) Hospitals which are determined to be in substantial FAL compliance by the end of the 2013 calendar year shall receive their 2014 FACP payments as soon as practical in 2014 in accordance with subdivision (b) of this section. Hospitals which are determined to be in substantial FAL compliance by the end of the 2014 calendar year shall receive their 2015 FACP funds as soon as practical in 2015 in accordance with subdivision (b) of this section[.]. Hospitals which are determined to be in substantial FAL compliance by the end of the 2015 calendar year shall receive their 2016 FACP payments as soon as practical in 2016 in accordance with subdivision (b) of this section. Hospitals which are determined to be in substantial FAL

compliance by the end of the 2016 calendar year shall receive their 2017 FACP payments as soon as practical in 2017 in accordance with subdivision (b) of this section. Hospitals which are determined to be in substantial FAL compliance by the end of the 2017 calendar year shall receive their 2018 FACP payments as soon as practical in 2018 in accordance with subdivision (b) of this section provided, however, that those hospitals which were determined to be not in such substantial compliance by the end of [2013] 2015 and 2016, but which are determined to be in such substantial compliance by the end of [2014] 2017, shall receive [both] their [2014] 2015, 2016 and [2015] 2017 FACP payments as soon as practical in [2015] 2018.

Section 86-1.47 is amended by adding subdivisions (f), (g), and (h) to read as follows:

(f) For the 2016 calendar year, payments shall be made as follows:

(1) One hundred thirty nine million four hundred thousand dollars (\$139,400,000) shall be distributed as Medicaid disproportionate share hospital (“DSH”) payments to major public general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital’s uncompensated care nominal need, as determined in accordance with the provisions of subdivision (b) of this section, as a share of the aggregate uncompensated care nominal need for all major public general hospitals, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than ten percent less than the average distributions such hospitals received pursuant to §2807-k of the Public Health Law for the three year period January 1, 2010, through December 31, 2012.

(2) Nine hundred ninety four million nine hundred thousand dollars (\$994,900,000) shall be distributed as Medicaid DSH payments to eligible general hospitals, other than major

public general hospitals, on the basis of each hospital's uncompensated care need share, as determined in accordance with the provisions of subdivision (b) of this section, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than ten percent less than the average distributions such hospitals received pursuant to §2807-k and §2807-w of the Public Health Law, excluding academic medical center grants received pursuant to §2807-k(5-b)(b)(v) of the Public Health Law, and after any reductions made pursuant to §2807-k(17) of the Public Health Law, for the three year period January 1, 2010, through December 31, 2012.

(3) Payments made pursuant to paragraphs (1) and (2) of this subdivision shall be further adjusted such that such payments made to hospitals that experience increases in payments, as compared to the average of such payments made pursuant to this section for the three year period January 1, 2010 through December 31, 2012, shall be further adjusted on a percentage basis, as determined by the Commissioner, sufficient to ensure, in conjunction with such other funding as may be made available, the full funding of the transition adjustments described in paragraphs (1) and (2) of this subdivision.

(g) For the 2017 calendar year, payments shall be made as follows:

(1) One hundred thirty nine million four hundred thousand dollars (\$139,400,000) shall be distributed as Medicaid disproportionate share hospital ("DSH") payments to major public general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital's uncompensated care nominal need, as determined in accordance with the provisions of subdivision (b) of this section, as a share of the aggregate uncompensated care nominal need for all major public general hospitals, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this

section that is greater than twelve and a half percent less than the average distributions such hospitals received pursuant to §2807-k of the Public Health Law for the three year period January 1, 2010, through December 31, 2012.

(2) Nine hundred ninety four million nine hundred thousand dollars (\$994,900,000) shall be distributed as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals, on the basis of each hospital's uncompensated care need share, as determined in accordance with the provisions of subdivision (b) of this section, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than twelve and a half percent less than the average distributions such hospitals received pursuant to §2807-k and §2807-w of the Public Health Law, excluding academic medical center grants received pursuant to §2807-k(5-b)(b)(v) of the Public Health Law, and after any reductions made pursuant to §2807-k(17) of the Public Health Law, for the three year period January 1, 2010, through December 31, 2012.

