Hospital Inpatient Reimbursement

Effective Date: 3/16/11

Summary of Express Terms

General Summary for 86-1.2 through 86-1.89

The amendments to sections 86-1.2 through 86-1.89 of Title 10 (Health) NYCRR are required to implement a new payment methodology for certain hospital inpatient fee-for-service Medicaid services based on All Patient Refined-Diagnostic Related Groups (APR-DRGs). The new payment methodology proposed by these amendments provides a more transparent and simplified reimbursement system that drives reimbursement consistent with efficiency, quality and public health priorities. It develops one statewide operating base rate using an updated and more reliable cost base rather than current regional and peer group operating base rates which were determined by using extremely outdated costs. The APR-DRG payment system will incorporate patient severity of illness and risk of mortality subclasses to better match patient resource utilization and provide a more precise method for equitable reimbursement.

Pursuant to the authority vested in the Commissioner of Health by sections 2807-c(35), 2807-c(4)(e-2) and 2807-k(5-b)(a)(ii) of the Public Health Law, Subpart 86-1 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is hereby amended, effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

The table of contents is REPEALED and a new table of contents is added to read as follows:

SUBPART 86-1

MEDICAL FACILITIES

(Statutory authority: Public Health Law §§ 2803, 2807, 2807-c, 2807-k, 3612, 3614)

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Section 86-1.2 (Medical facility rates) is REPEALED.

Section 86-1.3 is renumbered section 86-1.2 and amended to read as follows:

[86-1.3] 86-1.2. Financial and statistical data required.

(a) Each medical facility shall complete and file with the [New York State Department of Health] department 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 other medical facilities must report their operations [from January 1, 1977 forward] on a calendar-year basis.

(b) Financial and statistical reports required by this Subpart shall be submitted to the department and/or its agent no later than [120 days] 5 months following the close of the fiscal 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] subdivision

(k) of this section, the [State Commissioner of Health] commissioner shall reduce the current rate paid by State 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 the required reports are filed.

(d) In the event that any information or data which a facility has submitted to the [Department of Health] department 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 within 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) and (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 billing and for at least 100 percent of all patients discharged during the hospital's 12-month fiscal reporting period within 180 days from the end of the hospital's fiscal year reporting period. Where the 95 or 100 percent criteria are 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.

(g) (Reserved)

(h)] Specific additional data related to the rate setting process may be requested by the [State Commissioner of Health] commissioner. 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 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)] (g) 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] 86-1.25 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 report's 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 service, 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.]

[(l)] (h) General hospitals with exempt psychiatric units shall submit hospital data regarding patients in such units as required by the Office of Mental Health (see 14 NYCRR Part 580).

[(m)] (i) Each medical facility shall file with the [New York State Department of Health] department 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.

(j) 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.

(k) Accountant's certification. The institutional cost report 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.

(l) Certification by operator, officer or official. (1) The institutional cost report 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.

(2) The form of the certification required in paragraph (1) of this subdivision shall be as prescribed in the annual fiscal and statistical report forms provided by the commissioner.

Section 86-1.4 is renumbered section 86-1.3 and amended to read as follows:

Section [86-1.4] 86-1.3. Uniform system of accounting and reporting.

(a) Medical facilities shall maintain their records in accordance with:

(1) [section 400.18(g) of this Title] Accounting and reporting. Hospitals shall maintain their accounts and records in accordance with the Healthcare Financial Management Association's (HFMA) *Introduction to Hospital Accounting*, 5th edition, written by Michael Nowicki and published by the Health Administration Press. Such accounts and records are to be maintained on an accrual basis except where an alternate system is mandated by law. Hospitals shall also submit to the department or its authorized agent a certified Institutional Cost Report within 5 months after the close of each hospital's fiscal year. The data shall be reported as follows:

(i) In accordance with the policies and instructions in the following:

(a) *The Financial Management of Hospitals and Healthcare Organizations,* 4th edition, written by Michael Nowicki and published by the Health Administration Press.

(b) HFMA, Glossary of Terms.

(c) *Health Care Entities – American Institute of Certified Public Accountants (AICPA) Audit and Accounting Guide* published by the AICPA; and

(d) Medicare Provider Reimbursement Manual, Part 1.

(ii) All government subsidies shall be reported on the income statement of the Institutional Cost Report on the line provided and such amounts shall be itemized on the notes to financial statements by payor and purpose. Such grants shall not be used to reduce allowances as indicated in the American Institute of Certified Public Accountants manual, *Audit and Accounting Guide*.

(iii) Investments, other than donations, shall be reported on the balance sheet of the Institutional Cost Report at cost. The notes to the financial statements shall describe the assets and indicate the quoted market value and cost for each category of investment.

(iv) Fixed assets, other than donations, shall be reported on the balance sheet of the Institutional Cost Report at cost.

(v) Discounts, allowances and bad debts shall be reported and broken out on the Institutional Cost Report by hospital service.

(vi) Copies of HFMA's *Introduction to Hospital Accounting* and *The Financial Management of Hospitals and Healthcare Organizations* are available from the Health Administration Press, American College of Healthcare Executives, One North Franklin, Suite 1700, Chicago, IL 60606-3529 and at http://www.ache.org/PUBS/redesign/productcatalog.cfm?pc=WWW1-2060 and http://www.ache.org/PUBS/redesign/productcatalog.cfm?pc=WWW1-2087, respectively. Copies of HFMA's Glossary of Terms are available from HFMA, 2 Westbrook Corporate Center, Suite 700, Westchester, IL 60154 and at http://www.hfma.org/site/store/hfmaglossaryorderform.cfm. Copies of *Health Care Entities – AICPA Audit and Accounting Guide* are available from the AICPA, CPA2Biz Corporate Headquarters, 100 Broadway, 6th Floor, New York, NY 10005 and at

http://www.cpa2biz.com/AST/Main/CPA2BIZ_Primary/AuditAttest/IndustryspecificGuidance/HealthCare/PRDOVR~PC-012615/PC-012615.jsp. In addition, a copy of each publication is available for inspection at the offices of the Bureau of Primary and Acute Care Reimbursement, New York State Department of Health, Corning Tower, Empire State Plaza, Albany, NY 12237; and

(2) Article 8 of Subchapter A of Chapter V of this Title.

(b) 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(c)] 86-1.2(c) of this Subpart.

(c) For purposes of rate setting, medical facilities shall submit to the [New York State Department of Health] department, or its authorized agent, a certified [uniform financial report and a uniform statistical report] Institutional Cost Report in accordance with the policies and instructions as set forth in [section 400.18(g) of this Title] subdivision (a) of this section.

(d) The [institutional cost report] 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].

Sections 86-1.5 through 86-1.7 are REPEALED.

Section 86-1.8 is renumbered Section 86-1.4.

Section 86-1.9 is REPEALED.

Section 86-1.10 is renumbered section 86-1.5 and amended to read as follows:

[86-1.10] 86-1.5 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.

Sections 86-1.11 through 86-1.14 are REPEALED.

Section 86-1.15 (Calculation of trend factor) is REPEALED and a new Section 86-1.15 is added to read as follows:

Section 86-1.15. Definitions. As used in this Subpart, the following definitions shall apply:

(a) *Diagnosis related groups (DRGs)* shall mean the 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.

(b) *DRG case-based payment per discharge* shall mean the payment to be received by a hospital for all inpatient services, except for physician services, 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.

(c) *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).

(d) *Case mix index (CMI)* shall 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.

(e) *Reimbursable operating costs* shall mean reported operating costs which relate to the cost of providing inpatient hospital services to Medicaid patients, adjusted for inflation between the base period used to determine the statewide base price and the rate period in accordance with trend factors determined pursuant to the applicable provisions of section 2807-c(10) of the Public Health Law, but excluding the following costs:

(1) ALC costs;

(2) Exempt unit costs;

(3) Transfer costs; and

(4) High-cost outlier costs.

(f) *Graduate medical education (GME).* (1) *Direct GME costs* shall mean the reimbursable salaries, fringe benefits, non-salary costs and allocated overhead for residents, fellows, and supervising physicians trended to the rate year by the applicable provisions of section 2807-c(10) of the Public Health Law.

(2) *Indirect GME costs* shall 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.

(g) *High-cost outlier costs* for payment purposes shall mean 100 percent of the hospital's charges converted to cost, using the hospital's most recent ratio of cost-to-charges that exceed the DRG specific high-cost thresholds calculated pursuant to section 86-1.21 of this Subpart.

(h) *Alternate level of care (ALC) services* shall 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.

(i) *Exempt hospitals and units* shall mean those hospitals and units that are paid per diem rates of payment pursuant to the provisions of section 86-1.23 of this Subpart, rather than receiving per discharge case-based rates of payment.

(j) *The wage equalization factor (WEF)* shall 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.

(k) *Statewide Base Price* shall mean the numeric value calculated pursuant to section 86-1.16 of this Subpart which shall be used to calculate DRG case-based payments per discharge as defined in subdivision (b) of this section.

(l) *Non-comparable adjustments* shall mean those base year costs that are passed through the statewide base price calculation and applied to the case-based rate of payment as an add-on payment. The following shall be considered non-comparable adjustments:

(1) Medicaid costs associated with ambulance services operated by a facility and reported as inpatient costs in the institutional cost report; and

(2) Medicaid costs associated with hospital-based physicians at hospitals designated under the Medicare program as meeting the criteria set forth in section 1861(b)(7) of the federal Social Security Act; and

(3) Medicaid costs associated with schools of nursing operated by the facility and reported as inpatient costs in the Institutional Cost Report.

