8. *Inpatient psychiatric services provided in general hospitals, or distinct units of general hospitals, specializing in such inpatient psychiatric services,* for patients admitted on and after October 20, 2010, will be reimbursed on a per diem basis as follows:

   a. Reimbursement will use the All Patient Refined Diagnostic Related Group (APR-DRG) patient classification system.

   b. The operating component of the rate will be a statewide price, calculated utilizing 2005 Medicaid fee-for-service (FFS) inpatient costs developed using the ratio of cost to charges approach to determine costs and a regression model to price out various components of the costs to determine cost significance in such components. The components include patient age, rural designation, comorbidities, length of stay, and presence of mental retardation. The costs of these components as developed in the regression model were excluded in developing the statewide price.

      i. The facility-specific old operating per diem rates were trended to 2010, and for each case, these rates were multiplied by the length of stay (LOS) to calculate the "old payment."

      ii. Facility-specific 2005 Direct Graduate Medical Education (DGME) costs were divided by 2005 patient days to calculate DGME per diem rates. These rates were then trended to 2010.

      iii. The 2010 payment rate for Electroconvulsive Therapy (ECT) was established as $281 (based on the ECT rate in effect for Medicare psychiatric patients during the first half of 2010). This rate was then adjusted by each facility's wage equalization factor (WEF).

      iv. For each case, the proper DGME payment (DGME rate multiplied by the LOS) and ECT payment (WEF-adjusted ECT rate times the number of ECT treatments) was subtracted from the "old payments" to derive the "old payments subject to risk adjustment."

      v. For each case, a payment adjustment factor was derived based on the regression model, including the LOS adjustment factor as defined by the new payment methodology.

      vi. The sum of the old payments subject to risk adjustment from step iv ($502,341,057), was divided by the sum of payment adjustment factors from step v ($831,319), which resulted in the statewide per diem rate of $604.27.

c. The non-operating component of the rate will reflect the 2010 budgeted capital costs per diem and the 2005 Medicaid fee-for-service Direct GME costs (DGME). Capital costs will be calculated in accordance with this section including an adjustment to reflect allowable capital costs as reflect in the applicable rate year's Institutional Cost Report. DGME costs are the 2005 reimbursable salaries, fringe benefits, non-salary costs and allocated overhead for residents, fellows, and supervising physicians. The DGME costs allocated to the psychiatric unit is divided by the total patient days spent in the psychiatric unit to derive the 2005 per diem cost of the DGME attributable to the psychiatric unit. This 2005 per diem psychiatric DGME cost is then inflated by 2.95% for 2006, 2.1% for 2007, and 0% thereafter to trend it to October 2010 payment levels.

d. The statewide price will be adjusted for each patient to reflect the following factors:

i. A facility-specific wage equalization factor (WEF), calculated in accordance with the Wage Equalization Factor (WEF) section of this Attachment, will reflect differences in labor costs between hospitals.

ii. A service intensity weight (SIW) associated with the case, calculated utilizing the grouper assigned APR-DRG, will be applied to the adjusted operating per diem. The SIWs for the APR-DRGs as noted in the Inpatient Psychiatric Services Service Intensity Weights (SIWs) table are different than those for the acute system. The SIWs reflect the cost weights 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. The SIWs are developed using two years of Medicaid fee-for-service cost data as reported to the Statewide Planning and Research Cooperative System (SPARCS) for the years 2005 and 2006. Costs associated with statistical outliers will be excluded from the SIW calculation.

Inpatient Psychiatric Services Service Intensity Weights (SIWs)