(3) Payments made pursuant to paragraphs (1) and (2) of this subdivision shall be further adjusted such that such payments made to hospitals that experience increases in payments, as compared to the average of such payments made pursuant to this section for the three year period January 1, 2010 through December 31, 2012, shall be further adjusted on a percentage basis, as determined by the Commissioner, sufficient to ensure, in conjunction with such other funding as may be made available, the full funding of the transition adjustments described in paragraphs (1) and (2) of this subdivision.

(h) For the 2018 calendar year, payments shall be made as follows:

(1) One hundred thirty nine million four hundred thousand dollars (\$139,400,000) shall be distributed as Medicaid disproportionate share hospital ("DSH") payments to major public

general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital's uncompensated care nominal need, as determined in accordance with the provisions of subdivision (b) of this section, as a share of the aggregate uncompensated care nominal need for all major public general hospitals, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than fifteen percent less than the average distributions such hospitals received pursuant to §2807-k of the Public Health Law for the three year period January 1, 2010, through December 31, 2012.

(2) Nine hundred ninety four million nine hundred thousand dollars (\$994,900,000) shall be distributed as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals, on the basis of each hospital's uncompensated care need share, as determined in accordance with the provisions of subdivision (b) of this section, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than fifteen percent less than the average distributions such hospitals received pursuant to §2807-k and §2807-w of the Public Health Law, excluding academic medical center grants received pursuant to §2807-k(5-b)(b)(v) of the Public Health Law, and after any reductions made pursuant to §2807-k(17) of the Public Health Law, for the three year period January 1, 2010, through December 31, 2012.

(3) Payments made pursuant to paragraphs (1) and (2) of this subdivision shall be further adjusted such that such payments made to hospitals that experience increases in payments, as compared to the average of such payments made pursuant to this section for the three year period January 1, 2010 through December 31, 2012, shall be further adjusted on a percentage basis, as determined by the Commissioner, sufficient to ensure, in conjunction with such other funding as

may be made available, the full funding of the transition adjustments described in paragraphs (1) and (2) of this subdivision.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authority for this regulation is contained in Section 2807-k (5-d) of the Public Health Law (PHL), as amended by Section 1 of Part E of Chapter 57 of the Laws of 2015, which requires the Commissioner to promulgate regulations, including emergency regulations, with regard to the extension of a distribution methodology to make annual indigent care pool payments to general hospitals for the three-year period January 1, 2016 through December 31, 2018.

Legislative Objectives:

The legislation requires the Department of Health to develop an indigent care distribution methodology, for calendar years through 2018, which conforms to federal DSH (“Disproportionate Share Hospital”) reform guidelines by targeting payments to hospitals which provide a disproportionate share of uncompensated care to the uninsured and Medicaid inpatient population and to also strengthen hospital compliance with the Financial Aid Law contained in Section 2807-k (9-a) of the Public Health Law.

The current regulation contains, for calendar years 2013-2015, the detailed calculations required to determine a hospital’s relative uncompensated care need, incorporating both uninsured and Medicaid inpatient volume, which forms the basis for allocation of a proportional share of the total available pool funds. The proposed amendment would extend this methodology to calendar years 2016-2018, in conformance with amendments to PHL Section 2807-k (5-d).

The current regulation also provides, for calendar years 2013-2015, for a transition payment to ensure that no hospital experiences severe financial instability resulting from the redistribution of funding among the hospitals as a result of the indigent care distribution methodology. This transition payment establishes a minimum payment as a set percentage of the average indigent care pool payments received by the hospital in the years 2010-2012. Hospitals which experience gains have their distributions similarly capped by a set percentage of the average indigent care pool payments received in the years 2010-2012. The proposed amendment would extend the transition payments to calendar years 2016-2018, in conformance with amendments to PHL Section 2807-k (5-d).

