DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

JAN 28 2014

Jason A. Helgerson
State Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs
NYS Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

RE: TN 13-13

Dear Mr. Helgerson:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-13. Effective January 1, 2013, this amendment provides a new methodology to distribute DSH payments for indigent care.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of January 1, 2013. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please contact Tom Brady at 518-396-3810.

Sincerely,

Cindy Mann
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 13-13	2. STATE New York
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2013	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447	7. FEDERAL BUDGET IMPACT: a. FFY 01/01/13-09/30/13 $ 9,409,927 b. FFY 10/01/13-09/30/14 $ 12,546,570
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A: Contents Page; Pages 140, 143, 144, 144(a), 144(b), 144(c), 144(d), 152, 160, 161(a), 161(b), 161(b)(i), 161(c), 161(d), 161(e), 161(f), 161(g), 161(h), 161(i), 161(j)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-A: Contents Page; Pages 140, 143, 144, 144(a), 144(b), 144(c), 144(d), 152, 160, 161(a), 161(b), 161(b)(i), 161(c)

10. SUBJECT OF AMENDMENT:
Indigent Care Adjustments & Indigent Care Pool
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO: New York State Department of Health Bureau of Federal Relations & Provider Assessments 99 Washington Ave – One Commerce Plaza Room 1430 Albany, NY 12210
13. TYPED NAME: Jason A. Helgerson	
14. TITLE: Medicaid Director Department of Health	
15. DATE SUBMITTED: January 27, 2014	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JAN 28 2014
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2013	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, Policy Financial Mgt. CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

January 27, 2014

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMCS
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

Re: SPA #13-13
Institutional Services

Dear Mr. Cooley:

The State is resubmitting and requests approval of SPA #13-13 regarding Indigent Care Adjustments and Indigent Care Pool to be effective January 1, 2013.

Attached are the appropriate plan pages and CMS-179 form. As requested by CMS, this amendment is being resubmitted in order to restart the clock for the approval of this SPA.

If you have any questions regarding this State Plan Amendment submission, please do not hesitate to contact Mr. John E. Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting at (518) 474-6350.

Sincerely,

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

Attachments

New York
Contents

Hospital Inpatient Reimbursement – Effective December 1, 2009

New York
140

Supplemental indigent care distributions.

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

1. From funds in the pool for each year, except as otherwise provided for in this section, $27 million shall be reserved on an annual basis for the periods January 1, 2000 through May 1, 2009, to be distributed to each hospital based on each hospital's proportional annual reduction to their projected distribution from the New York State Health Care Reform Act Profession Education Pool, relative to the statewide annual reduction to said pool, as authorized by State law, up to the hospital specific disproportionate share (DSH) payment limits.

2. Effective May 1, 2009 through December 31, 2009:

   a. Each hospital eligible for supplemental indigent care distributions in 2008 shall receive 90% of its 2008 annual award amount as Medicaid DSH payment.

   b. $307 million shall be distributed to facilities designated by the Department as teaching hospitals as of December 31, 2008, to compensate such facilities for Medicaid and self-pay losses. The payment amounts apply consistently to all teaching hospitals, and are reasonably related to costs, based on Medicare GME payments as a proxy, and are pursuant to the following schedule of payments:

New York
143

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

c. Effective May 1, 2009 through December 31, 2009, $16 million shall be proportionally distributed to non-teaching hospitals based on their proportion of uninsured losses as determined according to the methodology contained in the High Need Indigent Care Adjustment Pool of this Attachment.

[d. Effective December 1, 2009, $25 million shall be distributed to non-major public hospitals having Medicaid discharges of 40% or greater from data reported in each hospital's 2007 annual cost report, based on each hospital's decrease in Medicaid revenues resulting from the reductions in trend factors for 2008 and 2009 as contained in this Attachment and the inpatient and outpatient reimbursement methodology changes effective December 1, 2009.]

3. For annual periods beginning on and after January 1, 2010 through December 31, 2012:

   a. From regional allotments specified below, $269.5 million shall be distributed to non-major public teaching hospitals on a regional basis to cover each eligible facility's proportional regional share of 2007 uncompensated care, as defined in the disproportionate share payment calculation provisions of this Attachment and offset by disproportionate share payments received by each facility during the respective pool year in accordance with the disproportionate share payment calculations provisions of this Attachment.