APR-DRG Codes	Severity of Illness	APR-DRG Description	APR-DRG SIW
042	1	Degenerative Nervous System Disorders Exc Mult Sclerosis, SOI-1	0.9317
042	2	Degenerative Nervous System Disorders Exc Mult Sclerosis, SOI-2	0.9317
042	3	Degenerative Nervous System Disorders Exc Mult Sclerosis, SOI-3	0.9317
042	4	Degenerative Nervous System Disorders Exc Mult Sclerosis, SOI-4	0.9317
052	1	Nontraumatic Stupor & Coma, SOI-1	1.0034
052	2	Nontraumatic Stupor & Coma, SOI-2	1.0034
052	3	Nontraumatic Stupor & Coma, SOI-3	1.0034
052	4	Nontraumatic Stupor & Coma, SOI-4	1.0034
561	1	Postpartum & Post Abortion Diagnoses w/o Procedure, SOI-1	1.0105
561	2	Postpartum & Post Abortion Diagnoses w/o Procedure, SOI-2	1.0105
561	3	Postpartum & Post Abortion Diagnoses w/o Procedure, SOI-3	1.0105
561	4	Postpartum & Post Abortion Diagnoses w/o Procedure, SOI-4	1.0105
566	1	Other Antepartum Diagnoses, SOI-1	0.9559
566	2	Other Antepartum Diagnoses, SOI-2	0.9559
566	3	Other Antepartum Diagnoses, SOI-3	1.0875
566	4	Other Antepartum Diagnoses, SOI-4	1.0875
740	1	Mental Illness Diagnosis w O.R. Procedure, SOI-1	1.1418
740	2	Mental Illness Diagnosis w O.R. Procedure, SOI-2	1.1418
740	3	Mental Illness Diagnosis w O.R. Procedure, SOI-3	1.1418
740	4	Mental Illness Diagnosis w O.R. Procedure, SOI-4	1.1418

750	1	Schizophrenia, SOI-1	0.9444
750	2	Schizophrenia, SOI-2	0.9938
750	3	Schizophrenia, SOI-3	1.0527
750	4	Schizophrenia, SOI-4	1.0703
751	1	Major Depressive Disorders & Other/Unspecified Psychoses, SOI-1	0.9887
751	2	Major Depressive Disorders & Other/Unspecified Psychoses, SOI-2	1.0492
751	3	Major Depressive Disorders & Other/Unspecified Psychoses, SOI-3	1.0666
751	4	Major Depressive Disorders & Other/Unspecified Psychoses, SOI-4	1.1208
752	1	Disorders of Personality & Impulse Control, SOI-1	0.9847
752	2	Disorders of Personality & Impulse Control, SOI-2	1.0223
752	3	Disorders of Personality & Impulse Control, SOI-3	1.0223
752	4	Disorders of Personality & Impulse Control, SOI-4	1.0223
753	1	Bipolar Disorders, SOI-1	0.9714
753	2	Bipolar Disorders, SOI-2	1.0109
753	3	Bipolar Disorders, SOI-3	1.0576
753	4	Bipolar Disorders, SOI-4	1.1495
754	1	Depression Except Major Depressive Disorder, SOI-1	1.0225
754	2	Depression Except Major Depressive Disorder, SOI-2	1.0611
754	3	Depression Except Major Depressive Disorder, SOI-3	1.0864
754	4	Depression Except Major Depressive Disorder, SOI-4	1.0864

755	1	Adjustment Disorders & Neuroses Except Depressive Diagnoses, SOI-1	1.0464
755	2	Adjustment Disorders & Neuroses Except Depressive Diagnoses, SOI-2	1.0464
755	3	Adjustment Disorders & Neuroses Except Depressive Diagnoses, SOI-3	1.0464
755	4	Adjustment Disorders & Neuroses Except Depressive Diagnoses, SOI-4	1.0464
756	1	Acute Anxiety & Delirium States, SOI-1	1.1144
756	2	Acute Anxiety & Delirium States, SOI-2	1.1558
756	3	Acute Anxiety & Delirium States, SOI-3	1.1558
756	4	Acute Anxiety & Delirium States, SOI-4	1.1558
757	1	Organic Mental Health Disturbances, SOI-1	1.0142
757	2	Organic Mental Health Disturbances, SOI-2	1.0142
757	3	Organic Mental Health Disturbances, SOI-3	1.0451
757	4	Organic Mental Health Disturbances, SOI-4	1.0451
758	1	Childhood Behavioral Disorders, SOI-1	0.9635
758	2	Childhood Behavioral Disorders, SOI-2	1.0365
758	3	Childhood Behavioral Disorders, SOI-3	1.0365
758	4	Childhood Behavioral Disorders, SOI-4	1.0365
759	1	Eating Disorders, SOI-1	0.8626
759	2	Eating Disorders, SOI-2	0.9256
759	3	Eating Disorders, SOI-3	0.9256
759	4	Eating Disorders, SOI-4	0.9256
760	1	Other Mental Health Disorders, SOI-1	0.9918
760	2	Other Mental Health Disorders, SOI-2	0.9918
760	3	Other Mental Health Disorders, SOI-3	0.9918
760	4	Other Mental Health Disorders, SOI-4	0.9918
770	1	Drug & Alcohol Abuse or Dependence, Left Against Medical Advice, SOI-1	0.9775
770	2	Drug & Alcohol Abuse or Dependence, Left Against Medical Advice, SOI-2	0.9775
770	3	Drug & Alcohol Abuse or Dependence, Left Against Medical Advice, SOI-3	0.9775
770	4	Drug & Alcohol Abuse or Dependence, Left Against Medical Advice, SOI-4	0.9775

