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State/Territory Name: New York

State Plan Amendment (SPA) #: 14-0021

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

July 1, 2020

Donna Frescatore
Medicaid Director
NYS Department of Health
One Commerce Plaza
Suite 1211
Albany, NY 12210

Reference: TN 14-0021

Dear Ms Frescatore:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-0021. This amendment proposes to revise the reimbursement method for acute inpatient hospital rates.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1923 and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This is to inform you that Medicaid State plan amendment 14-0021 is approved effective July 1, 2014. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Charlene Holzbaur at 609-882-4796 or Charlene.Holzbaur@cms.hhs.gov.

Sincerely,

[redacted]

Karen Shields
Acting Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 14-021	2. STATE New York
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2014	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: §1902(a) of the Social Security Act, and 42 CFR 447	7. FEDERAL BUDGET IMPACT: (in thousands) a. FFY 07/01/14-09/30/14 $ 0 b. FFY 10/01/14-09/30/15 $ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: 106(b), 106(c), 106(d), 106(e), 138.2, 138.3, 138.4, 138.5, 138.6, 138.7, 138.8 Attachment 4.19-A Pages: 103, 104, 105, 105(a), 106, 106(a), 107, 108, 109, [illegible], 110, 110(a), [illegible], 111, 111(a), 111(b), [illegible], 112, 113, 114, 121, [illegible]	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-A Pages: 103, 104, 105, 105(a), 106, 107, 108, 109, [illegible], 110, 110(a), 111, 111(a), 111(b), 112, 113, 114, 121, [illegible], [illegible] 106(a) 138.2, 138.3, 138.4

10. SUBJECT OF AMENDMENT:
Rebase Hospital Acute IP Rates to 2010
(FMAP = 50%)

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

[redacted]ENCY OFFICIAL:	16. RETURN TO: New York State Department of Health Bureau of Federal Relations & Provider Assessments 99 Washington Ave – One Commerce Plaza Suite 1460 Albany, NY 12210
13. TYPED NAME: Jason A. Helgerson	
14. TITLE: Medicaid Director Department of Health	
15. DATE SUBMITTED: SEP 30 2014	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/30/2014	18. DATE APPROVED: 7/1/20
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/14	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Karen Shields	22. TITLE: Acting Director, FMG
23. REMARKS:	

FORM HCFA-179 (07-92)

New York
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Hospital Acute Inpatient Reimbursement – [Effective December 1, 2009] July 1, 2014

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

1. *Diagnosis related groups (DRGs)* [shall]will 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. Effective January 1, 2013, Version 30 of the APR classification system will be used.]

2. *Acute Rate DRG case-based payment per discharge (herein after referred to as Acute Rate)* [shall]will mean the payment to be received by a hospital for inpatient services, except for physician services (unless allowed under paragraph 12(c) of this Section), 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) and will be updated no less frequently than every four years.

4. *Case mix index (CMI)* [shall]will 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.

   a. All payer CMI is developed using acute claims reported to the Statewide Planning and Research Cooperative System (SPARCS) which provides data for all payer sources.
   b. Medicaid fee-for-service CMI is developed based on Medicaid fee-for-service acute claims submission to New York State.
   c. Medicaid managed care CMI is developed based on Medicaid managed care acute claims submission to New York State.

5. *Reimbursable operating costs* [shall]will mean reported operating costs which relate to the cost of providing inpatient hospital services to Medicaid patients, [adjusted]trended for inflation between the base period, as defined in this Section, [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.

6. *Graduate medical education (GME).*

   a. *Direct GME (DGME) costs* [shall]will mean the reimbursable salaries, fringe benefits, non-salary costs and allocated overhead teaching costs for residents, fellows, and supervising physicians trended for inflation to the rate year by the applicable provisions of this section. Only the costs reported for Interns and Residents Services Salary and Fringes, Interns and Residents Services Other Program Costs, and Supervising Physician Teaching will be included in the direct GME cost development.

   b. *Indirect GME (IME) costs* [shall]will 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]will mean 100 percent of the hospital's total billed patient charges, as approved by IPRO, that have been converted to cost using the hospital's most recent [ratio of cost-to-charges] charge convertor for that same service period, as defined in this Section, that exceed the DRG specific high-cost thresholds calculated pursuant to the Outlier Rates of Payment[Exclusion of Outlier and Transfer Costs of this] Section.