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

   b. $25 million shall be distributed to non-major public hospitals eligible for payments based upon each facility's proportion of uninsured losses as determined according to the methodology in the High Need Indigent Care Adjustment Pool of this Attachment.

   c. $16 million shall continue to be proportionally distributed to non-teaching hospitals based on their proportion of uninsured losses as determined according to the methodology contained in the High Need Indigent Care Adjustment Pool of this Attachment.

   d. $25 million shall be distributed to non-major public hospitals having Medicaid discharges of 40% or greater from data reported in each hospital's 2007 annual cost report, based on each hospital's decrease in Medicaid revenues resulting from the reductions in trend factors for 2008 and 2009 as contained in this Attachment and the inpatient and outpatient reimbursement methodology changes effective December 1, 2009.

New York
144(a)

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

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

(i) Each eligible rural hospital will receive a payment of $140,000 on an annualized basis for the period January 1, 2000 through September 30, 2009. Effective on and after October 1, 2009 through December 31, 2012, each eligible rural hospital will receive a payment of $126,000 on an annualized basis, provided as a disproportionate share payment; provided, however, that if such payment pursuant to this clause exceeds a hospital's applicable disproportionate share limit, then the total amount in excess of such limit will be provided as a nondisproportionate share payment in the form of a grant directly from this pool without federal financial participation;

(ii) Each such hospital will also receive an amount calculated by multiplying the facility's uncompensated care need by the appropriate percentage from the following scale based on hospital rankings developed in accordance with each eligible rural hospital's weight as defined by this section:

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

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

New York
144(b)

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

(iv) "Eligible rural hospital weight", as used in paragraph (1), shall mean the result of adding, for each eligible rural hospital:

(a) The eligible rural hospital's targeted need, as defined in subparagraph (ii) of this section, minus the mean targeted need for all eligible rural hospitals, divided by the standard deviation of the targeted need of all eligible rural hospitals; and

(b) The mean number of beds of all eligible rural hospitals minus the number of beds for an individual hospital, divided by the standard deviation of the number of beds for all eligible rural hospitals.

(2) From the funds in the pool each year, except as otherwise provided for in this section, $36 million on an annualized basis for the periods January 1, 2000 through September 30, 2009, and for the periods on and after October 1, 2009 through December 31, 2012, $32.4 million on an annualized basis, of the funds not distributed in accordance with paragraph (1), shall be distributed in accordance with the formula set forth in paragraph (12) of the Medicaid disproportionate share payments section of this Attachment.

(3) From the funds in the pool each year, any funds not distributed in accordance with paragraphs (1) or (2), shall be distributed in accordance with the formula set forth in subparagraph (d) of paragraph (10) of the Medicaid disproportionate share payments section.

New York
144(c)

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

(a) $13.93 million will be distributed to major government hospitals and will be allocated proportionally, based on each facility's relative uncompensated care need as determined in accordance with (c);

(b) $70.77 million will be distributed to general hospitals other than major government general hospitals and will be allocated proportionally, based on each facility's relative uncompensated care need as determined in accordance with (c);

(c) each facility's relative uncompensated care need amount will be determined by multiplying inpatient units of services for all uninsured patients from the calendar year two years prior to the distribution year, excluding referred ambulatory units of services, by the applicable Medicaid inpatient rates in effect for such prior year, but not including prospective rate adjustments and rate add-ons, provided, however, that for distributions on and after January 1, 2010 through December 31, 2012, the uncompensated amount for inpatient services shall utilize the inpatient rates in effect as of July 1 of the prior year; and:

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

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

New York
144(d)

(d) (i) Continuing annually for periods on and after January 1, 2009 through December 31, 2012, no general hospital will receive DSH payment distributions that exceed the costs incurred by such hospital during the distribution period for providing inpatient and outpatient hospital services to Medicaid eligible patients or, uninsured patients. Such costs will be net of monies received from non-DSH related Medicaid payments and collections from uninsured patients.

(ii) DSH payment reductions will first be made from the public general hospital indigent care adjustment payments pursuant to this Attachment, and then from payments from this section.

(e) Distributions to voluntary sector general hospitals, excluding government general hospitals, made in accordance with the Medicaid Disproportionate Share Section, the Supplemental Indigent Care Distributions Section, and the High Need Indigent Care Adjustment Pool Section will be reduced proportionally by the final payment amounts paid to eligible voluntary sector general hospitals, excluding government general hospitals, made in accordance with the Additional Inpatient Hospitals Payments Section for the period commencing July 1, 2010 and annually thereafter through December 31, 2012.

