

Hospital Inpatient Reimbursement - Effective December 1, 2009

Definitions. As used in this Section, the following definitions shall apply:

1. Diagnosis related groups (DRGs) shall mean the 3M Corporation 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.
 - a. For the period December 1, 2009 through December 31, 2010, Version 26.1 of the APR classification system will be used.
2. DRG case-based payment per discharge shall mean the payment to be received by a hospital for inpatient 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.
3. 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).
4. 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.
5. 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 this Attachment, but excluding the following costs:
 - a. ALC costs;
 - b. Exempt unit costs;
 - c. Transfer costs; and
 - d. High-cost outlier costs.

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Supersedes TN New

Approval Date JAN 20 2010

Effective Date DEC - 1 2009

6. Graduate medical education (GME).
- a. 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 this Attachment.
 - b. 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.
7. 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 Exclusion of Outlier and Transfer Costs of this Section.
8. 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.
9. Exempt hospitals and units shall mean those hospitals and units that are paid per diem rates of payment pursuant to the provisions of Exempt Units and Hospitals of this Section, rather than receiving per discharge case-based rates of payment.
10. 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.
11. Statewide Base Price shall mean the numeric value calculated pursuant to Statewide Base Price of this Section, which shall be used to calculate DRG case-based payments per discharge as defined in paragraph (2) of this Section.
12. 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:
- a. Medicaid costs associated with ambulance services operated by a facility and reported as inpatient costs in the Institutional Cost Report (ICR); and

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- b. Medicaid costs associated with schools of nursing operated by the facility and reported as inpatient costs in the ICR; and
- c. Medicaid costs associated with hospital-based physicians at hospitals designated under the Medicare program as meeting the criteria set forth in §1861(b)(7) of the federal Social Security Act.
13. 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:
- a. 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
- b. is transferred to an out-of-state acute care facility; or
- c. is a neonate who is being transferred to an exempt hospital for neonatal services.
14. Discharges, as used in this Section, shall mean those inpatients whose discharge from the facility occurred on or after December 1, 2009, and:
- a. the patient is released from the facility to a nonacute care setting;
- b. the patient dies in the facility; or
- c. 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
- d. the patient is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain.
15. 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.
16. General hospital, as used in this Section, shall mean a hospital engaged in providing medical or medical and surgical services primarily to in-patients by or under the supervision of a physician on a twenty-four hour basis with provisions for admission or treatment of persons in need of emergency care and with an organized medical staff and nursing service, including facilities providing services relating to particular diseases, injuries, conditions or deformities.

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17. 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.
18. I^{PRO} shall mean the Island Peer Review Organization, Inc., a New York not-for-profit corporation providing health related services.

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Statewide base price.

1. For periods on and after December 1, 2009, a statewide average cost per discharge shall be established in accordance with the following:
 - a. Reimbursable Medicaid acute operating costs, excluding costs related to graduate medical education, alternate level of care, exempt units, patient transfers, high-cost outliers, and non-comparables, derived from the base period in paragraph (3);
 - b. Adjust subparagraph (a) for case mix and wage neutrality factors derived from the base period in paragraph (3);
 - c. Divide subparagraph (b) by Medicaid inpatient discharges from the base period in paragraph (3); and
 - d. Adjust subparagraph (c) for inflation between the base period and the rate period in accordance with trend factors determined pursuant to applicable provisions of this Attachment.

2. An adjustment will be made to the statewide average cost per discharge, calculated in accordance with subparagraph (1) of this section, to establish a "statewide base price" that generates the same level of total Medicaid payments for the reimbursement of operating costs as total Medicaid payments made for the reimbursement of operating costs during calendar year 2008 subsequent to the exclusion of prior period adjustments and the following reductions:
 - a. One hundred fifty-four million five hundred thousand dollars; and
 - b. Two hundred twenty-five million dollars.

No further reconciliation adjustment to the statewide base price to account for changes in volume or case mix will be implemented.

3. For periods on and after December 1, 2009, the "base period" shall be the 2005 calendar year except as noted in subparagraph (a) below and "operating costs" shall be those reported by each facility to the Department prior to July 1, 2009.
 - a. For those hospitals operated by the New York City Health and Hospitals Corporation, the base period shall be for the period 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 ended March 31, 2006.
 - b. Discharges to be used for direct graduate medical education and non-comparable adjustments in accordance with the Definitions section should be 2007.

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Supersedes TN New

Effective Date DEC - 1 2009

Exclusion of outlier and transfer costs.

1. In calculating rates pursuant to this Section, 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.

2. In calculating rates pursuant to this Section, 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.

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Supersedes TN New

Approval Date JAN 20 2010
Effective Date DEC - 1 2009

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

1. 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 paragraph (2) below. 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.
2. 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.

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Supersedes TN New

Approval Date JAN 20 2010

Effective Date DEC - 1 2009

Wage Equalization Factor (WEF).

1. 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:

a. 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 (ICR). The WEF shall be computed as follows:

i. For all occupations described in paragraph (a), 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:

$$\frac{1}{((\text{Labor Share}/\text{initial WEF}) + \text{Non-Labor Share})}$$

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 ICR for the same calendar year used to calculate the statewide base price for the applicable rate period. The "Non-Labor Share" equals 1 less the "Labor Share" of costs.

b. 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.

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- c. 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 exempt unit cost ceilings.

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Supersedes TN New

Approval Date JAN 20 2010

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Add-ons to the case payment rate per discharge.

Rates of payment computed pursuant to this Attachment shall be further adjusted in accordance with the following:

1. 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 inpatient Medicaid direct GME costs by its total reported Medicaid discharges as defined in the Statewide Base Price Section. Direct GME costs shall be those costs defined in the Definitions Section, 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 this Attachment, and shall be excluded from the cost included in the statewide base price.
2. (a) 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 or 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 ICR and submitted to the Department no later than June 30, 2009, but excluding exempt unit beds and nursery bassinets.

- (b) Indirect GME costs are those costs defined in the Definitions Section, 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 this Attachment, 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:

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

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

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Supersedes TN New

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3. 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 as defined in the Statewide Base Price Section. Non-comparable hospital costs are those costs defined in the Definitions Section, 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 this Attachment, and shall be excluded from the cost included in the computation of the statewide base price.