8. *Alternate level of care (ALC) services* [shall]will 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]will mean those hospitals and units that are paid per diem rates of payment pursuant to the provisions of the Exempt Units and Hospitals [of this] Section, rather than receiving per discharge case-based rates of payment.

10. *The wage equalization factor (WEF)* [shall]will 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]will mean the numeric value calculated pursuant to the Statewide Base Price [of this] Section, which [shall]will be used to calculate DRG case-based payments per discharge as defined in paragraph (2) of this Section.

12. *Non-comparable [adjustments]costs* [shall]will mean those base year costs, as defined in this Section, that are [passed through]excluded from the statewide base price calculation and applied to the case-based rate of payment as an add-on payment. The following [shall]will be considered non-comparable [adjustments]costs:

    a. Medicaid costs associated with ambulance services operated by a facility and reported as inpatient costs in the Institutional Cost Report (ICR); and

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 also referred to as Teaching Election Amendment (TEA) costs.

13. *Transfers,* For purposes of transfer per diem payments, a transfer patient [shall]will 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 as defined in the Mergers, Acquisitions, Consolidations, Restructurings and Closure Section, 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]will mean those inpatients whose discharge from the facility occurred on [or]and after [December 1, 2009]July 1, 2014, and:

    a. the patient is released from the facility to a non-acute care setting; or

    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]Average [Inlier] Length of Stay (ALOS)* [shall]will 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]will be calculated for each DRG on a statewide basis and will be rounded to the closest whole number.

16. *General hospital*, as used in this Section, [shall]will mean a hospital engaged in providing medical or medical and surgical services primarily to [in-patients] inpatients 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.

17. *Charge converter* [shall]will 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. *IPRO* [shall]will mean the Island Peer Review Organization, Inc., a New York not-for-profit corporation providing health related services.

19. *Medicaid,* when used to describe the calculation of the Medicaid Acute Rate in this section, will mean Medicaid Fee-for-Service (FFS) and Medicaid Managed Care (MC). Acute rates are developed using the FFS claims data and the MC encounter data using the methodologies described in this Attachment.

20. *Base year* will mean the period as determined pursuant to the applicable provisions of this Attachment and applies to the DRG case-based payment per discharge, based on the following:

    a. For periods beginning on and after July 1, 2014, the base year will be the 2010 calendar year and the data and statistics will be the audited costs reported by each facility to the Department pursuant to the Financial and Statistical Data Required and Audits Sections.

    b. For those hospitals operated by New York City Health and Hospitals Corporation (NYC H+H), the base year will be for the 12 months ended June 30, 2010, and for those hospitals operated by New York State, excluding the hospitals operated by the State University of New York (SUNY), the base year will be the 12-month period which ended March 31, 2011.

    c. The base year used for rate-setting for operating cost components 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 utilizes such new base year provided.

21. *Divisor for add-ons to the acute rates per discharge*, as used in this Section, will mean the discharges used in the development of the add-ons pursuant to the Add-Ons to the Acute Rate Per Discharge Section of this Attachment.

    a. For the period beginning on and after July 1, 2014, the discharges used as the divisor will be the 2011 calendar year reported to the Department prior to August 1, 2013.

22. *The year discharges* will mean the latest calendar year utilized pursuant to the Service Intensity Weights (SIWs) and Average Length of Stay (ALOS) Section of this Section.

    a. For the period beginning on and after July 1, 2014, the latest calendar year will be 2011.

23. *Goal Seek* is the process of finding the correct input when only the output is known.

    a. Wikipedia definition states, "In computing, goal seeking is the ability to calculate backward to obtain an input that would result in a given output. This can also be called "what-if analysis" or "back-solving."

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Statewide Base Price

1. For periods on and after July 1, 2014, a statewide base price (SBP) will be established for operating cost payments and will be used in the calculation of the payment of a Medicaid acute claim as follows:

	RATE ELEMENT	STATE PLAN SECTION
	Operating cost neutral statewide base price per discharge	Statewide Base Price
x	(1+ Budget neutrality factor)	Statewide Base Price
x	(1 + Trend factor)	Trend Factor
x	Institution-specific wage equalization factor (WEF) adjustment	Wage Equalization Factor (WEF)
x	(1 + Transition adjustment factor)	Transition
x	(1 + Potentially Preventable negative outcome reduction factor)	Potentially Preventable Negative Outcomes (PPNOs)
x	APR-DRG weight with severity level	Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS)
=	FFS adjusted statewide base price per discharge	
+	IME per discharge add-on	Add-Ons to the Acute Rate Per Discharge
+	DGME per discharge add-on	Add-Ons to the Acute Rate Per Discharge
+	Capital per discharge add-on	Capital expense reimbursement for DRG case-based rates of payment
+	Non-comparable cost per discharge add-on	Add-Ons to the Acute Rate Per Discharge
=	Medicaid FFS rate per discharge	

a. The rate elements included in the chart are developed as described within the sections of this Attachment.