(m) *Transfers.* For purposes of transfer per diem payments, a transfer patient shall 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, is not assigned to a DRG specifically identified as a DRG for transferred patients only, and meets one of the following conditions:

(1) 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

(2) is transferred to an out-of-state acute care facility; or

(3) is a neonate who is being transferred to an exempt hospital for neonatal services.

(n) *Discharges*, as used in this Subpart, shall mean those inpatients whose admission to the facility occurred on or after December 1, 2009, and:

(1) the patient is released from the facility to a nonacute care setting;

(2) the patient dies in the facility; or

(3) 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

(4) the patient is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.

(o) *Arithmetic Inlier Length of Stay (ALOS)* shall 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 shall be calculated for each DRG on a statewide basis.

(p) *Hospital*, as used in this Subpart, shall mean "general hospital" as defined in section 2801(10) of the Public Health Law.

(q) *Charge converter* shall 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.

(r) *IPRO* shall mean the Island Peer Review Organization, Inc., a New York not-for-profit corporation providing health related services.

(s) *Medicaid*, for the purposes of this subpart, shall mean Medicaid Fee-for-Service and Medicaid Managed Care for the period beginning October 1, 2010.

Section 86-1.16 (Adjustments to provisional rates based on errors) is REPEALED and a new Section 86-1.16 is added to read as follows:

Section 86-1.16. Statewide base price.

(a) For periods on and after December 1, 2009, a statewide base price per discharge shall be established based on targeted statewide Medicaid inpatient hospital expenditures and case-mix and wage neutral reimbursable Medicaid acute operating costs derived from the base period identified in subdivision (b) of this section, and as adjusted for inflation between the base period and the rate period in accordance with trend factors determined pursuant to applicable provisions of section 2807-c(10) of the Public Health Law, but excluding costs related to graduate medical education, exempt units, patient transfers, high-cost outliers, alternate level of care, and non-

comparables. Such trended operating costs shall then be divided by Medicaid inpatient discharges in the base period identified in subdivision (b) of this section to establish the average statewide base price per discharge for the applicable rate period.

(b) For periods on and after December 1, 2009, the "base period" shall be the 2005 calendar year and "operating costs" shall be those reported by each facility to the department prior to July 1, 2009.

(1) For those hospitals operated by the New York City Health and Hospitals Corporation, the base period shall be for the period which ended June 30, 2005, and for those hospitals operated by New York State, excluding the hospitals operated by the State University of New York, the base period shall be the 12-month period which ended March 31, 2006.

(2) Discharges, as defined in section 86-1.15(n) of this Subpart, used for direct graduate medical education adjustments shall be based on reported 2007 data.

(3) Discharges, as defined in subdivision (n) of section 86-1.15, but excluding the factors set forth in paragraph (3) of such subdivision (n), as used for non-comparable adjustments shall be based on reported 2007 data.

Section 86-1.17 (Revisions in certified rates) is REPEALED and a new Section 86-1.17 is added to read as follows:

Section 86-1.17. Exclusion of outlier and transfer costs.

(a) In calculating rates pursuant to this Subpart, 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. The Medicaid discharges to be applied to the high-cost outlier

thresholds shall be those that occurred in the base period used to calculate the statewide base price.

(b) In calculating rates pursuant to this Subpart, 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.

Section 86-1.18 (Rates for services) is REPEALED and a new Section 86-1.18 is added to read as follows:

Section 86-1.18. Service Intensity Weights (SIW) and average length-of-stay (LOS).

(a) The table of SIWs and statewide average LOS for each effective period is published on the New York State Department of Health website at: http://www.health.state.ny.us/ and reflects the cost weights and LOS 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 subdivision (b) 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.

(b) For periods on and after December 1, 2009, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2005, 2006 and 2007 calendar years as submitted to the department by September 30, 2009.

(c) For periods on and after January 1, 2011, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2006, 2007 and 2008 calendar years as submitted to the department by June 30, 2010.

(d) For each calendar year thereafter, the SIW and statewide average LOS table shall be updated by dropping the earliest year of SPARCS data and including the next subsequent calendar year data as submitted to the department by September 30 of the year prior to the rate year.

Section 86-1.19 (Rates for medical facilities without adequate cost experience) is REPEALED and a new Section 86-1.19 is added to read as follows:

Section 86-1.19. Wage Equalization Factor (WEF).

(a) The statewide base price per discharge shall be adjusted by a facility-specific wage equalization factor (WEF) to reflect differences in labor costs between hospitals. Such WEF adjustment shall be used to adjust for the level of wage and fringe benefit costs for each hospital in accordance with the following:

(1) The WEF shall 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, and the hospital's proportion of salaries and fringe benefit costs to total operating costs as reported to the Institutional Cost Report. The WEF shall be computed as follows:

(i) For each occupation described in this paragraph, a statewide average salary shall be calculated by dividing the statewide sum of hospitals' total dollars paid by the statewide sum of hospitals' hours paid; and

(ii) For each hospital an actual weighted average salary shall be calculated by dividing the total dollars paid for such occupations by the total hours paid for such occupations; and

(iii) An initial WEF shall 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 be calculated using the following formula:

(1 / ((Labor Share/initial WEF) + 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 institutional cost report for the same calendar year used to calculate the statewide base price for the applicable rate period. The "Non-Labor Share" equals total operating costs less the "Labor Share" of costs.

(2) A hospital may submit updated occupational service 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 in accordance with this section.

(3) 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 the exempt unit cost ceilings.

Section 86-1.20 (Less expensive alternatives) is REPEALED and a new Section 86-1.20 is added to read as follows:

Section 86-1.20. Add-ons to the case payment rate per discharge. Rates of payment computed pursuant to this Subpart shall be further adjusted in accordance with the following:

(a) A direct graduate medical education (GME) payment per discharge shall be added to the case payment rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and shall be calculated for each hospital by dividing the facility's total reported Medicaid direct GME costs by its total reported Medicaid discharges pursuant to section 86-1.16(b)(2) of this Subpart. Direct GME costs shall be those costs defined in section 86-1.15(f)(1) of this Subpart, 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 section 2807-c(10) of the Public Health Law, and shall be excluded from the cost included in the statewide base price.

(b)(1) An indirect GME payment per discharge shall be added to the case payment rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and shall 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 for the period ended June 30, 2005 as contained in the survey document submitted by the hospital to the department as of June 30, 2009 and the staffed beds for the general hospital reported in the 2005 institutional cost report and submitted to the department no later than June 30, 2009, but excluding exempt unit beds and nursery bassinettes.

(2) Indirect GME costs are those costs defined in section 86-1.15(f)(2) of this Subpart, 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 section 2807-c(10) of the Public Health Law, and shall be excluded from computation of the statewide base price. The amount of such exclusion shall be determined by multiplying the total reported Medicaid costs less reported direct GME costs by the following formula:

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

where "r" equals the ratio of residents and fellows to beds as determined in accordance with paragraph (1) of this subdivision.

(c) A non-comparable payment per discharge shall be added to case payment rates after the application of SIW and WEF adjustments to the statewide base price and shall be calculated for each hospital by dividing the facility's total reported Medicaid costs for qualifying non-comparable cost categories by its total reported Medicaid discharges pursuant to section 86-1.16(b)(2) of this Subpart. Non-comparable hospital costs are those costs defined in section 86-1.15(l) of this Subpart, 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 section 2807-c(10) of the Public Health Law, and shall be excluded from the cost included in the statewide base price.

Section 86-1.21 (Allowable costs) is renumbered Section 86-1.6.

A new Section 86-1.21 is added to read as follows:

Section 86-1.21. Outlier and transfer cases rates of payment.

(a)(1) High cost outlier rates of payment shall be calculated by reducing total billed patient charges, as approved by IPRO, to cost, as determined based on the hospital's ratio of cost to charges. Such calculation shall use the most recent data available as subsequently updated to reflect the data from the year in which the discharge occurred, and shall equal 100 percent of the

excess costs above the high cost outlier threshold. High cost outlier thresholds shall be developed for each individual DRG and adjusted by hospital-specific wage equalization factors (WEF) and increased by the Consumer Price Index from the base period used to determine the statewide base price and the rate period.

(2) A non-public, not-for-profit general hospital which has not established an ancillary and routine charges schedule shall be eligible to receive high-cost outlier payments equal to the average of high-cost outlier payments received by comparable hospitals, as determined using the following criteria:

(i) downstate hospitals;

(ii) hospitals with a Medicaid fee for service case mix greater than 1.75;

(iii) hospitals with Medicaid fee for service revenue greater than $30 million of total revenue; and

(iv) hospitals with a proportion of Medicaid fee for service outlier to inlier cases greater than 3.0 percent.

(b) Rates of payment to non-exempt hospitals for inpatients who are transferred to another non-exempt hospital shall 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 paragraphs (1), (2) and (3) of this subdivision. The total payment to the transferring facility shall not exceed the amount that would have been paid if the patient had been discharged. The per diem rate shall be determined by dividing the DRG case-based payment per discharge as defined in section 86-1.15(b) of this Subpart by the arithmetic inlier length of stay (LOS) for that DRG, as defined in section 86-1.15(o) of this Subpart, 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 LOS for the DRG is equal to one, the transfer adjustment factor shall not be applied.

(1) Transfers among more than two hospitals that are not part of a merged facility shall be reimbursed as follows:

(i) the facility which discharges the patient shall receive the full DRG payment; and

(ii) all other facilities in which the patient has received care shall receive a per diem rate unless the patient is in a transfer DRG.

(2) A transferring facility shall be paid the full DRG rate for those patients in DRGs specifically identified as transfer DRGs.