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4. For the rate periods on and after December 1, 2009, additional adjustments to the inpatient rates of payment for eligible general hospitals to facilitate improvements in hospital operations and finances will be made, in accordance with the following:
- a. General hospitals eligible for distributions pursuant to this section shall be those nongovernmental hospitals with total Medicaid discharges equal to or greater than seventeen and one-half percent for 2007.
 - b. For the period December 1, 2009 through March 31, 2010, \$33.5 million dollars shall be allocated to eligible hospitals such that no hospital's reduction in Medicaid inpatient revenue, as a result of the hospital acute care rate methodology changes that are effective December 1, 2009, exceeds 9.7%.
 - c. For periods on or after April 1, 2010, funds distributed pursuant to this section shall be allocated to eligible hospitals based on a proportion of the eligible hospital's allocation of the funds distributed for the period December 1, 2009 through March 31, 2010, to the total funds distributed for that period applied to the appropriate funds available for the applicable periods below:
 - i. for the period April 1, 2010 through March 31, 2011, \$75 million;
 - ii. for the period April 1, 2011 through March 31, 2012, \$50 million; and
 - iii. for the period April 1, 2012 through March 31, 2013, \$25 million.
 - d. Payments made pursuant to this section shall be added to rates of payments and not be subject to retroactive adjustment or reconciliation. The amount per discharge to be added to the rates shall be established by dividing the total allocated funds in accordance with paragraph (b) and (c) by the hospital's total reported Medicaid discharges in the applicable base period.
 - e. Each hospital receiving funds pursuant to this section 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.

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Supersedes TN New

Approval Date _____

Effective Date DEC - 1 2009

Outlier and transfer cases rates of payment.

1. a. 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 U.S. Consumer Price Index for all Urban Consumers from the base period to the rate period used to determine the statewide base price and the rate period.

b. Cost outlier thresholds for each base APR-DRG will be calculated as follows:

- i. using the applicable base year Medicaid claims data, organize costs per claim within each base APR-DRG from least to greatest value;
- ii. divide the listing of claims from subparagraph (i) for each base APR-DRG into three quartiles;
- iii. the first quartile (Q1) is the set of data having the property that at least one-quarter of the observations are less than or equal to Q1 and that at least three-quarters of the data are greater than or equal to Q1;
- iv. the third quartile (Q3) is conversely identified;
- v. determine the inter-quartile range (IQR) by identifying the spread of the difference between Q1 and Q3 (IQR = Q3 - Q1);
- vi. cost outlier thresholds are determined by applying the IQR as follows:

$$[(y) * IQR] + Q3$$

where (y) equals a predetermined standard multiplier. This multiplier is a factor of 5.5.

c. 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 case mix greater than 1.75;
- iii. hospitals with Medicaid revenue greater than \$30 million; and
- iv. hospitals with a proportion of outlier to inlier cases greater than 3.0 percent.

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2. 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 (a), (b) and (c) of this paragraph. 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 the Definitions Section by the arithmetic inlier length of stay (LOS) for that DRG, as defined in the Definitions Section, 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.
- a. 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.
- b. A transferring facility shall be paid the full DRG rate for those patients in DRGs specifically identified as transfer DRGs.
- c. 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.
- d. 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.

TN #09-34

Supersedes TN New

Approval Date JAN 20 2010

Effective Date DEC - 1 2009

Alternate level of care payments (ALC).

1. 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 Attachment 4.19-D trended to the rate year.

The determination of the group average operating rate for hospital-based residential health care facilities specified in this paragraph shall be based on the combination of residential health care facilities as follows:

- a. 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.
 - b. The upstate group consisting of all other residential health care facilities in the State.
2. Hospitals that convert medical/surgical beds to residential health care beds shall be reimbursed for services provided in the converted beds in accordance with Attachment 4.19-D.

TN #09-34

Supersedes TN New

Approval Date JAN 20 2010

Effective Date DEC - 1 2009

Exempt units and hospitals.

1. Physical medical rehabilitation inpatient services shall qualify for reimbursement as an exempt unit/hospital pursuant to this paragraph 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:
 - a. 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
 - b. 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 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 for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, not including reported direct medical education 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 paragraph (9) of this section. Such rates shall reflect trend adjustments in accordance with the applicable provisions this Attachment.
2. Chemical dependency rehabilitation inpatient services shall qualify for reimbursement pursuant to this paragraph 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:

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- a. 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
- b. 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 for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating costs as submitted to the Department prior to July 1, 2009, not including reported direct medical education 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 paragraph (9) of this section. Such rates shall reflect trend adjustments in accordance with the applicable provisions of this Attachment.

3. Critical access hospitals.

- a. Rural hospitals shall qualify for inpatient reimbursement as critical access hospitals 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.
- b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2005 operating 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 this Attachment.

4. Cancer hospitals.

- a. Hospitals shall qualify for inpatient reimbursement as cancer hospitals 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.

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Approval Date JAN 20 2010

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- b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this Section shall be a per diem amount reflecting the facility's reported 2005 operating 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 this Attachment.
5. Specialty long term acute care hospital.
- a. Hospitals shall qualify for inpatient reimbursement as specialty long term acute care hospitals 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.
- b. For days of service occurring on and after December 1, 2009, the operating component of rates of payment for inpatient services for facilities subject to this Section shall be a per diem amount reflecting the facility's reported 2005 operating 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 this Attachment.
6. Acute care children's hospitals. Hospitals shall qualify for inpatient reimbursement as acute care children's hospitals for periods on and after December 1, 2009, only if:
- a. 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
- b. 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 for facilities subject to this subdivision shall be a per diem amount reflecting the facility's reported 2007 operating 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 this Attachment.
7. 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.

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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:

- a. The operating cost component of the per diem rates will be computed using 2006 costs and statistics 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:
 1. 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 (b) through (f).
 2. 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 (b) through (f).
 3. For periods on and after April 1, 2010, 100% of the operating cost component will reflect 2006 operating costs in accordance with paragraphs (b) through (f).

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Approval Date JAN 20 2010

Supersedes TN New

Effective Date DEC - 1 2009

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- b. 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:
1. New York City - Bronx, New York, Kings, Queens and Richmond Counties;
 2. Long Island - Nassau and Suffolk Counties;
 3. Northern Metropolitan - Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester Counties;
 4. Northeast - Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington Counties;
 5. Utica/Watertown - Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida Counties;
 6. Central - Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga and Tompkins Counties;
 7. Rochester - Monroe, Ontario, Livingston, Wayne and Yates Counties; and
 8. Western - Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming Counties.
- c. 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.
- d. 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.
- e. 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.

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Approval Date JAN 20 2010

Supersedes TN New

Effective Date DEC - 1 2009

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- f. 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.
- g. 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.

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8. Hospitals or distinct units of hospitals that fail to maintain qualifying criteria for exempt status for reimbursement purposes, as set forth in this Attachment, shall continue to be reimbursed in accordance with such exempt status until the commencement of the next rate period, as determined by the Department.
9. Rates of payment for inpatient services described in paragraphs (1) and (2) above, which utilize regional averages for determining a cost ceiling shall utilize regions of the State set forth below, 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:
- a. New York City, consisting of the counties of Bronx, New York, Kings, Queens and Richmond;
 - b. Long Island, consisting of the counties of Nassau and Suffolk;
 - c. Northern Metropolitan, consisting of the counties of Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester;
 - d. Northeast, consisting of the counties of Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington;
 - e. Utica / Watertown, consisting of the counties of Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida;
 - f. Central, consisting of the counties of Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga and Tompkins;
 - g. Rochester, consisting of the counties of Monroe, Ontario, Livingston, Wayne and Yates; and
 - h. Western, consisting of the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.
10. 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 capital cost provisions of this Attachment divided by exempt hospital or unit patient days reconciled to actual total expense.