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106(a)

2. The SBP will be established based on the following process and mathematical sequence.

[4. To establish the Transition II Pool, effective October 20, 2010, the statewide base price will be reduced such that the level of total Medicaid payments shall be decreased for the periods specified on the 'Transition II Pool' section by the corresponding Transition II fund amount.]

[5. For the period effective July 1, 2011 through March 31, 2012, the statewide base price will be reduced such that the level of total Medicaid payments are decreased by $24.2 million.]

a. Steps in the mathematical sequence:

i. Step 1: Develop, by facility, an average facility specific, all payer, cost neutral per discharge rate.
ii. Step 2: Convert the by facility per discharge rates developed in Step 1 to a price.
iii. Step 3: Adjust the price developed in Step 2 for budget neutrality.

[6]b. For the period May 1, 2012 through March 31, 2013 and for state fiscal year periods on and after April 1, 2013, the statewide base price will be adjusted such that total Medicaid payments are decreased for such period and for each such state fiscal year period by $19,200,000.

c. Step 1: Develop an average facility specific, all payer, cost neutral per discharge rate. This rate represents the operating costs that will be paid by the statewide base price and is converted to a price in Step 2. The average per discharge rate developed in this process is represented as H in the chart in paragraph (2)(c)(iii).

i. Step 1 uses the following data on a facility specific basis and the mathematical process in the chart in paragraph (2)(c)(iii):

1. Total allowable facility ICR costs in the base year, as defined in the Definitions section. These costs are represented as A in the chart.

2. Total allowable facility specific costs in the ICR from the base year, as defined in the Definitions Section of this Attachment, that are associated with the rate add-ons as defined in the Add-Ons to the Acute Rate Per Discharge Section of this Attachment. These costs are represented as B in the chart.

3. Total facility ICR discharges in the base year, as defined in the Definitions section. These discharges are represented as D in the chart.

4. The wage equalization factor (WEF) for the base year, as defined in the Definitions section, and calculated based on the Wage Equalization Factor (WEF) section of this Attachment. This WEF factor is represented as F in the chart.

5. A facility specific all payer CMI, as defined in the definitions section.

a. Uses the all payer acute claims of the base year, as defined in the Definitions Section of this Attachment.

b. Requires grouping the all payer acute claims to determine the appropriate APR-DRG and Service Intensity Weight (SIW) for payment of the claim. This process uses the 3M grouper version and Service Intensity Weights (SIWs) that were used in the payment of claims during the base year, as defined in the Definitions section of this Attachment.

c. This CMI represents an average of the APR-DRG weights assigned for all cases used in this process.

d. The CMI is represented as G in the chart.

ii. The average facility specific per discharge rate is cost neutral as it represents the base year costs that are reflected in the SBP excluding the differences in the WEF and case mix that are applied to the SBP in the payment method. This per discharge rate is represented as H in the chart.

iii. Chart for mathematical sequence:

A	ICR base year total all payer allowable facility specific operating costs	A
	Less: Costs associated with Add-ons	
B	IME	
B	DGME	
B	Ambulance	
B	TEA	
B	School of Nursing	
B Sum	Total costs associated with Add-ons	B Sum
C	Total facility allowable operating costs for SBP development	A – B Sum = C
D	Total facility all payer ICR Discharges	D
E	Facility Specific all payer cost per discharge rate	C / D = E
F	Facility Specific WEF	F
G	Facility Specific all payer CMI	G
H	Average Facility Specific all payer cost neutral per discharge rate (WEF and CMI neutral)	E / F / G = H
	Note: For payments, H will be replaced by the SBP	

d. Step 2: Convert the average facility specific all payer cost neutral per discharge rate calculated in Step 1 (letter H in the preceding chart) to a price (operating cost neutral SBP). The SBP is a constant value used across all hospitals in the Acute payment calculation. The SBP reflects the value that when multiplied by the total statewide discharges the statewide total result equals the same statewide sum total result as using the average facility specific all payer cost neutral per discharge rate developed in Step 1 times the facility specific discharges. This process requires the development of the proposed statewide total Medicaid operating payments using the new proposed rate components that are developed using the base year costs in Step 1.