(3) Transfers among non-exempt hospitals or divisions that are part of a merged or consolidated facility shall be reimbursed as if the hospital that first admitted the patient had also discharged the patient.

(4) 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 be reimbursed and assigned to the applicable APR-DRG upon admission or readmission.

Section 86-1.22 (Recoveries of expense) is renumbered Section 86-1.7.

Section 86-1.23 (Depreciation) is REPEALED and a new Section 86-1.23 is added to read as follows:

86-1.23. Exempt units and hospitals.

(a) *Physical medical rehabilitation inpatient services* shall qualify for reimbursement pursuant to section 2807-c(4)(e-2) of the Public Health Law 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:

(1) 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

(2) 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 criteria set forth in section 2807-c(4)(e) of the Public Health Law 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 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, other than physician services, for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs, excluding physician costs, as submitted to the department prior to July 1, 2009, not including reported direct medical education costs and physician 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 subdivision (i) of this section. Such rates shall reflect trend adjustments in accordance with the applicable provisions of section 2807-c(10) of the Public Health Law.

(b) *Chemical dependency rehabilitation inpatient services* shall qualify for reimbursement pursuant to section 2807-c(4)(e-2) of the Public Health Law 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:

(1) 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

(2) 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, other than physician services, for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs, excluding physician costs, as submitted to the department prior to July 1, 2009, not including reported direct medical education costs and physician 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 subdivision (i) of this section. Such rates shall reflect trend adjustments in accordance with the applicable provisions of section 2807-c(10) of the Public Health Law.

(c) *Critical access hospitals*. (1) Rural hospitals shall qualify for inpatient reimbursement as critical access hospitals pursuant to section 2807-c(4)(e-2) of the Public Health Law 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.

(2) For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services, other than physician services, for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs, excluding physician 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 section 2807-c(10) of the Public Health Law.

(d) *Cancer hospitals.* (1) Hospitals shall qualify for inpatient reimbursement as cancer hospitals pursuant to section 2807-c(4)(e-2) of the Public Health Law 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.

(2) For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services, other than physician services, for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs, excluding physician 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 section 2807-c(10) of the Public Health Law.

(e) *Specialty long term acute care hospital.* (1) Hospitals shall qualify for inpatient reimbursement as specialty long term acute care hospitals pursuant to section 2807-c(4)(e-2) of the Public Health Law 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.

(2) For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services, other than physician services, for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs, excluding physician 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 section 2807-c(10) of the Public Health Law.

(f) *Acute care children's hospitals*. Hospitals shall qualify for inpatient and outpatient reimbursement as acute care children's hospitals pursuant to section 2807-c(4)(e-2) of the Public Health Law for periods on and after December 1, 2009, only if:

(1) 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

(2) 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, other than physician services, for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2007 operating costs, excluding physician 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 section 2807-c(10) of the Public Health Law.

(g) *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 (MDC 20, DRGs 743 through 751) will be made on a per diem basis. This includes inpatient detoxification, withdrawal, and observation services.

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:

(1) The operating cost component of the per diem rates will be computed using 2006 costs and statistics, excluding physician costs, 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:

(i) 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 (2) through (6).

(ii) 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 (2) through (6).

(iii) For periods on and after April 1, 2010, 100% of the operating cost component will reflect 2006 operating costs in accordance with paragraphs (2) through (6).

(2) 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:

(i) New York City - Bronx, New York, Kings, Queens and Richmond Counties;

(ii) Long Island - Nassau and Suffolk Counties;

(iii) Northern Metropolitan - Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester Counties;

(iv) Northeast - Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties;

(v) Utica/Watertown - Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida Counties;

(vi) Central - Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga and Tompkins Counties;

(vii) Rochester - Monroe, Ontario, Livingston, Wayne and Yates Counties; and

(viii) Western - Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.

(3) 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.

(4) 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.

(5) 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.

(6) 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.

(7) 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.

(h) Hospitals or distinct units of hospitals that fail to maintain qualifying criteria for exempt status for reimbursement purposes, as set forth in this section or in section 2807-c(4)(e-2) of the Public Health Law, shall continue to be reimbursed in accordance with such exempt status until the commencement of the next rate period, as determined by the department.

(i) Rates of payment for inpatient services for exempt distinct units of hospitals described in subdivisions (a), (b), (c), (d) and (e) of this section, for which separately identifiable 2005 reported costs data are not available, shall reflect the average reported 2005 operating cost per day for comparable exempt units, as determined by the department.

(j) Rates of payment for inpatient services described in subdivisions (a) and (b) of this section which utilize regional averages for determining a cost ceiling shall utilize regions of the

State set forth in section 2807-c(4)(l)(iii)(E) of the Public Health Law and this subdivision, 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:

(1) New York City, consisting of the counties of Bronx, New York, Kings, Queens and Richmond;

(2) Long Island, consisting of the counties of Nassau and Suffolk;

(3) Northern Metropolitan, consisting of the counties of Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester;

(4) Northeast, consisting of the counties of Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington;

(5) Utica / Watertown, consisting of the counties of Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida;

(6) Central, consisting of the counties of Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga and Tompkins;

(7) Rochester, consisting of the counties of Monroe, Ontario, Livingston, Wayne and Yates;

(8) Western, consisting of the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

(k) 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 provisions of section 86-1.25 of this Subpart divided by exempt hospital or unit patient days reconciled to actual total expense.

(l) *New hospitals and new hospital units*. The operating cost component of rates of payment for new hospitals, or hospital units, without adequate cost experience shall be computed based on either budgeted cost projections, subsequently reconciled to actual reported cost data, or the regional ceiling calculated in accordance with subdivision (i) of this section, whichever is lower. The capital cost component of such rates shall be calculated in accordance with section 86-1.25 of this Subpart.

(m) *Inpatient psychiatric services.* Per diem rates of payment for a general hospital or a distinct unit of a general hospital for inpatient psychiatric services shall be continue to be determined in accordance with the reimbursement methodology set forth in section 86-1.57 of this Subpart which was in effect for periods prior to December 1, 2009.

Section 86-1.24 (Interest) is REPEALED.

Section 86-1.25 is renumbered Section 86-1.8 and amended to read as follows:

[86-1.25] 86-1.8 Research and educational activities. (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.

(b) 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.

Section 86-1.26 (Educational activities) is REPEALED.

Section 86-1.27 (Compensation of operators and relatives of operators) is renumbered Section 86-1.9.

Section 86-1.28 (Related organizations) is renumbered Section 86-1.10.

A new Section 86-1.28 is added to read as follows:

Section 86-1.28. Adding or deleting hospital services or units.

(a) 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 Subpart 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.

(b) 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 section 86-1.29 of this Subpart. Such rates shall be effective the first day of the month following 30 days after such notification or the date of the approved certificate of need (CON) certification, whichever is later.

Sections 86-1.29 and 86-1.30 are REPEALED.

Section 86-1.31 is renumbered Section 86-1.11 and amended to read as follows:

[86-1.31] 86-1.11 Termination of service. The Division of Health Care Financing in the [Department of Health] department 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)] 86-1.4(f) of this Subpart.

A new Section 86-1.31 is added to read as follows:

Section 86-1.31. Mergers, acquisitions and consolidations.

(a) *Rates of Payment.* As used in this section, the terms merger, acquisition and consolidation shall mean the combining of two or more general hospitals 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. In order to be eligible for reimbursement pursuant to this section, the applicant facility must have previously received a certificate of need (CON) approval by the commissioner and/or Public Health Council approval for the merger, acquisition, or consolidation pursuant to the Public Health Law. Payments for hospitals subject to a 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 transaction is effected and shall be computed in accordance with this Subpart except as follows:

(1) The WEF used to adjust the statewide base price shall be calculated by combining all components used in the calculation pursuant to section 86-1.19 of this Subpart for all hospitals subject to the merger, acquisition or consolidation.

(2) The direct GME payment per discharge added to the case payment rates of teaching hospitals shall be calculated by dividing the total reported Medicaid direct GME costs for all teaching hospitals subject to the merger, acquisition, or consolidation by the total reported Medicaid discharges reported by such hospitals in the applicable base period.

(3) The indirect GME payment per discharge added to the case payment rates of teaching hospitals shall be calculated in accordance with section 86-1.20 of this Subpart, except the ratio of residents to beds used in the calculation shall be based on the total residents and beds of all such hospitals subject to the merger, acquisition, or consolidation.

(4) The non-comparable payment per discharge added to the case payment rates shall be calculated by dividing the total reported Medicaid costs for qualifying non-comparable cost categories for all hospitals subject to the merger, acquisition, or consolidation by the total reported Medicaid discharges reported by such hospitals in the applicable base period.

(b) *Temporary rate adjustment.*

(1) The commissioner may grant approval of a temporary adjustment to rates calculated pursuant to this section for hospitals subject to mergers, acquisitions or consolidations occurring on or after the year the rate is based upon, 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 adjustment. The temporary rate adjustment shall consist of the various rate components of the surviving entity for a specified period of time as approved by the commissioner. At the end of the specified timeframe, the hospital will be reimbursed in accordance with the statewide methodology set forth in this Subpart.

(2) The commissioner may withdraw approval of a temporary rate adjustment 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.

Section 86-1.32 (Sales, leases and realty transactions) is REPEALED and a new Section 86-1.32 is added to read as follows:

Section 86-1.32. Administrative rate appeals.

(a) Administrative rate appeals of rates of payment issued pursuant to this Subpart 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.

(b) 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 Subpart, 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.

(c) Rate appeals which are rejected or precluded on the grounds of being untimely may be considered in connection with subsequent audits conducted pursuant to section 86-1.4 of this Subpart.