JAN 20 2010

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Approval Date _____

Supersedes TN New

Effective Date DEC - 1 2009

11. 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 paragraph (10) of this section, whichever is lower. The capital cost component of such rates shall be calculated in accordance with the capital cost provisions of this Attachment.

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Supersedes TN New

Approval Date JAN 20 2010
Effective Date DEC - 1 2009

Trend factor.

1. The trend factor terms used in this section will be used to develop rates of payments on or after December 1, 2009.
2. 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 this Attachment, shall be trended to the applicable rate year by the trend factors developed in accordance with the provision of this section for rate periods through March 31, 2000.
3. 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 health-related services appointed by the Commissioner.
4. 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 non-supervisory employees. For 1996 through December 31, 1999, the Commissioner shall apply the 1995 trend factor methodology.
5. The Commissioner shall implement one interim adjustment to the trend factors, based on recommendations of the panel, and one final adjustment to the trend factors. 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 factor.
6. Trend factors used to project reimbursable operating costs to the rate period April 1, 1995 to December 31, 1995 shall not be applied in the development of the rates of payment. This section shall not apply to trend factors, adjusted trend factors or final trend factors used for the January 1, 1995 to December 31, 1995, rate period for purposes of projecting allowable operating costs to subsequent rate periods.
7. Trend factors used to project reimbursable operating costs to the rate period commencing April 1, 1996 through March 31, 1997, shall not be applied in the development of the rates of payment. This section shall not apply to trend factors or final trend factors used for the January 1, 1995 through December 31, 1995 or January 1, 1996 to March 31, 1996, rate period for purposes of projecting allowable operating costs to subsequent rates periods.

TN #09-34

Supersedes TN New

Approval Date DEC 1 2009

Effective Date DEC - 1 2009

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8. Trend factors used to project reimbursable operating costs to rate periods commencing July 1, 1999 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.
9. For rate periods on and after April 1, 2000, the Commissioner shall establish trend factors for rates of payment for hospitals to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs calculated pursuant to this Attachment.
 - a. In developing trend factors for such rates of payment, the Commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all Urban Consumers published in the Congressional Budget Office Economic and Budget Outlook after June first of the rate year prior to the year for which rates are being developed.
 - b. After the final U.S. Consumer Price Index (CPI) for all Urban Consumers is published by the United States Department of Labor, Bureau of Labor Statistics, for a particular rate year, the Commissioner shall reconcile such final CPI to the projection used in subparagraph (a) and any difference will be included in the prospective trend factor for the current year.
 - c. At the time adjustments are made to the trend factors in accordance with this section, adjustments shall be made to all inpatient rates of payment affected by the trend factor adjustment.
10. The final 2006 trend factor shall be the U.S. CPI for all Urban Consumers, as published in the U.S. Department Labor Statistics, minus 0.25%.
11. The final 2007 trend factor shall equal 75% of the final trend factor determined in paragraph (b) above.
12. The applicable trend factor for the 2008 and 2009 calendar year periods shall be zero.
13. The applicable trend factor for the 2010 calendar year shall be zero for the period January 1, 2010 through March 31, 2010.

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Approval Date _____

Supersedes TN New _____

Effective Date _____

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Capital expense reimbursement.

1. 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 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 paragraphs (7) and (8) of this section.
2. General hospitals shall submit a budgeted 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.
3. The following principles shall apply to budgets for inpatient capital-related expenses:
 - a. 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.
 - b. Any capital-related inpatient expense generated by a capital expenditure which requires or required approval pursuant to the Hospitals section of the Public Health Law, must have received such approval for the capital-related expense to be included in the rate calculation.

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Supersedes TN New

Approval Date JAN 20 2010

Effective Date DEC - 1 2009

- c. 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.
- d. 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.
4. Allocation of budgeted capital costs. In each rate year budgeted capital costs shall be allocated to exempt units and hospitals (including certified substance abuse detoxification services) and DRG case payment rates based on reported capital statistics for the year two years prior to the rate year.

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Supersedes TN New

Approval Date JAN 20 2010

Effective Date DEC - 1 2009

5. Payment for budgeted allocated capital costs.

- a. Capital per diems for exempt units and hospitals shall be calculated by dividing the budgeted capital costs allocated to such rates pursuant to paragraph (4) above by budgeted exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital-approved capital expense.
- b. Capital payments for APR-DRG case rates shall be determined by dividing the budgeted capital allocated to such rates pursuant to paragraph (4) above by the hospital's budgeted, nonexempt unit discharges, reconciled to rate year discharges and actual rate year nonexempt unit or hospital-approved capital expense.
- c. Capital payments for transferred patients shall be determined by dividing the budgeted capital allocated to the APR-DRG case rate by the hospital's budgeted non-exempt unit days, reconciled to rate year days and actual rate year non-exempt unit or hospital approved capital expense.

6. Depreciation.

- a. 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, 840 North Lake Shore Drive, Chicago, IL 60611, 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.
- b. In the computation of rates for voluntary facilities, depreciation shall be included on a straight line method on plant and non-movable 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

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- 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. Failure to meet the funding requirements will result in a reduction amount reimbursed for depreciation equal to the unfunded amount.
- c. In the computation of rates for public facilities, depreciation is to be included on a straight-line method on plant and non-movable 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.
- d. 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 Attachment.

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Supersedes TN New

Approval Date JAN 20 2010

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7. Interest.

- a. Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities.
- b. 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. 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.
- c. Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trustee 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

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- iii. any remaining amount of investment income after application of paragraph (ii) shall not be considered in the determination of allowable costs.
- d. Interest on current indebtedness shall be treated and reported as an operating, administrative expense.
- e. 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 is the lesser of 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 non-movable equipment; a note payable secured by the non-movable equipment of a facility; a capital lease;
 - ii. incurred for the purpose of financing the acquisition, construction or renovation of land, building or non-movable 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.
- f. 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.

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Approval Date JAN 20 2010

Effective Date DEC - 1 2009

g. 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.

8. Sales, leases and realty transactions.

a. If a medical facility is sold, 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.

b. If a medical facility is sold, 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 paragraph 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 paragraph 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.

c. An arms length lease purchase agreement with a non-related 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

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Supersedes TN New

Approval Date MAY 20 2010

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less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.

- d. If a lease is established as a virtual purchase under paragraph (c), 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 this paragraph, 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.

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Supersedes TN New

Approval Date JAN 20 2010
Effective Date DEC - 1 2009

- e. 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.

TN #09-34 _____

Supersedes TN New _____

Approval Date OAR 20 2010

Effective Date DEC - 1 2009

Reimbursable Assessment for Statewide Planning and Research Cooperative System (SPARCS).