New York
106(c)

i. Step 2 uses the following data and mathematical process.

1. By facility, develop historical claims detail using "the year discharges", as defined in the Definitions section, for the list below.

a. Medicaid fee-for-service (FFS) inlier discharges;
b. Medicaid managed care (MMC) inlier discharges;
c. Medicaid high cost cases;
d. Medicaid transfer cases.

2. By facility, develop the proposed statewide total Medicaid operating payments for each set of claims in paragraph 2(d)(i)(1) using the following:

a. Group the claims using the 3M grouper version as specified in the Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS) section, paragraph 3(a) to determine the APR-DRG and severity level assignment.
i. The service intensity weights (SIWs) that will be used are developed per the Service Intensity Weights (SIW) and Average Length-of-Stay (ALOS) section.
ii. Develop an average Medicaid fee-for-service (FFS) CMI, as defined in the Definitions section, based on the APR-DRG/severity level assignment and SIWs applied to all FFS claims.
iii. Develop an average Medicaid managed care (MMC) CMI, as defined in the Definitions section, based on the APR-DRG/severity level assignment and SIWs applied to all MMC claims.

b. The by facility payment will be developed as follows:
i. The payment methodology for each of the claims in accordance with this Attachment.
ii. The average facility specific all payer cost neutral per discharge rate calculated in Step 1, letter H, is used and represents the SBP in the payment method for the claims.
1. For the Medicaid FFS claims, apply the average Medicaid FFS CMI developed in paragraph 2(d)(i)(2)(a)(ii) to the SBP as the APR-DRG weight with severity level.
2. For the Medicaid MMC claims, apply the average Medicaid MMC CMI developed in paragraph 2(d)(i)(2)(a)(iii) to the SBP as the APR-DRG weight with severity level.
iii. The new proposed acute rate components based on costs, developed in accordance with this Attachment, using the same base year costs that were used to develop the average facility specific all payer cost neutral per discharge in Step 1.

c. Sum the by facility results for a proposed statewide total Medicaid operating payment based on costs. The proposed statewide total Medicaid operating payments will equal the Medicaid share of the total costs that are represented as A in the preceding chart. Therefore, Medicaid payments equal Medicaid costs.

3. Convert the average facility specific all payer cost neutral discharge rate in paragraph (2)(d)(i)(2)(b)(ii) to a price using "Goal Seek" as defined in the Definitions section. This will determine what value (price) can be consistently applied to replace the average facility specific all payer cost neutral per discharge rate within the payment of each case and the result is the same proposed statewide total Medicaid operating payments based on costs in paragraph (2)(d)(i)(2)(c), of this section.

4. The result is the "operating cost neutral SBP" that is based on costs.

e. Step 3: Develop a budget neutrality factor (BNF) to adjust the new proposed rate components to maintain budget neutrality to the statewide total existing Medicaid operating payments. Since rebased rates are implemented budget neutral, this will limit the proposed statewide total Medicaid operating payments to existing Medicaid operating payments.

i. Step 3 uses the following data and mathematical process.

1. Using the same cases developed in paragraph (2)(d)(i)(1)(a) thru (d), develop the statewide total existing Medicaid operating payments to be used as the targeted Medicaid operating payments for budget neutrality. These claims will be grouped using the 3M grouper version that was used with the latest effective acute rate paid (latest rate prior to the effective date of the Hospital Inpatient Reimbursement section) and the SIWs that were used in the payment of those rates. Grouping the claims will determine the appropriate APR-DRG and SIW for payment of the claims for the latest paid effective period.

2. By facility, develop the statewide total existing Medicaid operating payments using the data listed below.

a. The latest acute rate components for each facility used with the same 3M grouper version and SIWs in Step 3, paragraph (2)(e)(i)(1).
b. The operating budget neutral SBP used with the same 3M grouper version and SIWs in Step 3, paragraph (2)(e)(i)(1).
c. Medicaid fee-for-service (FFS) payment development utilizes an average FFS CMI, as defined in the Definitions section, based on the grouping and SIW assignment completed in paragraph (2)(e)(i)(1) of the FFS cases in paragraph (2)(d)(i)(1)(a) thru (d).
d. Medicaid managed care (MMC) payment development utilizes an average MMC CMI, as defined in the Definitions section, based on the grouping and SIW assignment completed in paragraph (2)(e)(i)(1) of the MMC cases in paragraph (2)(d)(i)(1)(a) thru (d).
e. The payment methodology for each of the cases in accordance with this Attachment.
f. Sum the by facility results for a statewide total existing Medicaid operating payment to be used as the targeted total statewide Medicaid operating payment.