(d) The department shall consider only those rate appeals that reflect one or more of the following bases.

(1) 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 Cooperate System (SPARCS) in accordance with section 400.18 of this Title, 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

(2) Any errors regarding a medical facility's capital cost reimbursement.

(e) The department may refuse to accept or consider a rate appeal from a facility that:

(1) is providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council; or

(2) 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 (1) of this subdivision; or

(3) has been determined by the department as being operated by a person or persons not properly established or licensed pursuant the Public Health Law; or

(4) is delinquent in the payment of a fine or penalty imposed on the facility pursuant to the Public Health Law.

Section 86-1.33 (Hospital closure/conversion incentive programs) is REPEALED and a new Section 86-1.33 is added to read as follows:

Section 86-1.33. Out-of-state providers.

(a) 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 set forth in section 365-a(4)(d) of the Social Services Law shall be as follows:

(1) 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, Bergin, Hudson, Essex, Union, Middlesex and Monmouth, in the Pennsylvania county of Pike, and in the Connecticut counties of Fairfield and Litchfield; and

(2) 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.

(3) High cost outlier rates of payment shall be calculated in accordance with 86-1.21 with the exception of the wage equalization factor (WEF) being based upon the weighted average of the upstate or downstate region.

(4) 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.

(b) 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.

(c) 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.

Section 86-1.34 (Pilot reimbursement projects) is REPEALED and a new Section 86-1.34 is added to read as follows:

Section 86-1.34. Supplemental indigent care distributions.

(a) For the period prior to December 31, 2009:

(i) $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 pursuant to the following schedule of payments:

	Calendar Year 2009
	$ 307,000,000
Hospital	**Uninsured Distribution to Teaching Hospitals**
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
ST JOSEPHS HOSPITAL HEALTH CENTER	$ 2,697,040
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
BENEDICTINE HOSPITAL	$ 459,898
KINGSTON HOSPITAL	$ 430,512
MOUNT VERNON HOSPITAL	$ 115,045
SOUND SHORE MEDICAL CENTER	$ 155,810
WESTCHESTER MEDICAL CENTER	$ 16,611,342
BRONX-LEBANON HOSPITAL CENTER	$ 37,193
JACOBI MEDICAL CENTER	$ 2,082,896
MONTEFIORE HOSPITAL & MEDICAL CENTER	$ 24,605,332
LINCOLN MEDICAL & MENTAL HEALTH CENTER	$ 3,019,391
NORTH CENTRAL BRONX HOSPITAL	$ 754,891
BROOKLYN HOSPITAL	$ 5,938,856
CONEY ISLAND HOSPITAL	$ 995,496
KINGS COUNTY HOSPITAL CENTER	$ 3,882,475
LONG ISLAND COLLEGE HOSPITAL	$ 3,448,174
NY METHODIST HOSPITAL OF BROOKLYN	$ 3,807,310
KINGSBROOK JEWISH MEDICAL CENTER	$ 121,313
WYCKOFF HEIGHTS HOSPITAL	$ 1,230,117
STATE UNIVERSITY HOSPITAL DOWNSTATE	$ 4,116,253

MEDICAL CENTER	
WOODHULL MEDICAL AND MENTAL HEALTH CENTER	$ 876,601
INTERFAITH MEDICAL CENTER	$ 831,511
BELLEVUE HOSPITAL CENTER	$ 2,636,659
BETH ISRAEL MEDICAL CENTER	$ 12,615,285
HARLEM HOSPITAL CENTER	$ 2,002,465
HOSPITAL FOR SPECIAL SURGERY	$ 3,247,177
LENOX HILL HOSPITAL	$ 12,658,212
MANHATTAN EYE EAR AND THROAT	$ 416,294
MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES	$ 5,831,787
METROPOLITAN HOSPITAL CENTER	$ 1,570,125
MOUNT SINAI HOSPITAL	$ 18,689,832
NY EYE AND EAR INFIRMARY	$ 407,797
ST LUKES - ROOSEVELT HOSPITAL CENTER	$ 8,823,583
SVCMC ST VINCENTS-MANHATTAN	$ 5,342,595
GOLDWATER MEMORIAL HOSPITAL	$ 10,006
COLER MEMORIAL HOSPITAL	$ 639
NYU HOSPITALS CENTER	$ 13,483,008
NEW YORK PRESBYTERIAN HOSPITAL	$ 27,337,202
ELMHURST HOSPITAL	$ 2,226,463
JAMAICA HOSPITAL	$ 1,185,404
LONG ISLAND JEWISH-HILLSIDE MEDICAL CENTER	$ 18,206,316
QUEENS HOSPITAL CENTER	$ 554,077
NY MED CTR OF QUEENS	$ 3,178,354
FOREST HILLS HOSPITAL	$ 1,334,742
STATEN ISLAND UNIVERSITY HOSPITAL	$ 5,084,762
RICHMOND UNIVERSITY MEDICAL CENTER	$ 2,274,908

(ii) $25 million shall be distributed to non-major public hospitals having Medicaid discharges of 40 percent or greater as determined by the commissioner from data reported in each hospital's 2007 annual cost report, to compensate each hospital's decrease in Medicaid revenue resulting from the trend factor reductions and the inpatient reimbursement methodology changes reflected in this Subpart pursuant to the following schedule of payments:

Hospital	Safety Net Hospitals Distribution (Hospitals > 40% Medicaid discharges)
BRONX-LEBANON HOSPITAL CENTER	$ 5,881,790
LUTHERAN MEDICAL CENTER	$ 3,164,515
BETH ISRAEL MEDICAL CENTER	$ 2,516,139
WYCKOFF HEIGHTS HOSPITAL	$ 1,994,409
JAMAICA HOSPITAL	$ 1,749,749
MAIMONIDES MEDICAL CENTER	$ 1,612,982
BROOKDALE HOSPITAL MEDICAL CENTER	$ 1,306,401
ST BARNABAS HOSPITAL	$ 1,173,571
INTERFAITH MEDICAL CENTER	$ 1,172,036
ST JOHNS RIVERSIDE HOSPITAL	$ 869,254
FLUSHING HOSPITAL AND MEDICAL CENTER	$ 806,993
NORTH GENERAL HOSPITAL	$ 666,114
NEW YORK DOWNTOWN HOSPITAL	$ 590,133
BROOKLYN HOSPITAL	$ 553,751
KALEIDA HEALTH – WOMEN AND CHILDRENS HOSPITAL	$ 481,839
EPISCOPAL HEALTH SERVICES, INC	$ 375,993
SHEEHAN MEMORIAL EMERGENCY HOSPITAL, INC	$ 65,384
BLYTHEDALE CHILDRENS HOSPITAL	$ 18,946

(b) For annual periods beginning on and after January 1, 2010:

(i) 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 section 2807-k(5-a)(c) of the Public Health Law and offset by disproportionate share payments received by each facility during calendar year 2010 in accordance with sections 2807-k and 2807-w of the Public Health Law and subdivision (a) of this section:

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

(ii) $25 million shall be distributed to non-major public hospitals having Medicaid discharges of 40 percent or greater as determined by the commissioner from data reported in each hospital's 2007 annual cost report in accordance with the methodology and schedule of payments set forth in paragraph (ii) of subdivision (a) of this section.

(iii) $24.5 million shall be distributed as non-Medicaid grants to non-major public academic medical centers pursuant to the following schedule of payments:

Hospital	**Major Academic Centers for Excellence Distributions**
NEW YORK PRESBYTERIAN HOSPITAL	$ 10,672,716
MOUNT SINAI HOSPITAL	$ 4,998,485
STRONG MEMORIAL HOSPITAL	$ 4,104,745
NYU HOSPITALS CENTER	$ 2,396,578
ALBANY MEDICAL CENTER HOSPITAL	$ 2,327,476

Section 86-1.35 is no longer RESERVED.

Section 86-1.36 (Financially distressed hospital pool) is REPEALED and a new Section 86-1.36 is added to read as follows:

Section 86-1.36. Hospital physician billing.

(a) With the exception of hospitals designated under the Medicare program as meeting the criteria set forth in section 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.

Sections 86-1.38 through 86-1.43 are REPEALED.

A new Section 86-1.38 is added, to read as follows:

86-1.38 Transition pool for 2010-2013 period.

(a) Subject to the availability of federal financial participation, the commissioner may, for rate periods effective on and after October 20, 2010, increase inpatient Medicaid fee-for-service rates subject to this Subpart for the following periods and in the following amounts:

(1) for the period October 20, 2010 through March 31, 2011, up to thirty-seven million five hundred thousand dollars;

(2) for the period April 1, 2011 through March 31, 2012, up to seventy-five million dollars;

(3) for the period April 1, 2012 through March 31, 2013, up to fifty million dollars;

(4) for the period April 1, 2013 through March 31, 2014, up to twenty-five million dollars.

(b) The distributions authorized pursuant to this section shall be made available through a reduction, as determined by the commissioner, in the state-wide base price as otherwise computed in accordance with this Subpart.

(c) Hospitals eligible for distributions pursuant to this section shall be public and non public general hospitals with Medicaid inpatient discharges equal to or greater than seventeen and one-half percent as reported for the 2007 period.

(d) Funds allocated pursuant to this section shall be allocated to eligible hospitals pursuant to a formula, as determined by the commissioner, such that, to the extent of funds available, no hospital's reduction in total Medicaid fee-for-service inpatient revenue for the corresponding rate periods, as a result of the application of otherwise applicable rate-setting methodologies in effect for such periods, exceeds a percentage reduction as determined by the commissioner.