772	1	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-1	0.8373
772	2	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-2	0.8373
772	3	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-3	0.8373
772	4	Alcohol & Drug Dependence w Rehab or Rehab/Detox Therapy, SOI-4	0.8373
773	1	Opioid Abuse & Dependence, SOI-1	1.0204
773	2	Opioid Abuse & Dependence, SOI-2	1.0204
773	3	Opioid Abuse & Dependence, SOI-3	1.0361
773	4	Opioid Abuse & Dependence, SOI-4	1.0361
774	1	Cocaine Abuse & Dependence, SOI-1	0.9807
774	2	Cocaine Abuse & Dependence, SOI-2	1.0360
774	3	Cocaine Abuse & Dependence, SOI-3	1.0513
774	4	Cocaine Abuse & Dependence, SOI-4	1.0513
775	1	Alcohol Abuse & Dependence, SOI-1	1.0196
775	2	Alcohol Abuse & Dependence, SOI-2	1.0709
775	3	Alcohol Abuse & Dependence, SOI-3	1.0709
775	4	Alcohol Abuse & Dependence, SOI-4	1.0709
776	1	Other Drug Abuse & Dependence, SOI-1	0.9363
776	2	Other Drug Abuse & Dependence, SOI-2	1.0926
776	3	Other Drug Abuse & Dependence, SOI-3	1.0926
776	4	Other Drug Abuse & Dependence, SOI-4	1.0926

iii. A rural adjustment factor of 1.2309 will be applied to the operating per diem for those hospitals designated as rural hospitals. A rural facility is a general hospital with a service area which has an average population of less than 175 persons per square mile, or a general hospital with a service area which has an average population of less than 200 persons per square mile measured as population density by zip code. Accordingly, there are 22 rural facilities that provide inpatient psychiatric services.

iv. An age adjustment payment factor of 1.0872 will be applied to the per diem operating component for adolescents ages 17 and under. For ages 18 and over, an adjustment payment factor of 1 will be applied.

v. A payment adjustment factor of 1.0599 will be applied to the operating component for the presence of a mental retardation diagnosis.

vi. The payment methodology will include one comorbidity factor per stay and if more than one comorbidity is present during a patient's stay, the comorbidity that reflects the highest payment factor will be used to adjust the per diem operating component.

Comorbidity Categories	Adjustment Factor
Cancers	1.0942
Protein-Calorie Malnutrition	1.0848
Disorders of Fluid/Electrolyte/Acid-Base Balance	1.0630
Other Endocrine/Metabolic/Nutritional Disorders	1.1405
Other Hepatitis and Liver Disease	1.0856
Peptic Ulcer, Hemorrhage, Other Specified Gastrointestinal Disorders	1.1032
Other Musculoskeletal and Connective Tissue Disorders	1.0638
Blood Disorders	1.1056
Other Developmental Disability	1.2014
Brain/Head Injury	1.1361
Cardiorespiratory Failure and Shock	1.1608
Acute Coronary Syndrome	1.4046
Stroke/Occlusion/Cerebral Ischemia	1.2109
Respiratory Illness	1.0662
Other Eye Disorders	1.1224
Renal Disease	1.0954
Complications of Medical Care and Trauma	1.1297
Major Organ Transplant Status	1.1762

vii. A variable payment factor will be applied to the operating per diem for each day of the stay, with the factor for days 1 through 4 established at 1.2, the factor for days 5 through 11 established at 1.0, the factor for days 12 through 22 established at 0.96 and the factor for stays longer than 22 days established at 0.92.

viii. An annual adjustment for inflation will be applied as determined in accordance with the trend factor provisions of this Attachment.