The current regulation also requires, for calendar years 2013-2015, the Commissioner to withhold one percent of the total indigent care pool funds available to distribute to hospitals who demonstrate substantial compliance with the Financial Aid Law PHL Section 2807-k (9-a). The proposed amendment would extend the one-percent withholding and distribution to hospitals to calendar years 2016-2018, in conformance with amendments to PHL Section 2807-k (5-d).

Needs and Benefits:

The proposed amendment would extend, through calendar year 2018, the current indigent care distribution methodology, which replaced an outdated and complex distribution methodology that expired December 31, 2012. Public Health Law Section 2807-k (5-d) requires the Department to have such a methodology in place through 2018.

Benefits of the current methodology include a simpler, more transparent methodology which relates indigent care pool payments directly to care of the poor and provides incentives for hospitals to comply with the provisions of the Financial Aid Law. Further, federal DSH matching funds are optimized by the State's conformance with federal guidelines.

Costs:

Costs to Private Regulated Parties:

There will be no additional costs to private regulated parties. The Department utilizes audited information contained in hospitals' Institutional Cost Reports, which the hospitals are already required to submit to the Department on an annual basis.

Costs to State Government:

There is no increase in Medicaid expenditures anticipated as a result of this proposed amendment.

Costs to Local Government:

Local districts' share of Medicaid costs is statutorily capped; therefore, there will be no additional costs to local governments as a result of this proposed amendment.

Costs to the Department of Health:

There will be no additional administrative costs to the Department of Health as a result of this proposed amendment.

Local Government Mandates:

The proposed amendment does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

There are no new reporting requirements, forms or additional paperwork as a result of this proposed amendment.

Duplication:

This proposed amendment does not duplicate any existing federal, state or local regulations.

Alternatives:

No significant alternatives are available. The Department developed the distribution methodology with extensive input from the industry associations representing the hospitals subject to the proposed amendment. The regulation is mandated by PHL Section 2807-k(5-d).

Federal Standards:

The proposed amendment does not exceed any minimum standards of the federal government for the same or similar subject area.

Compliance Schedule:

The proposed amendment grants the Commissioner of Health the authority to withhold one percent of the total indigent care pool funds available for years 2016, 2017 and 2018. Hospitals must demonstrate compliance with the provisions of the Financial Aid Law contained in Section 2807-k (9-a) of the Public Health Law to receive their share of the one percent withheld funds for years 2016, 2017 and 2018. There are no additional compliance efforts required by the hospitals.

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**REGULATORY FLEXIBILITY ANALYSIS
FOR
SMALL BUSINESSES AND LOCAL GOVERNMENTS**

Effect of Rule:

For the purpose of this regulatory flexibility analysis, small businesses were considered to be general hospitals with 100 or fewer full time equivalents. Based on recent financial and statistical data extracted from the Institutional Cost Report, five hospitals were identified as employing fewer than 100 employees.

Some hospitals subject to this regulation may see a decrease in their indigent care payments as a result of this regulation.

This rule will have no direct effect on local governments.

Compliance Requirements:

The proposed amendment requires the Commissioner of Health to withhold one percent of the total indigent care pool funds available for years 2016, 2017 and 2018. All hospitals must demonstrate compliance with the provisions of the Financial Aid Law as set forth in Section 2807-k (9-a) of the Public Health Law to receive their share of the funds held in this pool for years 2016, 2017 and 2018. No other compliance efforts are required.

A small business regulation guide will not be prepared.

The rule will have no direct effect on local governments.

Professional Services:

No new or additional professional services are required in order to comply with the proposed amendment.

Compliance Costs:

No additional compliance costs are anticipated as a result of this proposed amendment.