(e) 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 a resolution of the Board of Directors of each such hospital setting forth its current financial condition, including ongoing board oversight, and shall, after two years, issue a report as adopted by each such Board of Directors setting forth what progress has been achieved regarding such improvement, provided, however, if such report fails to set forth adequate progress, as determined by the Commissioner, the Commissioner will deem such facility ineligible for further distributions pursuant to this section and will redistribute such further distributions to other eligible facilities in accordance with the provisions of this section. The Commissioner shall be provided with copies of all such resolutions and reports.

A new Section 86-1.39 is added, to read as follows:

86-1.39 Inpatient psychiatric services. Inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals, specializing in such inpatient psychiatric services,

with regard to patients admitted on and after October 20, 2010, shall be reimbursed on a per diem basis in accordance with the following, provided, however, that such rates applicable to inpatients otherwise subject to the provisions of public health law section 2807-c(1)(a-2)(i) shall be effective with regard to patients admitted on and after January 1, 2011:

(a) Such reimbursement shall be based on the All Patient Refined Diagnostic Related Group (APR-DRG) patient classification system as defined in section 86-1.15(a) of this Subpart.

(b) The operating component of the rate shall be based on a statewide price, utilizing 2005 Medicaid fee-for-service (FFS) inpatient costs adjusted for case mix and the Wage Equalization Factor (WEF) and excluding costs for Direct GME, Electroconvulsive Therapy, and capital costs.

(c) The capital cost components of rates computed pursuant to this section shall be computed on the basis of budgeted capital costs allocated to the hospital, or to the distinct unit of a hospital, in accordance with the provisions of section 86-1.25 of this Subpart divided by the hospital or distinct unit patient days and reconciled to actual total expenses.

(d) The non-operating component of the rate shall reflect 2005 Medicaid fee-for-service Direct GME costs.

(e) The statewide price shall be adjusted for each patient to reflect the following factors:

(1) a service intensity weight (SIW) associated with the case based on the grouper assigned APR-DRG, as described in subdivision (f) of this section, will be applied to the adjusted operating per diem;

(2) a rural adjustment factor of 1.2309 will be applied to the operating per diem for those hospitals designated as rural hospitals;

(3) an age adjustment payment factor of 1.0872 will be applied to the per diem operating component for adolescents ages 17 and under;

(4) a payment adjustment factor of 1.0599 will be applied to the operating component for the presence of a mental retardation diagnosis;

(5) the payment methodology shall include one co-morbidity factor per stay and if more than one co-morbidity is presented, the co-morbidity that reflects the highest payment factor shall be used to adjust the per diem operating component; and

(6) 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.

(f) (1) The table of service intensity weights (SlW's) applicable to rates set pursuant to this section for each effective period is published on the New York State Department of Health website at http://www.health.ny.gov/nysdoh/hospital/drg/index.htm and reflects the cost weights assigned to each All Patient Refined (APR) diagnosis related group (DRG) patient classification category. The SIWs assigned to each DRG/APR indicates the relative cost variance of that DRG/APR classification from the average cost of all inpatients in all DRG/APRs. Such 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 set forth in paragraph (2) of this subdivision. Costs associated with hospitals that do not have an ancillary charge structure and costs associated with statistical outliers shall be excluded from the SIW calculations.

(2) For rate periods on and after the effective date of this section the SIW shall be computed using SPARCS and reported cost data from the 2005 and 2006 calendar years, as submitted to the department by September 30, 2009.

(g) The table of co-morbidity factors applicable to the rate adjustments described in paragraph (5) of subdivision (e) of this section is published on the New York State Department of Health website at http://www.health.state.ny.us/.

(h) The first day of a patient's readmissions to the same hospital within thirty days of discharge will be treated as day four for purposes of the variable payment factor computed pursuant to paragraph (6) of subdivision (d) of this section, with subsequent days treated in a conforming manner with the provisions of such paragraph.

(i) Reimbursement for physician services shall not be included in rates set pursuant to this section and such services may be billed on a fee-for-services basis as otherwise provided by applicable provisions of law.

(j) Reimbursement for Electroconvulsive Therapy shall be established at a statewide fee of $281, as adjusted for each facility's WEF, for each treatment during a patient's stay.

(k) Reimbursement for days of alternative level of care for patients whose reimbursement is otherwise subject to this section shall be in accordance with section 86-1.22 of this Subpart.

(l) New inpatient psychiatric exempt hospitals or units established pursuant to article 28 of the public health law shall be reimbursed at the statewide price plus budgeted capital and Direct GME.

(m) For rate periods through December 31, 2014, reimbursement pursuant to this section shall include transition payments of up to twenty-five million dollars on an annualized basis, which shall be distributed in accordance with the following:

(1)(i) Fifty percent of such payments shall be allocated to facilities that experience a reduction in Medicaid operating revenue in excess of threshold percentage set forth in subparagraph (ii) of this paragraph as a result of the implementation of rates set pursuant to this section. Such payments shall be allocated proportionally, based on each eligible facility's relative Medicaid operating revenue loss in excess of the threshold, as determined by the commissioner.

(ii) The threshold percentage described in subparagraph (i) of this paragraph shall be 6.02%.

(2)(i) Fifty percent of such payments shall be allocated to facilities with regard to which it is determined by the commissioner that rates otherwise set pursuant to this section result in Medicaid revenue that is less than the facility's Medicaid costs by a threshold percentage in excess of the threshold percentage set forth in subparagraph (ii) of this paragraph. Such payments shall be allocated proportionally, based on the degree each facility Medicaid operating revenue shortfall exceeds such threshold percentage. For those facilities without available Medicaid fee-for-service cost data, computations pursuant to this paragraph shall be based on each such facility's total operating costs as determined by the commissioner.

(ii) The threshold percentage described in subparagraph (i) of this paragraph shall be 1.20%.

(n) For rate period after October 20, 2010 through March 31, 2011, reimbursement pursuant to this paragraph may include transition payments totaling, in aggregate, up to twelve million dollars and distributed to eligible hospitals in accordance with the following, provided, however, that if less than twelve million dollars is distributed in such rate period, then additional distributions of up to such twelve million dollars may be made in accordance with the provisions of this subdivision in subsequent rate periods:

(1) Eligible hospitals shall 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 beds to their certified bed capacity as a direct result of 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 have complied with Department of Health requests to make other significant behavioral health service delivery adjustments in direct response to such decertification.

(2) Eligible hospitals shall, as a condition of their receipt of such rate adjustments, submit to the Department of Health proposed budgets for the expenditure of such additional Medicaid payments for the purpose of providing behavioral health services and such budgets must be approved by the Department of Health, in consultation with the Office of Mental Health, prior to such rate adjustments being issued.

(3) Distributions made pursuant to this paragraph shall be made as add-ons to each eligible facility's inpatient Medicaid rate and shall be allocated proportionally, based on the proportion of each approved hospital budget to the total amount of all approved hospital budgets and such distributions shall be subsequently reconciled to ensure that actual aggregate expenditures are within available aggregate funding.

Section 86-1.44 is no longer RESERVED.

Section 86-1.45 (Federal financial participation) is renumbered Section 86-1.12.

Section 86-1.46 (Certified home health agency rates) is renumbered Section 86-1.13.

Section 86-1.47 (Allowance for certified home health agencies providing a disproportionate share of bad debt and charity care) is renumbered Section 86-1.14 and paragraphs (1) and (2) of subdivision (c) are amended to read as follows:

(1) the facility must ensure the availability of patient service 24 hours a day, 7 days a week as specified in [sections 763.1 and 764.2] section 763.3(d) of this Title;

(2) the facility must demonstrate compliance with minimum charity care service requirements specified in section [763.1(a)(14)] 763.11(a)(11) of this Title;

Sections 86-1.48 and 86-1.49 are no longer RESERVED.

Sections 86-1.50 through 86-1.55 are REPEALED.

Section 86-1.56 is renumbered Section 86-1.22 and amended to read as follows:

[86-1.56] 86-1.22. Alternate level of care payments.

(a) Hospitals shall be reimbursed for ALC days at the appropriate 1987 group average operating cost component of rates of payment for hospital-based residential health care facilities established pursuant to Subpart 86-2 of this Part trended to the rate year.

[(b) A bad debt and charity care allowance, a health care services allowance and a financially distressed allowance as determined pursuant to the provisions of section 86-1.65 of this Subpart shall be added to the rates specified in subdivision (a) of this section.

(c)] The determination of the group average operating rate for hospital-based residential health care facilities [specified in subdivision (a)] shall be based on the combination of residential health care facilities as follows:

(1) The downstate group consisting of residential health care facilities located in the five boroughs of New York City and Nassau, Suffolk, Westchester and Rockland Counties.

(2) The upstate group consisting of all other residential health care facilities in the State.

[(d)] (b) Hospitals that convert medical/surgical beds to residential health care beds shall be reimbursed for services provided in the converted beds in accordance with Subpart 86-2 of this Part.

[(e) Payor rates of payment.

(1) The same alternate level of care rate of payment adjusted for uncovered services, determined pursuant to this section, shall be paid for all alternate level of care (ALC) services provided on or after January 1, 1988 and shall be used by the following payors:

(i) State government agencies;

(ii) corporations organized and operating in accordance with article 43 of the Insurance Law;

(iii) organizations operating in accordance with article 44 of the Public Health Law; and

(iv) effective January 1, 1991 local governmental agencies shall pay for ALC services provided to inmates of local correctional facilities as defined in subdivision 16 of section 2 of the Correction Law at rates determined for State government agencies.