The Commissioner will inform each such hospital of its actual fee to support the statewide planning and research cooperative system and each hospital will submit such fee on a quarterly basis to be received by the Commissioner no later than the 15th of February, May, August and November of each year. Failure to submit such fees in accordance with this schedule will result in a one-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.

TN #09-34

Supersedes TN New

Approval Date DEC 2009

Effective Date DEC - 1 2009

Federal upper limit compliance.

1. In the event the State cannot provide assurances satisfactory to the Secretary of the Department of Health and Human Services related to a comparison of rates of payment for general hospital inpatient services to beneficiaries of the Title XIX program in the aggregate to maximum reimbursement payments provided in Federal law and regulation for purposes of securing Federal financial participation in such payments, such rates of payments shall be adjusted proportionally as necessary to meet Federal requirements for securing Federal financial participation.

TN #09-34

Supersedes TN New

Approval Date JAN 20 2010

Effective Date DEC - 1 2009

Adding or deleting hospital services or units.

1. 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 Section 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.

2. 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 the provisions of this Attachment. 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.

TN #09-34

Supersedes TN New

Approval Date JAN 20 2010

Effective Date DEC - 1 2009

New hospitals and hospitals on budgeted rates.

1. 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 this Attachment except as follows:
 - a. Rates of payment shall be computed on the basis of 100 percent of the statewide base price multiplied by the service intensity weight for each DRG as determined and set forth with the provisions of this Attachment.
 - b. The WEF used to adjust the statewide base price shall be equal to 1.0 until adequate data becomes available.
 - c. The non-comparable operating costs of new facilities as defined in the Definitions Section and direct graduate medical education costs shall consist of the hospital's budgeted operating costs for these services.

2. 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 this Subpart except as follows:
 - a. Reimbursement for the costs of graduate medical education and non-comparable services shall be calculated pursuant to the provisions of paragraph (1)(c) above.
 - b. The WEF used shall be calculated for the facility based on available historical data.

TN #09-34

Supersedes TN New

Approval Date MAR 20 2010

Effective Date DEC - 1 2009

Swing bed reimbursement.

1. Definitions.

- a. For purposes of this Section, a swing bed program operated by a rural hospital that has an approval from the Centers for Medicare and Medicaid Services (CMS) to provide post-hospital skilled nursing facility (SNF) care, shall mean beds used interchangeably as either general hospital or nursing home beds with reimbursement based on the specific type of care provided so that use of beds in this manner provides small hospitals with greater flexibility in meeting fluctuating demands for inpatient general hospital and nursing home care.
- b. Rate shall mean the aggregate governmental payment made to eligible facilities per patient day as defined in Attachment 4.19-D for the care of patients receiving care pursuant to Title XIX of the federal Social Security Act (Medicaid).

2. Rates of payment.

Payments to eligible hospitals for patient days resulting from the usage of swing beds in caring for patients for whom it has been determined that inpatient hospital care is not medically necessary, but that skilled nursing or health related care is required, shall be determined as follows:

- a. The operating component of the rate shall consist of the following:
 - i. a direct component which shall be equivalent to the 1988 statewide average direct case mix neutral cost per day for hospital-based residential health care facilities, after application of the Regional Direct Input Price Adjustment Factor (RDIPAF) as determined pursuant to Attachment 4.19-D, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A;
 - ii. an indirect component which shall be equivalent to the 1988 statewide average indirect cost per day for hospital-based residential health care facilities, after application of the RDIPAF pursuant to Attachment 4.19-D, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A; and
 - iii. a non-comparable component which shall be equivalent to the 1988 statewide average non-comparable cost per day for hospital-based residential health care facilities, adjusted for inflation with trend factors determined pursuant to the applicable provisions of Attachment 4.19-A.

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Supersedes TN New

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- b. For general hospitals with more than 49 beds, the maximum number of days for which the operating component of the rate as defined in this Attachment shall be paid shall be equivalent to fifteen (15) percent of a hospital's total annual patient days for acute, exempt unit, and alternate level of care services, excluding swing bed days.
- c. The operating component of the rate as defined in this Attachment shall be paid for the first sixty (60) days per year during which a patient is receiving care as a participant in the swing bed program. Any patient stay in excess of sixty (60) days per year shall be reimbursed at the prevailing average rate paid for the care of Alternate Level of Care (ALC) patients pursuant to the Alternate Level of Care Payments provisions of this Attachment. The sixty-day period shall begin the first day on which the patient receives care as a participant in the swing bed program.
- d. A capital cost per diem shall be paid on the basis of budgeted capital costs allocated to the swing bed program, pursuant to the capital cost provisions of this Attachment, divided by patient days associated with the swing bed program, reconciled to actual total capital expense.

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Supersedes TN New _____

Approval Date JAN 20 2010 _____

Effective Date DEC - 1 2009 _____

Mergers, acquisitions and consolidations.

1. Rates of Payment. As used in this Section, the terms merger, acquisition and consolidation shall mean the combining of two or more general hospitals 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 and approved through the Department's Certificate of Need process. 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 Section except as follows:

- a. The WEF used to adjust the statewide base price shall be calculated by combining all components used in the calculation pursuant to the WEF Section for all hospitals subject to the merger, acquisition or consolidation.
- b. 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.
- c. The indirect GME payment per discharge added to the case payment rates of teaching hospitals shall be calculated in accordance with the Add-ons to the Case Payment Rate Per Discharge Section, 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.
- d. 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.

2. Temporary rate adjustment.

- a. 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) other 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 amount 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.

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- b. The Commissioner shall 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.

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Supersedes TN New

Approval Date JAN 20 2010

Effective Date DEC - 1 2009

Administrative rate appeals

1. Administrative rate appeals of rates of payment issued pursuant to this Attachment 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.
2. 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 Attachment, 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.
3. Rate appeals which are rejected or precluded on the grounds of being untimely may be considered in connection with subsequent audits conducted pursuant to the audit provisions of this Attachment.
4. The Department shall consider only those rate appeals that reflect one or more of the following bases.
 - a. 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 Cooperative System (SPARCS), 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

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Supersedes TN New

Approval Date DEC 20 2009

Effective Date DEC - 1 2009

- b. Any errors regarding a medical facility's capital cost reimbursement.
5. The Department may refuse to accept or consider a rate appeal from a facility that:
- a. is providing an unacceptable level of care as determined after review by the State Hospital review and Planning Council; or
 - b. 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 (a) of this subdivision; or
 - c. has been determined by the Department as being operated by a person or persons not properly established or licensed pursuant to the Public Health Law; or
 - d. is delinquent in the payment of a fine or penalty imposed on the facility pursuant to the Public Health Law.
6. Any hospital whose Medicaid inpatient rates are subject to this Subpart and which is determined by the federal Department of Health and Human Services to be no longer eligible for reimbursement pursuant to Title XVIII (Medicare) of the federal social security act shall not be eligible for reimbursement by Medicaid until re-certification of the facility by the federal Department of Health and Human Services as eligible for reimbursement pursuant to Title XVIII of the federal Social Security Act.