Economic and Technological Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this proposed amendment because there are no technological requirements other than the use of existing technology, and the overall economic aspect of complying with the requirements is expected to be minimal.

Minimizing Adverse Impact:

A transition payment will be provided, in each of the three years, to ensure that no hospital experiences severe financial instability resulting from the methodology. This transition payment will establish a minimum payment as a set percentage of the average indigent care pool payments received by the hospital in the three years 2010-2012.

Local districts' share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

Small Business and Local Government Participation:

The State filed a Federal Public Notice, published in the State Register on March 25, 2015, prior to the effective date of the change. The Notice provided a summary of the action to be taken and instructions as to where the public, including small businesses and local governments, could locate copies of the corresponding proposed State Plan Amendment. The Notice further invited the public to review and comment on the related proposed State Plan Amendment. In addition, contact information for the Department of Health was provided for anyone interested in further information.

Draft regulations, prior to filing with the Secretary of State, were shared with the industry associations representing hospitals and comments were solicited from all affected parties. Such associations include hospitals with 100 or fewer FTEs.

RURAL AREA FLEXIBILITY ANALYSIS

Effect on Rural Areas:

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

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

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

Albany	Monroe	Orange
Broome	Niagara	Saratoga
Dutchess	Oneida	Suffolk
Erie	Onondaga	

Compliance Requirements:

The proposed amendment requires the Commissioner of Health to withhold one percent of the total indigent care pool funds available for years 2016, 2017 and 2018. All hospitals must demonstrate compliance with the provisions of the Financial Aid Law as set forth in Section

2807-k (9-a) of the Public Health Law to receive their share of the funds held in this pool for years 2016, 2017 and 2018. No other compliance efforts are required.

Professional Services:

No new additional professional services are required in order for providers in rural areas to comply with the proposed amendment.

Compliance Costs:

No additional compliance costs are anticipated as a result of this proposed amendment.

Minimizing Adverse Impact:

A transition payment will be provided, in each of the three years, to ensure that no hospital experiences severe financial instability resulting from the methodology. This transition payment will establish a minimum payment as a set percentage of the average indigent care pool payments received by the hospital in the three years 2010-2012.

Local districts' share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

Rural Area Participation:

The State filed a Federal Public Notice, published in the State Register on March 25, 2015, prior to the effective date of the change. The Notice provided a summary of the action to be taken and instructions as to where the public, including rural area members and local governments, could locate copies of the corresponding proposed State Plan Amendment. The Notice further invited the public to review and comment on the related proposed State Plan Amendment. In addition, contact information for the Department of Health was provided for anyone interested in further information.

Draft regulations, prior to filing with the Secretary of State, were shared with the industry associations representing hospitals and comments were solicited from all affected parties. Such associations include members from rural areas.

JOB IMPACT STATEMENT

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. The proposed amendment extends the hospital indigent care pool payment methodology for the three-year period January 1, 2016 through December 31, 2018. It is apparent, from the nature and purpose of the proposed amendment, that it will not have a substantial adverse impact on jobs or employment opportunities.

EMERGENCY JUSTIFICATION

The proposed amendment extends a distribution methodology for indigent care pool payments to general hospitals for another three year period, from January 1, 2016 through December 31, 2018.

Public Health Law Section 2807-k (5-d)(b) provides the Commissioner of Health with the authority to revise the regulation on an emergency basis. Emergency adoption of the proposed regulation with an effective date of January 1, 2016 is necessary to satisfy the statutory timeframe prescribed by Section 1 of Part E of Chapter 57 of the Laws of 2015 and to secure federal approval of the associated Medicaid State Plan Amendment. The State has unofficial approval of the Indigent Care Pool Extender State Plan Amendment.

The State has been making SFY 2016 hospital indigent care pool payments using the extender distribution methodology pursuant to statute while it seeks approval of both the proposed amendment and the associated Medicaid State Plan Amendment.