(f) In addition to reductions noted in paragraph (e), distributions to voluntary sector general hospitals, made in accordance with the Medicaid Disproportionate Share Section, the Supplemental Indigent Care Distributions Section, and the High Need Indigent Care Adjustment Pool Section will be reduced proportionally by $69.4M for the period commencing July 1, 2010 through December 31, 2010 and by $73.2M annually for rate periods commencing January 1, 2011 [and thereafter] through December 31, 2012 excluding distributions made in accordance with subparagraphs (b), (c), and (d) of paragraph (3) of the Supplemental Indigent Care Distributions Section.

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

5. **Projection methodology.** Each hospital's projected disproportionate share limitation for each rate year shall be the sum of its inpatient and outpatient Medicaid and uninsured gains/(losses) as calculated using reported base year data and statistics from the year two years immediately preceding the rate year and as used for projection methodology purposes for that prior year. For the two thousand eleven calendar year, maximum disproportionate share payment distributions shall be determined initially based on each hospital's submission of a fully completed two thousand eight disproportionate share hospital data collection tool, and shall subsequently be revised to reflect each hospital's submission of a fully completed two thousand nine disproportionate share hospital data collection tool. For calendar years on or after January 1, 2012, inpatient and outpatient Medicaid and uninsured gains/(losses) based on data for the most recent calendar year available [2 years] prior to the DSH payment year submitted by hospitals as prescribed by the Commissioner shall be used to determine maximum disproportionate share payments. All such initial determinations shall subsequently be revised to reflect actual calendar year inpatient and outpatient Medicaid and uninsured gains/(losses) applicable to the DSH payment year.

6. **Reconciliation methodology**. The Commissioner shall revise the projected limitation based on actual audited and certified data reported to the Commissioner for such calendar year in accordance with the following and in accordance with final regulations issued by the federal Department of Health and Human Services implementing 42 USC §1396r-4. The Commissioner shall revise the projected limitations for each hospital within eight months from the date required reports are submitted to the Department, except if such reports are determined to be unacceptable by the Department. For hospitals which have submitted unacceptable reports, the Commissioner shall revise the projected limitations within eight months from the date acceptable reports have been resubmitted to the Department.

[a.]

New York
160

Government General Hospital Indigent Care Adjustment.

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

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

New York
161(a)

Medicaid disproportionate share payments.

1. For the rate periods commencing January 1, 1991 and thereafter, Medicaid disproportionate share payments shall be made to hospitals to reimburse a portion or all of the costs associated with serving those patients unable or unwilling to pay for services rendered.

2. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, uncompensated care need shall mean losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient services. The cost of services provided as an employment benefit or as a courtesy shall not be included.

3. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, targeted need shall be defined as the relationship of uncompensated care need to reported costs expressed as a percentage. Reported costs shall mean costs allocated as prescribed by the Commissioner to government general hospital inpatient services. Targeted need shall be determined based on base year data and statistics for the calendar year two years prior to the distribution period.

4. Nominal payment amount shall be defined as the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to the scale specified in this section. This paragraph sunsets on December 31, 2012.

5. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, targeted need share shall mean the relationship of each general hospital's nominal payment amount of uncompensated care need determined in accordance with the scale specified in this section to the nominal payment amounts of uncompensated care need for all eligible general hospitals applied to funds available for distribution pursuant to this section.

6. Major government general hospitals shall mean all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospital Corporation and all other government general hospitals having annual inpatient operating costs in excess of $25 million. This paragraph sunsets on December 31, 2012.

7. Voluntary sector hospitals shall mean all voluntary non-profit, private proprietary and government general hospitals other than major government general hospitals. This paragraph sunsets on December 31, 2012.

8. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, uninsured care shall be defined as losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient services, which are not eligible for payment in whole or in part by a governmental agency, insurer or other third-party payor on behalf of a patient, including payment made

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

9. In order to be eligible for distributions, a general hospital's targeted need must exceed one-half of one percent. This paragraph sunsets December 31, 2012.

10. For rate years commencing January 1, 1991 and prior to January 1, 1997, each eligible major government general hospital shall receive a portion of its bad debt and charity care need equal to 110 percent of the result of the application of the percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of Medicare, developed on the basis of 1985 financial and statistical reports, to the statewide resources for the rate year.

    a. Statewide resources shall mean the sum of the result of multiplying a statewide average 5.48% by each general hospital's (including major government general hospitals and all other hospitals) rate year reimbursable inpatient costs used in the initial promulgation of rates, adjusted of case mix and volume changes, excluding inpatient costs related to services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare), and without consideration of inpatient uncollectible amounts, and including income from invested funds.

11. For rate periods commencing January 1, 1997 through December 31, [2014] 2012, each eligible major government general hospital shall receive an amount equal to the amount allocated to such major government general hospital for the period January 1, 1996 through December 31, 1996.