(2) Workers' compensation, volunteer firefighters, volunteer ambulance workers and no-fault insurance programs and commercial carriers. Payments to general hospitals for reimbursement of ALC services provided to patients eligible for payments pursuant to the Comprehensive Motor Vehicle Insurance Reparations Act or enrolled in a self-insured fund which meets the criteria specified in section 86-1.51(c) of this Title, or insured under a commercial insurer meeting the criteria of section 86-1.51(c) of this Title, shall be the ALC rate specified in this section for services provided to subscribers of article 43 corporations, adjusted for uncovered services, and increased by 13 percent or, for payments to general hospitals for reimbursement of ALC services provided to patients eligible for payments pursuant to the

Workers' Compensation Law, the Volunteer Firefighters' Benefit Law, Volunteer Ambulance Workers' Benefit Law, increased by five percent.

(3) With the exception of the payments provided for in paragraphs (1) and (2) of this subdivision and payments made pursuant to section 86-1.51(e) of this Title, payments for all other ALC patients shall be on the basis of charges. The maximum amount to be charged to any charge paying patients for ALC services shall be 120 percent of the ALC rate determined in paragraph (2) of this subdivision without adjustment in accordance with section 2807-c(11)(i) of the Public Health Law.]

Section 86-1.57 (Exempts units and hospitals) is REPEALED.

Section 86-1.58 is renumbered Section 86-1.24 and amended to read as follows:

[86-1.58] 86-1.24. Trend factor.

[(a)] 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 [section 86-1.52] this Subpart, shall be trended to the applicable rate year by the trend factors developed in accordance with the provisions of [this section] subdivision 10 of section 2807-c of the Public Health Law.

[(b) 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 heath-related services appointed by the commissioner.

(c) 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 nonsupervisory employees.

(d) The commissioner shall implement one prospective interim annual adjustment to the trend factors, based on recommendations of the panel, effective on January 1st, one year after the

initial trend factor was established and one prospective final annual adjustment to the trend factors based on recommendations of the panel to be effective on January 1st, two years after the initial trend factor was established. 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 factors.]

Section 86-1.59 is renumbered Section 86-1.25 and amended to read as follows:

[86-1.59] 86-1.25. Capital expense reimbursement [for DRG case-based rates of payment.

Capital expense shall not include capital expense allocated to exempt units and designated AIDS centers.]

(a) The allowable costs of fixed capital (including but not limited to depreciation, rentals and interest on capital debt), [or, for hospitals financed pursuant to article 28-B of the Public Health Law, amortization in lieu of depreciation, and interest and other approved expenses associated with both fixed capital and major movable equipment)] and major movable equipment shall[, with the exception noted in subdivision (c) of this section,] be reimbursed based on budgeted data and shall be reconciled to total actual expense for the rate year and shall be determined and computed in accordance with the provisions of [sections 86-1.23, 86-1.24, 86-1.29, 86-1.30 and 86-1.32 of this Subpart] subdivisions (f), (g), and (h) of this section. [In order for budgeted expenses to be reconciled to actual:

(1) Rates of payment for a general hospital shall be adjusted to reflect the dollar difference between budgeted capital related inpatient expenses included in the computation of

rates of payment for a prior rate period and actual capital related inpatient expenses for the same prior rate period.

(2) This amount shall be adjusted to reflect increases or decreases in volume for the same rate period.

(3) Capital related inpatient expenses included in the computation of payment rates based on budget shall not be included in the computation of a volume adjustment as described in section 86-1.64(a) of this Subpart.

(4) Prospective adjustments shall not be carried forward except for those adjustments authorized in of section 86-1.64(a) of this Subpart.]

(b) General hospitals shall submit a 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.

(c) [For hospitals whose average budgeted capital expense in 1984, 1985 and 1986 exceeded 110 percent of average actual allowable capital expense for those years, the commissioner shall use the most recently available certified cost report data for purposes of effecting capital cost reimbursement pursuant to this section.

(d)] The following principles shall apply to budgets for inpatient capital-related expenses:

(1) The basis for determining capital-related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for construction of the capital asset.

(2) Any capital-related inpatient expense generated by a capital expenditure which requires or required approval pursuant to article 28 of the Public Health Law, must have received such approval for the capital-related expense to be included in the rate calculation.

(3) 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.

(4) 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.

[(e)] (d) Allocation of budgeted capital costs. In each rate year budgeted capital costs shall be allocated to exempt [and nonexempt units and to the Medicare program,] units and hospitals (including certified substance abuse detoxification services) to DRG case-payment rates[, and to payments for transfer patients (other than patients assigned to the transfer DRG's) and short-stay patients as follows:

(1) Allocation to exempt units and to Medicare within exempt units. Budgeted capital costs shall be allocated to exempt units based on reported exempt unit costs and statistics for the year two years prior to the rate year. The Medicare share of exempt unit capital costs shall be based on budgeted Medicare exempt unit days for the rate year (reconciled to actual rate year days) and the exempt unit's average budgeted capital cost per day, calculated using total budgeted days for the exempt unit. Exempt unit budgeted capital costs shall be reconciled to actual exempt unit capital costs in the rate year after these data are available.

(2) Allocation to nonexempt units and to non-Medicare DRG case payment rates within nonexempt units and hospitals. The balance of budgeted capital costs, after allocation to exempt units, shall be allocated to nonexempt units. The non-Medicare share of budgeted capital costs

in both nonexempt units and nonexempt hospitals shall be based on budgeted non-Medicare nonexempt unit days for the rate year (which, for purposes of this paragraph only, shall exclude short stay and transferred-out patient days and which shall be reconciled to actual rate year days) and the nonexempt hospital's average budgeted capital cost per day calculated using total nonexempt budgeted days. Budgeted capital costs shall be reconciled to actual capital costs for the nonexempt hospital in the rate year after these data are available based upon the non-Medicare share of capital costs derived by subtracting Medicare capital costs from total capital costs. Medicare capital costs shall be determined by applying the relationship of Medicare ancillary charges to total ancillary times total inpatient ancillary capital costs. Total Medicare capital shall be these ancillary costs added to the routine portion of Medicare inpatient capital, adjusted for secondary payors.

(3) Allocation to payments for transfer patients and short-stay patients. Budgeted capital costs shall be allocated to payments for transferred patients and short-stay patients based on estimated nonexempt unit non-Medicare days reconciled to actual rate year days.] based on reported capital traceback statistics for the two years prior to the rate year.

[(f)] (e) Payment for budgeted allocated capital costs.

(1) Capital per diems for exempt units and hospitals shall be calculated by dividing the [allocated non-Medicare] budgeted capital costs [identified] allocated to such rates in paragraph [(e)(1)] (d) of this section by [1985] the exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital-approved capital expense.

(2) Capital payments for DRG case rates shall be determined by dividing the budgeted capital allocated to such rates in paragraph (d) of this section by the hospital's [most recently

available annual non-Medicare,] budgeted nonexempt unit discharges, reconciled to rate year discharges and actual rate year nonexempt unit or hospital-approved capital expense.

(3) Capital payments for transferred [and short stay] patients shall be [the nonexempt hospital's average budgeted capital cost per day determined pursuant to paragraphs (e)(2) and (3) of this section] determined by dividing the budgeted capital allocated to the DRG case payment rates by the budgeted nonexempt hospital's unit days, reconciled to rate year days and actual rate year nonexempt unit or hospital approved capital expense.

(f) Depreciation.

(1) 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, American Hospital Association, consistent with title XVIII provisions. Copies of this publication are available from the American Hospital Association, One North Franklin, Chicago, IL 60606-3421, 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.

(2) In the computation of rates 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 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 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 to be considered as valid funding transactions unless expended for the purpose for which it was funded.

(3) In the computation of rates 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.

(4) 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 commissioner 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 the 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.

(5) Article IX-C corporations may elect to include in their reimbursement rates depreciation computed by a method other than that used in paragraphs (2) and (3) of this subdivision, subject to approval by the commissioner.

(6) With respect to outpatient facilities, capital cost reimbursement may include an amount for rent, provided the following conditions are met:

(i) the lease is reviewed and approved by the department or any other appropriate State agency;

(ii) the space rented is in a multi-purpose, multi-use building not specifically constructed for the purpose of housing an outpatient facility;

(iii) the rental, if the lease is a sublease, is the same or less than comparable leases in the geographic area;

(iv) the applicant has no interest, direct or indirect, beneficial or of record, in the ownership of the building or any overlease; and

(v) the rental per square foot, in the judgment of the department, is the same as or is comparable to other rentals in the building in which the outpatient service is to be located, and the rental per square foot is comparable to the rental of similar space in other comparable buildings in the area when such comparisons can be made.

(g) Interest.

(1) Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities.

(2) 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 and exclude costs and fees 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 specific project shall exist when all available restricted funds designated for capital acquisition of that type have been considered for equity purposes.

(3) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trusteed 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

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

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

(5) 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:

(i) 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;

(ii) incurred for the purpose of financing the acquisition, construction or renovation of land, building or nonmovable 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.

(6) 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.

(7) 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.

(h) Sales, leases and realty transactions.

(1) 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, the capital cost component of such rate shall be determined in accordance with the provisions of this section.

(2) 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 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.

(3) An arms length lease purchase agreement with a nonrelated lessor involving plant facilities or equipment which meets any one of the four following conditions, establishes the lease as a virtual purchase.

(i) The lease transfers 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 less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.

(4) If a lease is established as a virtual purchase under subdivision (d) of this section, 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 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.

(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.

(5) 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.

Sections 86-1.60 through 86-1.66 are REPEALED.