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Supersedes TN New

Approval Date _____
Effective Date DEC - 1 2009

Out-of-state providers.

1. 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 shall be as follows:
 - a. 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, Bergen, Hudson, Essex, Union, Middlesex and Monmouth, in the Pennsylvania county of Pike, and in the Connecticut counties of Fairfield and Litchfield; and
 - b. 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.
2. 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 providers usual and customary charges for such services.
3. 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.

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Supersedes TN New

Approval Date 11/20/2009

Effective Date DEC - 1 2009

Supplemental indigent care distributions.

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:

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<u>Hospital</u>	<u>Calendar Year 2009</u>
	\$ 307,000,000
	Uninsured Distribution to Teaching Hospitals
<u>ALBANY MEDICAL CENTER HOSPITAL</u>	\$ 7,207,099
<u>ST PETERS HOSPITAL</u>	\$ 1,001,662
<u>ALBANY MEDICAL CENTER SOUTH CLINICAL CAMPUS</u>	\$ 3,880
<u>UNITED HEALTH SERVICES, INC</u>	\$ 1,140,730
<u>OLEAN GENERAL HOSPITAL</u>	\$ 24,817
<u>ERIE COUNTY MEDICAL CENTER</u>	\$ 597,922
<u>MERCY HOSPITAL OF BUFFALO</u>	\$ 319,739
<u>ROSWELL PARK MEMORIAL INSTITUTE</u>	\$ 1,652,987
<u>KALEIDA HEALTH</u>	\$ 4,938,527
<u>HIGHLAND HOSPITAL OF ROCHESTER</u>	\$ 2,845,852
<u>ROCHESTER GENERAL HOSPITAL</u>	\$ 3,553,825
<u>STRONG MEMORIAL HOSPITAL</u>	\$ 11,695,895
<u>THE UNITY HOSPITAL OF ROCHESTER</u>	\$ 572,019
<u>GLEN COVE HOSPITAL</u>	\$ 471,540
<u>WINTHROP UNIVERSITY HOSPITAL</u>	\$ 6,071,885
<u>SOUTH NASSAU COMMUNITIES HOSPITAL</u>	\$ 530,429
<u>NASSAU UNIVERSITY MEDICAL CENTER</u>	\$ 1,783,090
<u>NORTH SHORE UNIVERSITY HOSPITAL</u>	\$ 13,118,952
<u>ST FRANCIS HOSPITAL OF ROSLYN</u>	\$ 425,667
<u>ST ELIZABETH MEDICAL CENTER</u>	\$ 7,889
<u>FAXTON - ST LUKE'S HEALTHCARE</u>	\$ 23,436
<u>COMMUNITY-GENERAL HOSPITAL OF GREATER SYRACUSE</u>	\$ 196,351
<u>ST JOSEPHS HOSPITAL HEALTH CENTER</u>	\$ 2,697,040
<u>UNIVERSITY HOSPITAL SUNY HEALTH SCIENCE CENTER</u>	\$ 6,987,635
<u>CROUSE HOSPITAL</u>	\$ 958,865
<u>MARY IMOGENE BASSETT HOSPITAL</u>	\$ 472,619
<u>ELLIS HOSPITAL</u>	\$ 960,657
<u>ST CHARLES HOSPITAL</u>	\$ 249,445
<u>UNIVERSITY HOSPITAL AT STONY BROOK</u>	\$ 13,197,922
<u>HUNTINGTON HOSPITAL</u>	\$ 64,200
<u>GOOD SAMARITAN HOSPITAL OF WEST ISLIP</u>	\$ 589,318

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<u>BENEDICTINE HOSPITAL</u>	\$ 459,898
<u>KINGSTON HOSPITAL</u>	\$ 430,512
<u>MOUNT VERNON HOSPITAL</u>	\$ 115,045
<u>SOUND SHORE MEDICAL CENTER</u>	\$ 155,810
<u>WESTCHESTER MEDICAL CENTER</u>	\$ 16,611,342
<u>BRONX-LEBANON HOSPITAL CENTER</u>	\$ 37,193
<u>JACOBI MEDICAL CENTER</u>	\$ 2,082,896
<u>MONTEFIORE HOSPITAL & MEDICAL CENTER</u>	\$ 24,605,332
<u>LINCOLN MEDICAL & MENTAL HEALTH CENTER</u>	\$ 3,019,391
<u>NORTH CENTRAL BRONX HOSPITAL</u>	\$ 754,891
<u>BROOKLYN HOSPITAL</u>	\$ 5,938,856
<u>CONEY ISLAND HOSPITAL</u>	\$ 995,496
<u>KINGS COUNTY HOSPITAL CENTER</u>	\$ 3,882,475
<u>LONG ISLAND COLLEGE HOSPITAL</u>	\$ 3,448,174
<u>NY METHODIST HOSPITAL OF BROOKLYN</u>	\$ 3,807,310
<u>KINGSBROOK JEWISH MEDICAL CENTER</u>	\$ 121,313
<u>WYCKOFF HEIGHTS HOSPITAL</u>	\$ 1,230,117
<u>STATE UNIVERSITY HOSPITAL DOWNSTATE MEDICAL CENTER</u>	\$ 4,116,253
<u>WOODHULL MEDICAL AND MENTAL HEALTH CENTER</u>	\$ 876,601
<u>INTERFAITH MEDICAL CENTER</u>	\$ 831,511
<u>BELLEVUE HOSPITAL CENTER</u>	\$ 2,636,659
<u>BETH ISRAEL MEDICAL CENTER</u>	\$ 12,615,285
<u>HARLEM HOSPITAL CENTER</u>	\$ 2,002,465
<u>HOSPITAL FOR SPECIAL SURGERY</u>	\$ 3,247,177
<u>LENOX HILL HOSPITAL</u>	\$ 12,658,212
<u>MANHATTAN EYE EAR AND THROAT</u>	\$ 416,294
<u>MEMORIAL HOSPITAL FOR CANCER AND ALLIED DISEASES</u>	\$ 5,831,787
<u>METROPOLITAN HOSPITAL CENTER</u>	\$ 1,570,125
<u>MOUNT SINAI HOSPITAL</u>	\$ 18,689,832
<u>NY EYE AND EAR INFIRMARY</u>	\$ 407,797
<u>ST LUKES - ROOSEVELT HOSPITAL CENTER</u>	\$ 8,823,583
<u>SVCMC ST VINCENTS-MANHATTAN</u>	\$ 5,342,595
<u>GOLDWATER MEMORIAL HOSPITAL</u>	\$ 10,006
<u>COLER MEMORIAL HOSPITAL</u>	\$ 639
<u>NYU HOSPITALS CENTER</u>	\$ 13,483,008

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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. \$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.