3. Using the "Goal Seek" data tool in Microsoft Excel, as defined in the Definitions Section, develop the Budget Neutrality Factor (BNF). This will derive the percent that can be consistently applied to all components of the proposed new rebased rates to reduce them by an equal percentage to limit the proposed operating payments to the targeted total statewide Medicaid operating payments developed in paragraph (2)(e)(i)(2)(f). This process uses the following:

   a. The new proposed rate components used in Step 2, paragraph (2)(d)(i)(2)(a).
   b. The operating cost neutral SBP developed in Step 2, paragraph (2)(d)(i)(3).
   c. The targeted total statewide Medicaid operating payment developed in Step 3, paragraph (2)(e)(i)(2)(f).

4. The "operating cost neutral SBP" will be reduced by the BNF. The result is the "operating budget neutral SBP" that was based on targeted Medicaid operating payments. This is the SBP that will be used with the rebased rate add-on components in the payment of claims. The rebased rate add-on components are also adjusted by the BNF in accordance with the Add-Ons to the Acute Rate Per Discharge section.

f. No reconciliation adjustment will be made to the SBP to account for changes in volume or CMI during the effective period of the SBP.

g. The SBP will be updated at the time the SIWs are updated in accordance with the SIW and ALOS Section or at the time the base year, as defined in the Definitions Section, is updated.

New York

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[Exclusion of outlier and transfer costs.] RESERVED

[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.

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.]

Service Intensity Weights (SIW) and [a]Average [l]Length-of-[s]Stay (ALOS).

1. The table of SIWs and statewide [average]ALOS [for each] effective [period]on and after July 1, 2014 is published on the New York State Department of Health website at:

   http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/weights/

   and reflects the cost weights and ALOS 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]3) [below]of this section. Costs associated with hospitals that do not have an ancillary charge structure or associated with hospitals and services exempt from the case payment methodology, and costs associated with statistical outliers are excluded from the SIW calculations.

2. [For periods on and after December 1, 2009 through December 31, 2010, 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.] For periods beginning on and after July 1, 2014, the SIWs and statewide ALOS table will be computed using SPARCS and reported cost data from the 2009, 2010, and 2011 calendar years as submitted to the Department by August 29, 2013.

[3. For periods on and after January 1, 2011 through December 31, 2011, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2006, 2007 and 2008 calendar years as submitted to the Department by June 30, 2010.]

3. The DRG classification system used in rates, as defined in paragraph (1) of the Definitions Section of this Attachment, will be as follows:

   a. Effective July 1, 2014 through December 31, 2014, Version 31 of the APR-DRG classification system will be used.

   b. Effective January 1, 2015 through September 30, 2015, Version 32 of the APR-DRG classification system will be used.

   c. Effective beginning on and after October 1, 2015, Version 33 of the APR-DRG classification system will be used.

[4. For periods on and after January 1, 2012 through December 31, 2012, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2007, 2008 and 2009 calendar years as submitted to the Department by September 30, 2011.]

[5. For periods on and after January 1, 2013 through June 30, 2014, the SIW and statewide average LOS table shall be computed using SPARCS and reported cost data from the 2008, 2009 and 2010 calendar years as submitted to the Department by September 30, 2012.]

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Wage Equalization Factor (WEF).

1. The statewide base price per discharge [shall]will be adjusted by a facility-specific wage equalization factor (WEF) to reflect differences in labor costs between hospitals. Such WEF adjustment [shall]will 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]will 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 for the Final Rule Wage Index, which is posted on the Centers for Medicare and Medicaid Services (CMS) website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/, and the hospital's proportion of salaries and fringe benefit costs to total operating costs as reported [to]in the Institutional Cost Report (ICR). The WEF [shall] will be computed as follows:
      (i) For all occupations described in paragraph (a), a statewide average salary [shall]will be calculated [by dividing the statewide sum of hospitals' total dollars paid by the statewide sum of hospitals' hours paid] utilizing an average of three years data by dividing the statewide sum of three years of hospitals' total dollars paid by the statewide sum of three years of hospitals' hours paid. The three years utilized for this calculation will be the base year as defined in the Definitions Section and two years prior to the base year; and
      (ii) For each hospital, an actual [weighted] average salary [shall]will be calculated by dividing the [total dollars paid for such occupations by the total hours paid for such occupations] sum of three years total dollars paid for such occupations by the sum of three years total hours paid for such occupations. The three years utilized for each hospital will be the three years as identified in subparagraph (a)(i) of this paragraph; and
      (iii) An initial WEF [shall]will 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]will be calculated using the following formula:

      (1 / ((Labor Share/initial WEF) + Non-Labor Share))

      where "Labor Share" is calculated by dividing the hospital's total salary cost plus the hospital's total fringe benefits by the hospital's total operating costs as reported in the ICR for the [same calendar year used to calculate the statewide base price for the applicable rate period.] base year as defined in the Definitions Section. One minus the "Labor Share" is the "Non-Labor Share."

   b. A hospital [may]will submit updated occupational [service]mix 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, at the time the base year is updated, in accordance with this Section.

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Add-[o]Ons to the [case payment]Acute [r]Rate [p]Per [d]Discharge.

Rates of payment computed pursuant to this Attachment [shall]will [be further adjusted in accordance with the following]include operating cost add-on payments to the statewide base price payment as follows:

1. The base period used for the add-on development will be as defined in the Definitions Section.
2. The costs and discharges used in the development of the add-ons will be total acute inpatient costs and discharges.
3. Medicaid costs will be calculated based on a percentage ratio of Medicaid acute days to Total acute days using the base year days, as defined in the Definitions Section. For the purpose of this Section, Medicaid is as defined in the Definitions Section.
4. All add-on components of the acute operating per discharge rate will be reduced by the Budget Neutrality Factor pursuant to the Statewide Base Price Section of this Attachment.

5.[1.] A direct graduate medical education (DGME) payment per discharge [shall]will be added to the [case payment] acute rates of teaching general hospitals after the application of SIW, [and] WEF, and Indirect Graduate Medical Education (IME) adjustments to the statewide base price. The DGME [and shall]will be calculated for each hospital by dividing the facility's total reported [inpatient] Medicaid [direct] DGME costs by its total reported Medicaid discharges [as defined in the Statewide Base Price]pursuant to paragraphs (1) through (3) of this Section. D[irect]GME costs [shall]will 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.

6.[2.] a. An indirect GME payment per discharge [shall]will be added to the [case payment]acute rates of teaching general hospitals after the application of SIW and WEF adjustments to the statewide base price and [shall]will be calculated by multiplying such rates by the indirect teaching cost percentage determined by the following formula:

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

where "r" equals the ratio of residents and fellows to beds based on the medical education statistics for the hospital based on paragraph (7) of this Section [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,]base period, as defined in the Definitions Section, but excluding exempt unit beds and nursery bassinettes.

[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.]

b. Indirect GME costs are those costs defined in the Definitions Section, derived from the base year, as also defined in the Definitions Section, and trended forward to such rate period in accordance with applicable provisions of this Attachment.

7. Hospitals will furnish to the Department such reports and information as will be required by the Department to access the cost, quality, and health system needs for medical education. Such reports and information will include, but not be limited to, the Indirect Medical Education Survey.

a. The Indirect Medical Education Survey is completed annually by hospitals and collects the actual interns and residents in a program year.

i. For rates beginning on and after July 1, 2014, the ratio of residents and fellows to bed will be based on the medical education statistics for the hospital for the period ended June 30, 2011 as contained in the Indirect Medical Education survey document submitted by the hospital to the Department as of June 30, 2013.

8.[3.] A non-comparable payment per discharge [shall]will be added to [case payment]acute rates after the application of SIW, [and] WEF, and IME adjustments to the statewide base price and the addition of the DGME payment and [shall]will be calculated for each hospital by dividing the facility's total reported Medicaid costs, pursuant to paragraphs (1) through (3) of this Section, for qualifying non-comparable cost categories by its total reported Medicaid discharges [as defined in the Statewide Base Price] pursuant to the Definitions 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]year, as also defined in the Definitions Section, 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.