Section 86-1.67 (Statewide Planning and Research Cooperative System (SPARCS) is renumbered Section 86-1.26 and amended to read as follows:

Section [86-1.67] 86-1.26 - Statewide Planning and Research Cooperative System (SPARCS).

Each general hospital shall be assessed an annual fee calculated on the basis of the hospital's proportionate share of the sum of total costs reported by all general hospitals in the

most recent calendar year for which certified data are available. Such amount shall not exceed one tenth of one percent of the total certified cost of the hospital. The commissioner shall inform each such hospital of its actual fee to support the statewide planning and research cooperative system and each hospital shall submit such fee on a quarterly basis to be received by the commissioner not later than the 15th of February, May, August and November of each year. Failure to submit such fees in accordance with this schedule may 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. These funds shall be pooled on a statewide basis and will be restricted and used to support the costs of the statewide planning and research cooperative systems. [Rates established for periods commencing January 1, 1988 and thereafter under the provisions of section 86-1.54 of this Subpart shall be adjusted and charges established in accordance with this Subpart may be increased to reflect the proportionate share of costs associated with such annual fee.]

Section 86-1.68 (Federal upper limit compliance) is renumbered Section 86-1.27.

Section 86-1.69 is no longer RESERVED.

Sections 86-1.70 and 86-1.71 are REPEALED.

Section 86-1.72 is renumbered Section 86-1.29 and amended to read as follows:

Section [86-1.72] 86-1.29. New hospitals and hospitals on budgeted rates.

(a) *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 [section 86-1.52 of] this Subpart except as follows:

(1) Rates of payment shall be computed on the basis of 100 percent of the [hospital's group average reimbursable inpatient operating cost per discharge] statewide base price

determined pursuant to section [86-1.54(b)] 86-1.16 of this Subpart multiplied by the service intensity weight for each DRG set forth in section [86-1.62] 86-1.18 of this Subpart.

(2) The WEF [and PEF] used to adjust the [group average cost per discharge] statewide base price shall be [those calculated for the hospital in the group that is geographically closest to the new facility] equal to 1.0 until adequate data becomes available.

(3) The indirect teaching adjustment shall be determined pursuant to the provisions of section [86-1.54(h)] 86-1.20 of this Subpart.

(4) The noncomparable operating costs of new facilities [associated with] as defined in section 86-1.15 of this Subpart and direct graduate medical education[, ambulance services, organ acquisition, schools of radiology, nursing and/or laboratory technology, and hospital-based physicians] costs shall consist of the hospital's budgeted operating costs for these services[, divided by the weighted average case mix index for the hospital's group].

(b) *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 [section 86-1.52 of] this Subpart except as follows:

(1) [In 1988, the DRG specific operating cost factor shall be computed as the sum of 90 percent of the hospital's case mix neutral budgeted average reimbursable non-Medicare inpatient operating cost per discharge and 10 percent of the hospital's group average reimbursable inpatient operating cost per discharge determined pursuant to subdivision (b) of section 86-1.54 of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart. In 1989, the DRG specific operating cost factor shall be computed as the sum of 75 percent of the hospital's case mix neutral budgeted average reimbursable non-

Medicare inpatient operating cost per discharge and 25 percent of the hospital's group average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54(b) of this Subpart multiplied by the service intensity factor for each DRG set forth in section 86-1.62 of this Subpart. For rate years commencing 1990 and thereafter, the DRG specific operating cost factor shall be computed as the sum of 45 percent of the hospital's case mix neutral budgeted average reimbursable non-Medicare inpatient operating cost per discharge and 55 percent of the hospital's group average reimbursable inpatient operating cost per discharge determined pursuant to subdivision (b) of section 86-1.54 of this Subpart multiplied by the service intensity factor for each DRG set forth in section 86-1.62 of this Subpart.

(2)] Reimbursement for the costs of graduate medical education and non comparable services shall be calculated pursuant to the provisions of paragraphs (a)(3) and (4) of this section.

[(3)] (2) The WEF [and PEF] used shall be [those] calculated for the facility based on available historical data.

Section 86-1.73 (Swing bed reimbursement) is renumbered Section 86-1.30.

Sections 86-1.74 and 86-1.75 are REPEALED.

Sections 86-1.76 through 86-1.79 are no longer RESERVED.

Sections 86-1.80 through 86-1.84 are REPEALED.

Section 86-1.85 is no longer RESERVED.

Section 86-1.86 (Rural health network rate enhancements) is REPEALED.

Section 86-1.87 is renumbered Section 86-1.35 and amended to read as follows:

Section [86-1.87] 86-1.35. Disproportionate share limitations.

(a) [Effective April 1, 1994 and thereafter for public hospitals and April 1, 1995 and thereafter for all other hospitals, disproportionate] Disproportionate share payment distributions

made to general hospitals pursuant to [subdivisions (k) and (o)(4) of section 86-1.65 and sections 86-1.74 and 86-1.84 of this Subpart] Article 28 of the Public Health Law 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 [subdivisions] subdivision (b) [and (c)] of this section and for projected limits pursuant to subdivision [(f)] (e) of this section. 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 subdivision [(g)] (f) of this section.

(b) [Effective April 1, 1994, general] General hospitals whose inpatient Medicaid eligible patient days are less than one percent of total inpatient patient days shall not be eligible to receive disproportionate share distributions.

(c) [For the period April 1, 1994 through March 31, 1995, the disproportionate share limit of public general hospitals with inpatient Medicaid eligible patient days, as a percentage of total inpatient patient 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 pursuant to subdivision (d) of 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. Payments to public hospitals in excess of 100 percent of unreimbursed costs shall not be distributed until the facility submits to the commissioner a written certification

signed by its chief executive and/or financial officer, stating that all distributions in excess of the 100 percent limit will be used for health services.

(d)] No general hospital shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred during the periods described in subdivision (a) of this section 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 for the services provided 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.

[(e)] (d) 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 [and bad debt and charity care] reports. The commissioner shall use [revised projected limitations calculated pursuant to subdivision (g) of this section, rather than] annual cost reports [for the same fiscal period,] in accordance with the provisions of subdivision (e) of this section 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".

[(f)] (e) 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 [for] from the [base] year two years immediately preceding the rate year and as used for projection methodology purposes for that prior year. [and shall be calculated as follows:

(1) Medicaid revenue per unit of inpatient service shall be determined by using the Medicaid rates effective January 1st, for such rate year, after hotline changes for both case payment and exempt units, including prospective adjustments for prior rate years, but excluding prospective adjustments in rates for the rate years prior to the implementation of the Federal hospital specific disproportionate share payment limits.

(i) For general hospitals, except financially distressed hospitals, the Medicaid revenue per unit of inpatient service shall be reduced by 1.7 percent to provide for consideration of assessments paid by hospitals pursuant to Public Health Law sections 2807-c and 2807-d.

(ii) For all hospitals, revenues for the health maintenance organization/prepaid health services plan inpatient services for Medicaid patients shall be reduced by 15 percent.

(2) Medicaid cost per unit of inpatient service shall be determined as follows:

(i) Base year non-Medicare inpatient costs for such rate year, for each service area cost center, shall be divided by units of service, and, except for exempt hospitals and exempt units of general hospitals, adjusted by the non-Medicare case mix index to arrive at the non-Medicare inpatient case mix neutral cost per unit.

(ii) The result, except for exempt hospitals and exempt units of general hospitals, shall be multiplied by the Medicaid case mix index, and then increased in each year from the base year to the rate year by two percent for anticipated changes in projected Medicaid and self-pay losses resulting from Medicaid and self-pay case mix and volume increases. Such amount shall then be trended to the rate year pursuant to section 86-1.58 of this Subpart.

(3) Medicaid inpatient gain/(loss) shall be equal to each hospital's Medicaid revenue per unit of inpatient service reduced by Medicaid cost per unit of inpatient service, for each service area cost center, multiplied by Medicaid units for each such cost center and summed for all such inpatient cost centers.

(4) Medicaid revenue per unit of outpatient service for each outpatient service category shall be determined by using the latest available Medicaid rate per visit for each outpatient service category. The calculated cost-based clinic and ambulatory surgery average rates per visit, as provided to hospitals by the commissioner, shall be used instead of Products of Ambulatory Care rates pursuant to section 86-4.37 of this Part and Products of Ambulatory Surgery rates pursuant to section 86-4.40 of this Part.

(i) For general hospitals, except financially distressed hospitals, the Medicaid revenue per unit of outpatient service shall be reduced by .7 percent to provide for consideration of assessments paid by hospitals pursuant to Public Health Law section 2807-d.

(5) Medicaid cost per unit of outpatient service for each outpatient service area shall be determined by dividing the applicable base year outpatient costs, for the service area cost center, by the latest available reported total outpatient visits for such cost centers. The result for each such cost center shall then be increased in each year from the base year to the rate year by two percent for anticipated changes in projected Medicaid and self-pay losses resulting from

Medicaid and self-pay case mix and volume increases. Such amount shall then be trended to the rate year pursuant to section 86-1.58 of this Subpart.

(6) Medicaid outpatient gain/(loss) shall be equal to the hospital's Medicaid revenue per unit of outpatient service reduced by Medicaid cost per unit of outpatient service for each service area cost center multiplied by Medicaid units for each such cost center and summed for all such cost centers.

(7) Self-pay cost per unit of inpatient service for each rate year shall be calculated for case payment cases by multiplying the non-Medicare case mix neutral cost per unit as defined in subparagraph (2)(i) of this subdivision by the hospital's self-pay case mix index. For self-pay exempt unit cases, self-pay cost per unit for each rate year shall be determined by dividing non-Medicare base year costs for such exempt units by base year exempt unit days. The results of these calculations shall then be increased in each year from the base year to the rate year by two percent for anticipated changes in projected Medicaid and self-pay losses resulting from Medicaid and self-pay case mix and volume increases. Such amount shall then be trended to the rate year pursuant to section 86-1.58 of this Subpart.