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3. For annual periods beginning on and after January 1, 2010:
- 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 calendar year 2010 in accordance with the disproportionate share payment calculations provisions of this Attachment.

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

- b. \$25 million shall be distributed to non-major public hospitals having 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.

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Supersedes TN New

Approval Date JAN 20 2010

Effective Date DEC - 1 2009

**New York
144(a)**

**Attachment 4.19-A
(10/09)**

(I) 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, 2010, 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, 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;

(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:

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

(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.

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Approval Date JAN 20 2010

Supersedes TN New _____

Effective Date DEC - 1 2009

**New York
144(b)**

**Attachment 4.19-A
(10/09)**

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, \$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.

TN #09-34 _____

Supersedes TN New

Approval Date 11/25/2009

Effective Date DEC - 1 2009

**New York
144(c)**

**Attachment 4.19-A
(10/09)**

For annual periods beginning January 1, 2009 through December 31, 2010, disproportionate share hospital (DSH) payments shall be 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, 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, 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.

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Approval Date _____ 2010

Supersedes New

Effective Date _____ DEC - 1 2009

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144(d)**

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(10/09)**

- (d) (i) Continuing annually for periods on and after January 1, 2009, 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 government general hospital indigent care adjustment payments pursuant to this Attachment, and then from payments from this section.

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Approval Date _____

Supersedes New _____

Effective Date DEC - 1 2009 _____

Serious Adverse Events.

Effective October 1, 2008, the New York State Medicaid program shall deny reimbursement or reduce payment for the higher DRG arising from the following three serious adverse events, defined as avoidable hospital complications and medical errors that are identifiable, preventable, and serious in their consequences to patients: foreign object left in patient after surgery, air embolism, and blood incompatibility. On and after November 1, 2009, hospitals will be required to bill all claims associated with one of the remaining ten (10) serious adverse events using the following procedures:

- a. For those cases where a serious adverse event occurs and the hospital elects to receive no payment for the admission (i.e., it is expected that Medicaid will deny the entire payment based on the type of event), the hospital will notify Medicaid of this case by submitting a claim using a new rate code 2590 (non-reimbursable with serious adverse events), along with the requisite billing information submitted with a claim.

Department of Health will identify claims billed with rate code 2590 and instruct the Island Peer Review Organization (IPRO), the New York State Medicaid review agent, to request the medical record for the admission and conduct a case review.

- b. For those cases where a serious adverse event occurs and the hospital anticipates at least partial payment for the admission, the hospital will follow a two-step process for billing the admission:
- i. The hospital will first submit their claim for the entire stay in the usual manner, using the appropriate rate code (i.e., rate code 2946 for DRG claims or the appropriate exempt unit per diem rate code such as 2852 for psychiatric care, etc.). That claim will be processed in the normal manner and the provider will receive full payment for the case.

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Approval Date JAN 20 2010

Supersedes TN New

Effective Date DEC - 1 2009

- ii Once remittance for the initial claim is received, it will be necessary for the hospital to then submit an adjustment transaction to the original paid claim using one of the following two new rate codes associated with identification of claims with serious adverse events:
- 2591 (DRG with serious adverse events), or
 - 2592 (Per Diem with serious adverse events)

The adjusted claim will then pend to the Department and will be forwarded to Island Peer Review Organization (IPRO) for further review. IPRO will review the medical record for the case to determine appropriate payment. Once IPRO has completed its review of the medical record, a preliminary notification indicating their findings will be issued. Hospitals will be required to respond to this preliminary finding within thirty days indicating whether it agrees or disagrees with the finding. If the provider disagrees with this preliminary finding, they may appeal by submitting additional rationale and supporting documentation to the IPRO. IPRO will then re-review the case taking into account the provider's rationale and supporting documentation. A final determination will be made at the conclusion of this process.

The thirteen serious adverse events are as follows:

- (1) Surgery performed on the wrong body part
- (2) Surgery performed on the wrong patient
- (3) Wrong surgical procedure on a patient
- (4) Foreign object inadvertently left in patient after surgery
- (5) Medication error
- (6) Air embolism
- (7) Blood incompatibility
- (8) Patient disability from electric shock

TN #09-34

Supersedes TN New

Approval Date JAN 20 2010

Effective Date DEC - 1 2009

Graduate Medical Education - Medicaid Managed Care Reimbursement

Teaching hospitals shall receive direct reimbursement from the State Medicaid Agency for graduate medical education (GME) costs associated with inpatient services rendered to patients enrolled in Medicaid managed care or Family Health Plus plans.

GME payments for DRG based services shall include the following:

- a. A direct graduate medical education (GME) payment per discharge calculated for each teaching hospital by dividing the facility's total reported acute care Medicaid direct GME costs by its total Medicaid acute care discharges in the applicable base period. Direct GME costs shall be those costs defined in the Definitions Section, 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 this Attachment.
- b. An indirect GME payment per discharge calculated for each teaching hospital by applying the actual applicable Service Intensity Weight for the discharge, Wage Equalization Factor Adjustment, and indirect teaching cost percentage described in this Attachment to the statewide base price. Each of these variables will be for the applicable rate year in which the discharge occurs.

GME payments for exempt unit or hospital services shall include a direct GME and an indirect GME component calculated as follows:

- a. A direct GME payment per discharge for each exempt unit or hospital by dividing the facility's applicable exempt unit or hospital Medicaid direct GME costs by the total Medicaid discharges for that exempt unit or hospital in the applicable base period. Direct GME costs shall be those costs defined in the Definitions Section, derived from the same base period used to calculate the average operating cost per diem for the applicable rate period, and trended forward to such rate period in accordance with applicable provisions of this Attachment.

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Approval Date DEC 28 2010

Supersedes TN New

Effective Date DEC - 1 2009

- b. An indirect GME payment per discharge for each exempt unit or hospital by applying the indirect teaching cost percentage calculated in accordance with this Attachment to the hospital's operating cost per diem calculated in accordance with the provisions of this Attachment excluding the costs of direct GME calculated in (a) above, converted to a per diem basis, and trended forward to the rate period in accordance with the provisions of this Attachment. Exempt unit or hospital GME rates per diem will be further adjusted by each applicable exempt unit or hospital's average length of stay based on the latest available data reported on the Institutional Cost Report for the reporting period two years prior to the rate year.

TN #09-34

Supersedes TN New

Approval Date 20 2010

Effective Date DEC - 1 2009

Disproportionate share limitations.