9. At the time non-comparable base year costs are updated in accordance with applicable provisions of this Section, cost transfers between affiliated facilities, for non-comparable costs as defined in the Definitions Section for other than DME or IME, due to the transfer of an entire service for organizational restructuring, will be adjusted in the payment rate. The non-comparable costs will be eliminated from the rate for the hospital closing the service and included in the rate for the receiving hospital. The costs transferred and utilized in the receiving hospital's rate will be the base year costs of the facility closing the service as defined in the Definitions Section. No revisions to the costs will be allowed.

10. The add-ons described in this section will be adjusted to reflect potentially preventable negative outcomes (PPNOs) in accordance with the Potentially Preventable Negative Outcomes (PPNO) Section of this Attachment and the transition factor per paragraph (1)(a)(ii) of the Transition Section of this Attachment.

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1. Transition

a. For discharges beginning on July 1, 2014 through December 31, 2017, a transition factor will be applied as follows:

i. The factor will be applied to the operating statewide base price as stated in paragraph (5) of the Statewide Base Price Section of this Attachment.

ii. The factor will be applied to all add-on operating cost components of the acute case per discharge rate as stated in paragraph (10) of the Add-ons to the Case Payment Rate per Discharge Section of this Attachment.

b. Hospital estimated losses and gains for the transition development will be calculated by comparing the estimated revenue, by provider, based on the newly developed rate using the updated base year and associated policy updates in comparison to the last rate developed with the previous base year and policy.

c. Hospital estimated losses which are due to the implementation of the updated base year pursuant to the Definitions Section of this Attachment and associated policy updates, will be limited as follows:

i. for the period July 1, 2014 through December 31, 2015, hospital specific estimated losses will be limited to 2% of the hospital's current revenues;

ii. for the period January 1, 2016 through December 31, 2016, the limitation on estimated losses will be increased to 2.5% of the hospital's current revenues;

iii. for the period January 1, 2017 through December 31, 2017, the limitation on estimated losses will be increased to 3.5% of the hospital's current revenues.

d. The transition limitation on estimated losses, defined in paragraph (1)(b) of this section, shall be funded as follows:

i. Utilizing sixty percent of the historical estimated revenues, valued at forty-two million dollars, for hospitals that have closed since January 1, 2011;

ii. A cap on a hospital's estimated gain, as described in paragraph (1)(b) of this Section, shall be applied as necessary each year in order to achieve budget neutrality pursuant to the Statewide Base Price Section of this Attachment. This will be accomplished as follows:

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[5. *Transition II Pool.* For the rate periods on and after October 20, 2010, 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. Hospitals eligible for distributions pursuant to this section shall be those governmental and nongovernmental general hospitals with:

i. total Medicaid inpatient discharges equal to or greater than 17.5% for the 2007 period; and

ii. total reduction in Medicaid inpatient revenue, as a result of the application of otherwise applicable rate-setting methodologies in effect for the period October 20, 2010 through March 31, 2011, in excess of 10.2%.

b. For the period October 20, 2010 through March 31, 2011, total funding equaling $37.5 million shall be allocated. The allocation amount for each eligible hospital shall equal the amount of inpatient Medicaid revenue for that hospital that existed using the Medicaid reimbursement provisions in effect immediately prior to the revisions instituted on December 1, 2009, multiplied by that hospital's percentage of reduced Medicaid revenue that is in excess of the threshold set forth in paragraph (a)(ii).

c. For the periods on and after April 1, 2011, 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 October 20, 2010 through March 31, 2011, to the total funds distributed for that period applied to the appropriate funds for the applicable periods below:

i. for the period April 1, 2011 through March 31, 2012, $75 million;
ii. for the period April 1, 2012 through March 31, 2013, $50 million; and
iii. for the period April 1, 2013 through March 31, 2014, $25 million.

d. The distributions authorized pursuant to this section shall be made available through a commensurate reduction in the statewide base price for the October 20, 2010 through March 31, 2011, and each applicable period thereafter, as otherwise computed in accordance with the Statewide Base Price Section.]

1. A hospital's estimated gain shall be adjusted to exclude the portion of the gain related to an increase in the teaching resident count. The increase in resident count shall be determined by comparing the medical education statistics supplied to the Department of Health pursuant to the Add-ons to the Case Payment Rate per Discharge Section of this Attachment.

2. The cap on the adjusted estimated gain is derived through the "Goal Seek" programming in Microsoft Excel, as defined in the Definitions Section, to determine the percentage necessary to hold payments budget neutral to the target total Medicaid operating payments, per the Statewide Base Price Section of this Attachment, with the limit on the losses.