(8) Inpatient self-pay cost for case payment and exempt unit cases shall be determined by multiplying the self-pay cost per unit of inpatient service by the most currently available reported number of units.

(9) Self-pay inpatient loss shall be determined by multiplying inpatient self-pay costs for case payment and exempt unit cases by the most current uncollectible percentage for case payment and exempt unit cases reported by each hospital to the commissioner on its bad debt and charity care reports.

(10) Self-pay gross cost per visit for each outpatient service area cost center shall be estimated using as a proxy the Medicaid cost per unit of outpatient services as defined in paragraph (5) of this subdivision.

(11) Self-pay outpatient gross costs for each outpatient service area cost center shall be calculated by multiplying the latest available reported self-pay outpatient visits for each cost center by self-pay gross cost per visit for each cost center.

(12) Self-pay outpatient loss shall be determined by multiplying self-pay outpatient gross costs for each outpatient service area cost center by the most current uncollectible percentage for each cost center reported by the hospital to the commissioner on their bad debt and charity care reports and summing the results for all outpatient service area cost centers.

(13) Each hospital's disproportionate share limit shall be equal to the sum of its inpatient and outpatient gains/(losses) for both Medicaid and self-pay as determined in accordance with this subdivision.]

[(g)] (f) Reconciliation methodology. The commissioner shall revise the projected limitation based on actual data reported to the commissioner for such rate 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 section 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.

(1) Each hospital shall submit, by the same date the annual cost reports are required to be filed pursuant to section [86-1.3] 86-1.2 of this Subpart, a disproportionate share limitation schedule in a form and manner prescribed by the commissioner within which the hospital shall calculate, in accordance with the instructions, its inpatient and 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.

(2) [The limitations established pursuant to this subdivision shall represent the final limits applicable to disproportionate share general hospital distributions described in section 86-1.65(k) of this Subpart for each applicable annual rate year.

(3)] 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 all subsequent disproportionate share distributions. Such withholding shall continue until the hospital complies with the reporting requirements of this subdivision.

Sections 86-1.88 and 86-1.89 are REPEALED.

REGULATORY IMPACT STATEMENT

Statutory Authority:

The requirement to implement a modernized Medicaid reimbursement system for hospital inpatient services based upon 2005 base year operating costs pursuant to regulations is set forth in section 2807-c(35) of the Public Health Law. In addition, section 2807-c(4)(e-2) of the Public Health Law requires new per diem rates of reimbursement be implemented for certain exempt units and hospitals based on updated reported operating costs. Section 2807-k(5-b)(a)(ii) and (iv); and (b)(i), (iv) and (v) requires schedules of payment to be set forth in regulations for supplemental indigent care distributions made to certain eligible hospitals.

Legislative Objectives:

After numerous discussions between the Executive, Legislature, hospital associations and other key stakeholders, the Legislature chose to create a new, modernized reimbursement methodology for the State's Medicaid hospital inpatient system. Pursuant to statute, the APR-DRG methodology was chosen as the new reimbursement system for these services.

Needs and Benefits:

The proposed regulations implement the provisions of Public Health Law section 2807-c(35) which requires a new hospital inpatient reimbursement system based on APR-DRGs and rebased costs. This methodology provides a more transparent and simplified reimbursement system that drives reimbursement consistent with efficiency, quality and public health priorities. This new payment methodology will also allow the Department to publish hospital rates more timely, and provide hospitals with greater predictability of their income streams.

The current reimbursement system for hospital inpatient services is extremely outdated, and does not effectively serve the interests of patients, providers, or the Medicaid system. Not only does the system's overall reimbursement greatly exceed the cost of providing such services, the methodology for allocating payments does not appropriately reflect the acuity of the patient, the quality of service, or the efficiency of the hospital. Over the years the current system has accrued numerous groupings, weightings, adjustments, and add-ons that have ultimately distorted the health care delivery system.

Per diem rates of payment by governmental agencies for inpatient services provided by a general hospital or a distinct unit of a general hospital for services in accord with physical medical rehabilitation and chemical dependency rehabilitation; services provided by critical access hospitals; inpatient services provided by specialty long term acute care hospitals; and services provided by facilities designated by the federal department of health and human services as exempt acute care children's hospitals are also developed using an outdated cost base which does not properly reflect current costs incurred for providing such services.

The APR-DRG methodology addresses the inadequacies of the current system by using an updated and more reliable cost base and a patient classification system that incorporates patient severity of illness and risk of mortality subclasses, reflecting the variable costs associated with each individual patient being treated. Utilizing an updated and more precise cost base will have the effect of reducing the total amount of Medicaid reimbursement paid to hospitals for inpatient services, which is found to be significantly overpaid. Accordingly, the State would be able to, consistent with budgetary constraints, reinvest these savings in primary and preventive care and other traditionally under-paid ambulatory care services in order to improve the quality

of patient care, ensure adequate access to these services, and avoid more costly inpatient admissions.

COSTS:

Costs to State Government:

Section 2807-c(35) of the Public Health Law requires that the rates of payment for hospital inpatient services result in a net state wide decrease in aggregate Medicaid payments of no less than $75 million for the period December 1, 2009 through March 31, 2010 and no less than $225 million for the period April 1, 2010 through March 31, 2011. Effective for annual periods beginning January 1, 2010, distributions to hospitals for indigent care pool DSH payments will be made as follows: $269.5 million will be distributed to hospitals, excluding major public hospitals, on a regional basis and within the amounts available for each region, to compensate each eligible hospital's proportional share of unmet need for calendar year 2007; $25 million will be distributed to hospitals, excluding major publics, having Medicaid discharges of 40% or greater as determined from date reported in the 2007 Institutional Cost Report. The distributions will be proportionately distributed based on each eligible facility's uninsured losses to such losses of all the eligible facilities; $16 million will be proportionately distributed to non-teaching hospitals based on each eligible facility's uninsured losses to such losses for all non-teaching hospitals statewide.

Costs of Local Government:

There will be no additional cost to local governments as a result of these amendments because local districts' share of Medicaid costs is statutorily capped.

Costs to the Department of Health:

There will be no additional costs to the Department of Health as a result of these amendments.

Local Government Mandates:

There are no local government mandates.

Paperwork:

There is no additional paperwork required of providers as a result of these amendments.

Duplication:

These regulations do not duplicate existing State and Federal regulations.

Alternatives:

No significant alternatives are available. The Department is required by the Public Health Law sections 2807-c(4)(e-2) and (35); 2807-k(5-b)(a)(ii) and (iv); and (b)(i), (iv), and (v) to promulgate implementing regulations.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

The proposed amendment establishes the new APR-DRG reimbursement methodology for discharges on or after December 1, 2009; there is no period of time necessary for regulated parties to achieve compliance.

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REGULATORY FLEXIBILITY ANALYSIS
FOR
SMALL BUSINESS AND LOCAL GOVERNMENTS

Effect on Small Business and Local Governments:

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, seven hospitals were identified as employing fewer than 100 employees.

In aggregate, health care providers subject to this regulation will see a decrease in average per discharge Medicaid funding, but this is not anticipated for all affected providers.

This rule will have no direct effect on Local Governments.

Compliance Requirements:

No new reporting, record keeping or other compliance requirements are being imposed as a result of these rules. Affected health care providers will bill Medicaid using procedure codes and ICD-9 codes approved by the American Medical Association, as is currently required. Some billing rate codes will change, but this will have a minimal impact on providers.

The rule should have no direct effect on Local Governments.

Professional Services:

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

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor will there be an annual cost of compliance. As a result of these amendments to 86-1.2 through 86-1.89 there will be an

anticipated decrease in statewide aggregate hospital Medicaid revenues for hospital inpatient services. Revenues will shift among individual hospitals.

Economic and Technical Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this rule. The proposed amendments are technologically feasible because it requires the use of existing technology. The overall economic impact to comply with the requirements of this regulation is expected to be minimal.

Minimizing Adverse Impact:

The proposed amendments reflect statutory intent and requirements. The Legislature considered various alternatives for creating a new Medicaid hospital inpatient reimbursement methodology; however, the enacted budget adopted the APR-DRG methodology.

Small Business and Local Government Participation:

Draft regulations, prior to filing with the Secretary of State, were shared with industry associations representing hospitals and comments were solicited from all affected parties. Informational briefings were held with such associations.

RURAL AREA FLEXIBILITY ANALYSIS

Effect on Rural Areas:

Rural areas are defined as counties with a population less than 200,000 and, for counties with a population greater than 200,000, includes towns with population densities of 150 persons or less per square mile. The following 44 counties have a population 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	Saratoga	

The following 9 counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Compliance Requirements:

No new reporting, record keeping, or other compliance requirements are being imposed as a result of this proposal.

Professional Services:

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

Compliance Costs:

No initial capital costs will be imposed as a result of this rule, nor is there an annual cost of compliance.

Minimizing Adverse Impact:

The proposed amendments reflect statutory intent and requirements. The Legislature considered various alternatives for creating a new Medicaid fee-for-service reimbursement methodology; however, the enacted budget adopted the APR-DRG methodology.

Rural Area Participation:

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. It is apparent, from the nature and purpose of the proposed rules, that they will not have a substantial adverse impact on jobs or employment opportunities. The proposed regulations revise the reimbursement system for inpatient hospital services. The proposed regulations have no implications for job opportunities.