e. The first day of a patient's readmissions to the same hospital within 30 days of discharge will be treated as day four for purposes of the variable payment factor computed as aforementioned, with subsequent days treated in a conforming manner with the provisions.

f. Reimbursement for physician services will not be included in rates and such services may be billed on a fee-for-services basis pursuant to the Hospital Physician Billing Section in Attachment 4.19-B.

g. Reimbursement for electroconvulsive therapy will be established at a statewide fee of $281, as adjusted for each facility's WEF, for each treatment during a patient's stay.

h. New inpatient psychiatric exempt hospitals or units established pursuant to Article 28 of the Public Health Law will be reimbursed at the statewide price plus budgeted capital and Direct GME. Budgeted capital will be adjusted as described in this section and will be adjusted to actual costs in future years. Direct GME will be adjusted to actual costs based upon the first twelve months reporting following the calendar year after the opening of the new unit.

i. The base period costs and statistics used for inpatient psychiatric per diem rate setting operating cost components, including the weights assigned to diagnostic related groups, will be updated no less frequently than every four years and the new base period will be no more than four years prior to the first applicable rate period that utilized such new base period. The payment factors for rural designation, age, certain defined comorbidities, and the presence of mental retardation may also be updated to reflect more current data.

j. For rate periods through December 31, 2014, reimbursement will include transition payments of $25 million on an annualized basis, which will be distributed as follows:

i. Fifty percent of the payments will be allocated to facilities that experience a reduction in Medicaid operating revenue relative to payments prior to this new methodology in excess of threshold percentage set forth in this paragraph as a result of the implementation of rates set pursuant to this section. The payments will be allocated proportionally, calculated utilizing each eligible facility's relative Medicaid operating revenue reduction in excess of the threshold, as determined by the Commissioner. The threshold percentage described in this paragraph will be 6.02%. Therefore, 50% of the $25 million will be allocated to hospitals such that they will not lose more than 6.02% of revenue from the existing payment to the new payments in year 1.

ii. Fifty percent of the payments will be allocated to facilities whose rates otherwise set pursuant to this section result in Medicaid revenue that is less than the facility's calculated Medicaid costs by a threshold percentage in excess of 1.20%. The payments will be allocated proportionally, utilizing the degree by which each facility's Medicaid operating revenue shortfall exceeds such threshold percentage. Therefore, with the utilization of 2006 data, 50% of the $25 million will be allocated to hospitals whose costs are above their revenues.

iii. In 2010-11, the $25 million investment will be allocated to a transition fund pool. In future years through December 31, 2014, the $25 million transition fund pool will be reduced, and the excess funds will be reinvested into the statewide base price as follows:

Period	Transition	Statewide Rate
10/20/2010 – 12/31/2011	$25 million	$0
1/1/2012 – 12/31/2012	$17 million	$8 million
1/1/2013 – 12/31/2013	$8 million	$17 million
1/1/2014 – 12/31/2014	$0	$25 million

k. For the rate period October 20, 2010 through March 31, 2011, reimbursement will include transition payments totaling, in aggregate, $12 million and will be distributed to eligible hospitals as described below, provided, however, that if less than $12 million is distributed in such rate period then additional distributions of the $12 million will be made in subsequent rate periods as follows:

i. Eligible hospitals will be those general hospitals which receive approval for certificate of need applications submitted to the Department of Health between April 1, 2010 and March 31, 2011 for adding new behavioral health inpatient beds in response to the decertification of other general hospital behavioral health inpatient beds in the same service area, or which the Commissioner of Health, in consultation with the Commissioner of Mental Health, has determined to have complied with Department of Health requests to adjust behavioral health service delivery in order to ensure access.

ii. Eligible hospitals will, as a condition of their receipt of the rate adjustments, submit to the Department of Health proposed budgets for the expenditure of the additional Medicaid payments for the purpose of providing inpatient behavioral health services to Medicaid eligible individuals. The budgets must be approved by the Department of Health, in consultation with the Office of Mental Health, prior to the rate adjustments being issued.

iii. Distributions will be made as add-ons to each eligible facility's inpatient Medicaid rate and will be allocated proportionally, utilizing the proportion of each approved hospital budget to the total amount of all approved hospital budgets. Distributions will be subsequently reconciled to ensure that actual aggregate expenditures are within available aggregate funding.

[8] 9. 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] 10. 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] 11. 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.

[11] 12. *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.