1. Disproportionate share payment distributions made to general hospitals pursuant to this Attachment 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 paragraph (2) and for projected limits pursuant to paragraph (5). 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 paragraph (6).
2. General hospitals must meet the following conditions to receive disproportionate share distributions:
 - a. The hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for obstetric services under a state plan. This requirement doesn't apply to a hospital if their inpatients are predominantly under 18 years old or if the hospital does not offer nonemergency obstetric services to the general population as of December 22, 1987. If the hospital is a rural hospital, an obstetrician is any physician with staff privileges to perform nonemergency obstetric procedures.
 - b. The hospital must have a Medicaid inpatient utilization rate of at least one percent.
3. No general hospital shall receive in total from disproportionate share payment distributions an amount which exceeds the costs incurred during the periods described in paragraph (1) 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 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.
4. 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 reports. The

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Supersedes TN New

Approval Date 7/1/2009

Effective Date DEC - 1 2009

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.
6. 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 §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. Each hospital shall submit, by the same date the annual cost reports are required to be filed pursuant to the cost reporting requirements of this Attachment, 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.
 - b. 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.

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Supersedes TN New _____

Approval Date MAY 20 2010

Effective Date DEC - 1 2009

Government general hospital disproportionate share payments will be made to increase reimbursement to hospitals operated by the State of New York, the State University of New York or by county governments. To be eligible, hospitals must be operating at the time the payments are made. The payments are subject to the payment limits established in this Attachment of this plan.

1. Government general hospitals operated by the State of New York or the State University of New York shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007 and April 1, 2007 through March 31, 2009, and for the state fiscal years beginning April 1, 2009 through March 31, 2011, subject to the limits established pursuant to this Attachment. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002 after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006.

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Approval Date JAN 20 2010

Supersedes TN New

Effective Date DEC - 1 2009

Such payments shall continue to be established for periods beginning on April 1, 2007, through March 31, 2008, based initially on 100% of reported 2000 reconciled data and further reconciled to 100% of actual reported data for 2007. For periods beginning April 1, 2008, through March 31, 2009, such payments shall be based initially on 100% of reported 2000 reconciled data and further reconciled to 100% of actual reported data for 2008. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For periods beginning April 1, 2009 through March 31, 2011, such payments shall be established based initially on reported 2007 reconciled data, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data for 2009, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

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Approval Date JAN 20 2010

Supersedes New

Effective Date DEC - 1 2009

2. Government general hospitals operated by a county, which does not include a city with a population of over one million, shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007, and April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, for the state fiscal years beginning April 1, 2009 through March 31, 2011, subject to the limits established pursuant to this Attachment. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002, after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006.

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Approval Date JAN 20 2010

Supersedes TN New

Effective Date DEC - 1 2009

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156(a)

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Government general hospitals operated by a county, which does not include a city with a population of over one million, or beginning April 1, 1997, government general hospitals located in the county of Erie, shall receive additional payments effective April 1, 1997 for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999 for the period April 1, 1999 through March 31, 2000, April 1, 2000 for the period April 1, 2000 through March 31, 2001, April 1, 2001 for the period April 1, 2001 through March 31, 2002, April 1, 2002 for the period April 1, 2002 through March 31, 2003, for the state fiscal year beginning April 1, 2005 through March 31, 2006, for the state fiscal year beginning April 1, 2006 through March 31, 2007, April 1, 2007 through March 31, 2008 and April 1, 2008 through March 31, 2009, subject to the limits established in accordance with disproportionate share limitations. Such payments shall be established based on medical assistance and uninsured patient losses for 1996, 1997, 1998, 1999, 2000, 2001 and 2002 after considering all other medical assistance based initially for 1996 on 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data, as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2000 reconciled data, for 2001 based initially on reported 1995 reconciled data, as further reconciled to actual reported 2001 reconciled data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 reconciled data, for the state fiscal year beginning on April 1, 2005, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2005, and for the state fiscal year beginning on April 1, 2006, based initially on up to one hundred percent of reported 2000 reconciled data as further reconciled to up to one hundred percent of actual reported data for 2006. Such payments shall continue to be established for periods beginning on April 1, 2007, based initially on up to 100% of reported 2000 reconciled data as further reconciled to 100% of actual reported data for 2007 and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

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Approval Date JAN 20 2010

Supersedes TN New

Effective Date DEC - 1 2009

Government general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million, shall receive 120 million dollars in additional disproportionate share payments effective January 1, 1997 and 120 million dollars in additional disproportionate share payments during each state fiscal year commencing April 1, 1997 and thereafter until March 31, 2000, 120 million dollars in initial additional disproportionate share payments each state fiscal year commencing April 1, 2000 and thereafter until March 31, 2003, \$120 million during the state fiscal year April 1, 2005 through March 31, 2006, \$120 million during the state fiscal year beginning April 1, 2006 through March 31, 2007, \$120 million beginning April 1, 2007 through March 31, 2008, \$120 million during the state fiscal year beginning April 1, 2008 through March 31, 2009, \$420 million annually for the state fiscal years beginning April 1, 2009 through March 31, 2011, \$120 million annually for the state fiscal year beginning April 1, 2011, and annually thereafter. Such payments will be made to each qualified individual hospital based on the relative share of each such hospital's medical assistance and uninsured patient losses for 1997 after considering all other medical assistance payments to such government general hospitals based on 1994 reconciled data as further reconciled to actual reported 1997 reconciled data, for any payments made in 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 or 1998 reconciled data, for payments made during the state fiscal year beginning April 1, 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 or 1999 data, for payments made during the state fiscal year ending March 31, 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 or 2000 data, for payments made during the state fiscal year beginning April 1, 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 or 2001 data, for payments made during the state fiscal year beginning April 1, 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 or 2002 data, for payments made during the state fiscal year beginning April 1, 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 or 2003 data, for payments made for the state fiscal year beginning April 1, 2005 based initially on reported 2000 reconciled data, as further reconciled to actual reported 2005 or 2006 data, and for payments made for the state fiscal year beginning April 1, 2006, based initially on reported 2000 reconciled data, as further reconciled to actual reported 2006 or 2007 data.

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Approval Date JAN 20 2010 _____

Supersedes TN New _____

Effective Date DEC - 1 2009 _____

Such payments shall continue to be established for the state fiscal year beginning on April 1, 2007 based initially on reported 2000 reconciled data, as further reconciled to actual reported 2007 or 2008 data, for the state fiscal year beginning on April 1, 2008 through March 31, 2009, based initially on reported 2000 reconciled data, as further reconciled to actual reported 2008 or 2009 data. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For periods beginning April 1, 2009 through March 31, 2011, such payments shall be established based initially on reported 2007 reconciled data, as adjusted for statutorily authorized Medicaid rate changes impacting this applicable payment year, and further reconciled to actual reported data for 2009, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

Beginning April 1, 2000 government general hospitals, other than those operated by the State of New York or the State University of New York, located in a city with a population of over one million are authorized to receive additional disproportionate share payments as projected or reconciled pursuant to this Attachment governing disproportionate share payments to hospitals, based on the relative share of each such non-state operated government general hospital of projected or reconciled medical assistance and uninsured patient losses after payment of all other medical assistance, including disproportionate share payments to such government general hospitals. For the period April 1, 2000 through March 31, 2001, an additional payment of \$103 million is authorized. Effective April 1, 2001 through March 31, 2002, additional payments of \$113 million are authorized. For the state fiscal years beginning April 1, 2002 and ending March 31, 2009, and each state fiscal year thereafter, additional annual payments of \$210 million are authorized. The payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