12. For rate periods commencing January 1, 1997 [and thereafter] through December 31, 2012, the balance of unallocated funds after the Medicaid disproportionate share payments are made in accordance with paragraph (11) of this section and funds are reserved for distribution as high need adjustments in accordance with paragraph (13) of this section and shall be distributed to eligible hospitals, excluding major government general hospitals, on the basis of targeted need share.

    a. Need calculations shall be based on need data for the year two years prior to the rate year.

New York
161(b)(i)

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

c. The scale utilized for development of each hospital's nominal payment amount shall be as follows:

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

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

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

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

New York
161(d)

Indigent Care Pool Reform – effective January 1, 2013

The provisions of this section will be effective for the period January 1, 2013 through December 31, 2015.

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

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

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

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

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

New York
161(e)

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

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

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

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

New York
161(f)

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

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

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

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

New York
161(g)

(b) Indigent Care Pool. Indigent care pool distributions will be made to eligible hospitals in the following amounts, which will be paid in twelve, approximately equal lump sum, monthly installments:

1. **Major Government General Hospital Pool Distributions.** $139.4 million, less the amount allocated pursuant to the Financial Assistance Compliance Pool section in subparagraph (7) below, will be distributed as Medicaid disproportionate share hospital (DSH) payments to major government general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital's relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all major government general hospitals determined in accordance with the Indigent Care Pool Reform methodology described in paragraph (a) of this section.

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

2. **Voluntary General Hospital Pool Distributions.** $994.9 million, less the amount allocated pursuant to the Financial Assistance Compliance Pool section in subparagraph (7) below, will be distributed as Medicaid disproportionate share hospital (DSH) payments to eligible voluntary general hospitals, other than major public general hospitals, on the basis of each hospital's relative share of uncompensated care nominal need to the aggregate uncompensated care nominal need for all eligible voluntary general hospitals as determined in accordance with the Indigent Care Pool Reform methodology described in paragraph (a) of this section.

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

New York
161(h)

3. Transition Pool. A three-year transition pool utilizing a floor/ceiling model has been established to help hospitals avoid large funding swings. The transition pool funding will be generated through a redistribution of dollars from those hospitals which experience an increase in distributions using the new Indigent Care Reform Methodology to those that experience a decrease. Transition amounts will be determined based on a comparison of the distributions for the applicable calendar year 2013 through 2015 to an average of the annual distributions for the three year period January 1, 2010 through December 31, 2012.

A separate transition pool will be established for major government general hospitals and voluntary general hospitals. Individual hospital gains and losses in each pool will be capped by means of the following transition adjustments.

a. Distribution Amount. A hospital's distribution will be determined by means of a comparison between their allocation as calculated in accordance with the Indigent Care Reform Methodology described in section (a)(1) through (a)(7), the Floor Amount in 3(c) below, and the Ceiling Amount in 3(d) below. If the Indigent Care Reform Methodology allocation is:

i. less than or equal to the Floor Amount, the hospital will receive the Floor Amount.
ii. greater than or equal to the Ceiling Amount, the hospital will receive the Ceiling Amount.
iii. greater than the Floor Amount but less than the Ceiling Amount, the hospital will receive the Indigent Care Reform Methodology allocation payment.

b. Separate uniform Floor percentages and uniform Ceiling percentages are calculated for each of the major governmental and voluntary pools.

c. The Floor Amount For each hospital is equal to the average payment received in the three year period between 1/1/10 and 12/31/12 multiplied by the Floor Percentage for its respective pool. The Floor percentage is:

i. 97.5% for 2013
ii. 95.0% for 2014
iii. 92.5% for 2015

d. The Ceiling Amount for each hospital is equal to the average payment received in the three year period between 1/1/10 and 12/31/12 multiplied by the Ceiling Percentage for its respective pool. The ceiling percentage is calculated using an iterative process to obtain the unique percentage value such that:

i. The total payments to all providers in each pool equals the amount of the respective pool in subdivision (b)(1) or (b)(2) and
ii. The individual hospital payments will comply with the requirements described in paragraphs 3(a) through (c) above

e. For 2014 and 2015, these amounts will be further adjusted to carve out amounts provided for in the Financial Assistance Compliance Pool payments in paragraph 6.