For state fiscal years beginning April 1, 2003 and ending March 31, 2005, the Department of Health is authorized to pay government general hospitals, operated by the State of New York or by the State University of New York additional payments for inpatient hospital services as medical assistance payments for patients eligible for federal financial participation under Title XIX of the federal social security act pursuant to the federal laws and regulations governing disproportionate share payments to hospitals 175 percent of each such government general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such government general hospital, based initially on reported 2000 reconciled data. Such payments for the periods ending March 31, 2004 and March 31, 2005, shall be further reconciled to actual reported 2003 and 2004 data respectively, provided, however, that such payments for all eligible hospitals shall be reduced to the extent such payments would result in the exceeding of the State's disproportionate share allotment limit, as determined in accordance with federal statute and regulations, provided, however, that such reduction shall be based on each such hospital's proportionate share of the sum of all such payments that would be made without regard to such allotment limit. Such payments may be added to rates of payment or made as aggregate payments to an eligible government general hospital.

TN #09-34 Approval Date JAN 20 2010
Supersedes TN New Effective Date DEC - 1 2009

Reimbursable Assessment on Hospital Inpatient Services

Effective January 1, 2006, and thereafter, an assessment on net patient services revenue for hospital inpatient services rendered to Medicaid beneficiaries shall be considered an allowable cost and reimbursed through an adjustment to Medicaid services rates of payment.

TN #09-34 _____

Approval Date JAN 20 2010

Supersedes TN New

Effective Date DEC - 1 2009

Government general hospital indigent care adjustment.

For rate periods commencing January 1, 1997 and thereafter, each eligible government general hospital shall 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.

TN #09-34 _____

Approval Date JAN 20 2010

Supersedes TN New

Effective Date DEC - 1 2009

Effective for the state fiscal years beginning April 1, 2001 and ending March 31, 2009, specialty hospital adjustments for services provided on or after April 1, 2001, are authorized to government general hospitals, other than those operated by the State of New York or the State University of New York, receiving reimbursement for all inpatient services under Title XIX of the federal Social Security Act (Medicaid) pursuant to this Attachment of this State Plan and located in a city with a population of over one million, of up to \$286 million annually, as medical assistance payments. For the period beginning April 1, 2008 through March 31, 2009, such payments shall total \$232.1 million. Such payments, when aggregated with other medical assistance payments, shall not exceed 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state government owned or operated government general hospitals for the respective periods and shall be based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

Effective for the period September 1, 2001 through March 31, 2002 and state fiscal years beginning April 1, 2002 and ending March 31, 2008, additional specialty hospital adjustments for services provided on or after September 1, 2001 are authorized to government general hospitals, other than those operated by the State of New York or the State University of New York, receiving reimbursement for all inpatient services under Title XIX of the federal social security act (Medicaid) pursuant to this Attachment of this State Plan and located in a city with a population of over one million, of up to \$463 million for the period September 1, 2001 through March 31, 2002 and \$794 million annually for state fiscal years beginning April 1, 2002 and ending March 31, 2008, as medical assistance payments based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payments may be added to rates of payment or made as aggregate payments to eligible government general hospitals.

TN #09-34 _____

Approval Date JAN 20 2010

Supersedes TN New

Effective Date DEC - 1 2009

New York
161(a)

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(10/09)

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, 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, 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.
5. For rate periods commencing January 1, 1997 and thereafter, 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.
7. Voluntary sector hospitals shall mean all voluntary non-profit, private proprietary and government general hospitals other than major government general hospitals.
8. For rate periods commencing January 1, 1997 and thereafter, 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

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Approval Date JAN 20 2010

Supersedes TN New

Effective Date DEC - 1 2009

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161(b)**

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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.

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, 2010, 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, the balance of unallocated funds after the Medicaid disproportionate share payments are made in accordance with paragraph (10) of this section and funds are reserved for distribution as high need adjustments in accordance with paragraph (12) 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.

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Approval Date 11-20-2010

Supersedes TN New

Effective Date DEC - 1 2009

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161(b)(i)**

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- 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, 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:

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

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

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Approval Date 2009 _____

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

12. For rate periods commencing January 1, 1997 through December 31, 2010, \$36 million 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.

TN #09-34 _____

Approval Date _____

DEC - 1 2009

Supersedes TN New _____

Effective Date _____

Additional disproportionate share payments.

Beginning April 10, 1997 and for annual periods beginning April 1st thereafter, additional disproportionate share payments shall be paid to voluntary non-profit general hospitals. Such payments shall not exceed each such general hospital's cost of providing services to uninsured and Medicaid patients after taking into consideration all other medical assistance payments received, including disproportionate share payments made to such general hospitals and payments from and on behalf of such uninsured patients and shall also not exceed the amount of state aid for which the hospital or its successor would have been eligible pursuant to the Funding for Substance Abuse Services and the Local Unified Services Sections of the Mental Hygiene Law (as described below) for fiscal year 1996-97, the Base Year. Such additional disproportionate share payments will be calculated by aggregating net approved operating costs for such mental health and/or alcoholism or substance abuse programs in each hospital. Net operating costs are defined as operating costs offset by revenues, other income, federal aid and fees. The payments may be made as quarterly aggregate payments to an eligible hospital.

Payments beginning April 1, 1998 and thereafter will be related to the hospital's willingness to continue to provide services previously funded by state aid grants. The Commissioners of the Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS), in consultation with county directors of community services, will annually designate to the Department of Health those general hospitals eligible for the additional disproportionate share payment, and the amount thereof. If a hospital does not continue to provide substantially the same level of program and/or services as in the Base Year, the local governmental unit can recommend to the Commissioner of OMH and/or the Commissioner of OASAS that the provider not be designated to receive disproportionate share payments for mental health and/or substance abuse and alcoholism services in the future. In addition, if a hospital reduces its deficit from that of the Base Year, either as a result of increased program revenues, or as a result of program or service cutbacks, or as a result of lower costs, the local governmental unit can recommend to OMH and/or OASAS that the additional disproportionate share payment be reduced commensurate with the decrease in the deficit.

Services funded under the Local and Unified Services Section of the Mental Hygiene Law include mental health services. Alcoholism services funded under the Local and Unified Services section of the Mental Hygiene Law include health and alcoholism treatment services. Substance abuse services funded under Funding for Substance Abuse Services Section of the Mental Hygiene Law include health and substance abuse services.

TN #09-34 _____

Approval Date _____

Supersedes TN New _____

Effective Date DEC - 1 2009 _____

Attachment A

STATE <u>NY</u>	A
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DATE APPV'D <u>JAN 20 2010</u>	
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