An example of this methodology follows:

New York
161(i)

Sample Transition Period DSH Pool Payment Calculations

CY 2014

	Floor Pct.:	Ceiling Pct.:
	95.0%	109.9%
	(i)	(ii)

Hospital Name	Indigent Care Pool Payment Before Transition Period Adjustment	Three Year Historical Average of Pool Payments (2010-2012)	Floor Amount	Ceiling Amount	Tentative Transition Period Payment	Financial Assistance Compliance Pool Carve-out (2014-2015)	Actual Transition Period Payment	Allocation Before Adjustment as Pct. of Three Year Avg	Tentative Transition Period Payment as Pct of Three Year Avg
(a)	(b)	(c)	(d)	(e)	(f)				
Hospital A	$25,000,000	$18,000,000	$17,100,000	$19,782,000	$19,782,000	$454,106	$19,327,894	138.9%	109.9%
Hospital B	$14,000,000	$12,000,000	$11,400,000	$13,188,000	$13,188,000	$302,737	$12,885,263	116.7%	109.9%
Hospital C	$20,000,000	$19,600,000	$18,620,000	$21,540,400	$20,000,000	$459,110	$19,540,890	102.0%	102.0%
Hospital D	$30,000,000	$30,400,000	$28,880,000	$33,409,600	$30,000,000	$688,666	$29,311,334	98.7%	98.7%
Hospital E	$27,000,000	$31,000,000	$29,450,000	$34,069,000	$29,450,000	$676,040	$28,773,960	87.1%	95.0%
Hospital F	$19,000,000	$23,000,000	$21,850,000	$25,277,000	$21,850,000	$501,578	$21,348,422	82.6%	95.0%
Hospital G	$4,400,000	$5,400,000	$5,130,000	$5,934,600	$5,130,000	$117,762	$5,012,238	81.5%	95.0%
Statewide Totals	$139,400,000	$139,400,000	$132,430,000	$153,200,600	$139,400,000	$3,200,000	$136,200,000		

(1) Tentative Transition Period Payment:
(a) Hospital name
(b) The unadjusted amount that would otherwise be paid to each hospital under the new DSH pool allocation methodology beginning 1/1/2013
(c) The actual average amount paid to each hospital under the prior DSH pool allocation methodology in CYs 2010 - 2012
(d) The amount for each hospital in (c) multiplied by the Floor Percentage in (i)
(e) The amount for each hospital in (c) multiplied by the Ceiling Percentage in (ii)
(f) For each individual hospital, if the Indigent Care Pool Actual Transition Period Payment is:
(1) < the Floor Amount, the Transition Period Payment is the Floor Amount
(2) > the Ceiling Amount, the Transition Period Payment is the Ceiling Amount
(3) Otherwise it is the amount in (b) calculated using the new DSH pool allocation methodology effective 1/1/2013.
Using the formula =IF(Bn<Dn,Dn,IF(Bn>En,En,Bn))

(2) Percentages:
(i) The Floor Percentage equals 97.5% in 2013, 95.0% in 2014, and 92.5% in 2015
(ii) A unique Ceiling Percentage is calculated using an iterative set of calculations where both:
(1) the total transition payments equal the respective pool amounts, and
(2) all the constraints in (f) are respected
For instance, using the Excel Goal Seek data tool:
Set Cell F15
Equal to $139,400,000
By Changing Cell E2

(3) Financial Assistance Compliance Pool Carve-out for 2014 & 2015:
The carve out will be calculated by using each hospital's share of the $139.4M allocation and applying that percentage to the $3.2M in compliance pool funds.

(4) This same process would apply to the Voluntary Allocations of $994.9M

New York
161(j)

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

5. **DSH Payment Limits.** The distributions in this section are subject to the provisions of the Disproportionate share limitations section.

6. **Financial Assistance Compliance Pool.** For calendar years 2014 and 2015, an amount equivalent to one percent of total DSH funds will be segregated into the Financial Assistance Compliance Pool (FACP) and allocated to all hospitals which prior to December 31, 2015 demonstrate substantial compliance with §2807-k(5-d)(b)(iv) of the Public Health Law (New York State Financial Aid Law) as in effect on January 1, 2013. There will be separate pool amounts for major governmental and voluntary hospitals. The amounts are $3.2 million for major governmental hospitals and $23.2 million for voluntary hospitals.

   The DSH funds in the FACP will be proportionately allocated to all compliant hospitals using the Indigent Care Reform Methodology described in subparagraph (3)(a) of this section. Compliance will be on a pass/fail basis. When a hospital is deemed compliant, one hundred percent of its share of the FACP funds will be released; there will be no partial payment for partial compliance. Any unallocated funds resulting from hospitals being non-compliant will be proportionally reallocated to compliant hospitals in each respective group based on their relative share of the distributions calculated in subparagraph (3)(a).