3. For the period July 1, 2014 through December 31, 2015, the cap on gains is 3.4308%. When the cap on losses is revised, based on paragraph (c) of this section, the cap on gains will be increased.

e. The facility specific transition factor is determined by dividing the dollars associated with the total transition adjustment from gains or losses by the total facility specific projected revenue based on the newly developed rates using the updated base year and associated policy updates.

i. The total projected facility specific revenue excludes revenue from cost outlier cases since the transition factor does not apply to cost outlier payments.

f. The transition factor will not be subject to reconciliation.

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[e. 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 on to the rates for the period October 20, 2010 through March 31, 2011 shall be established by dividing the total funds allocated in accordance with paragraph (b) by six months of the hospital's total reported Medicaid discharges in accordance with paragraph (3)(b) in the 'Statewide Base Price' section of this Attachment. For the periods on and after April 1, 2011 the amount per discharge to be added on to the rates shall be established by dividing the total funds allocated in accordance with paragraph (c) by the hospital's total reported Medicaid discharges in accordance with paragraph (3)(b) in the 'Statewide Base Price' section of this Attachment

f. Hospitals receiving funds pursuant to this section that did not previously receive funds to facilitate improvements in hospital operations and finances beginning on December 1, 2009, shall, as a condition for eligibility for such funds, adopt and submit a restructuring plan that includes both an assessment of the hospital's current financial position and the plan to restructure and improve its financial operations. The plan must also provide for ongoing Board oversight of plan implementation, along with measurable objectives. Two years following receipt of funds, the Board of Directors must issue a report setting forth what progress has been made toward accomplishing the goals of the restructuring plan. The Commissioner shall be provided with copies of all such resolutions and reports. If such report fails to set forth adequate progress toward the goals of the hospital's restructuring plan as determined by the Commissioner, the Commissioner will deem such facility ineligible for further distributions and will redistribute such further distributions to other eligible facilities in accordance with the provisions of this section.

g. Unallocated funds awarded to hospitals deemed ineligible by the Commissioner, as a result of paragraph (f) of this section, shall be redistributed to all remaining eligible hospitals using the proportion of each eligible hospitals' allocation of the funds distributed for the period October 20, 2010 through March 31, 2011, to the total funds distributed for that period.]

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Outlier [and transfer cases r]Rates of [p]Payment.

1. [a.]High cost outlier rates of payment [shall]will be calculated by [reducing]converting 100% of the total billed patient charges, as approved by IPRO, to cost [, as determined based on the hospital's ratio of cost to charges] by applying the hospital's charge converter as defined in the Definitions Section. Such calculation [shall]will use the most recent charge converter[data] available as subsequently updated to reflect the data from the year in which the discharge occurred, and [shall]will 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.]

   i. For payment, the high cost outlier threshold will be adjusted by the hospital specific wage equalization factor (WEF), as defined in the Definitions Section of this Attachment, prior to determining the excess costs above the high cost outlier threshold as stated in paragraph (1) of this Section.

2. The high cost outlier threshold will be developed for each Diagnosis Related Group (DRG) using acute Medicaid operating costs which are derived from the year discharges used in the Statewide Base Price Section and defined in the Definitions Section of this Attachment. The high cost thresholds will be scaled to maintain budget neutrality to targeted outlier payments developed pursuant to the Statewide Base Price Section.

   i. The high cost outlier thresholds will be updated at the time the Service Intensity Weights (SIWs) are updated in accordance with the SIW and ALOS Section.

[b]ii. Cost outlier thresholds for each base APR-DRG [will be calculated as follows:],effective on and after July 1, 2014, have been posted to the Department of Health's public website at the following:

http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/tresholds/

   [i. using the applicable base year Medicaid claims data, organize costs per claim with 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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Transfer Cases Rates of Payment.

[2]1. Rates of payment to non-exempt hospitals for inpatients who are transferred to another non-exempt hospital [shall]will 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 subparagraphs (a)[, (b), and (c)]through (d) of this paragraph. The total payment to the transferring facility [shall]will not exceed the amount that would have been paid if the patient had been discharged. The per diem rate [shall]will be determined by dividing the DRG case-based payment per discharge as defined in the Definitions Section by the [arithmetic]average [inlier] length of stay (ALOS) 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] ALOS for the DRG is equal to one, the transfer adjustment factor [shall]will not be applied.

a. Transfers among more than two hospitals that are not part of a merged facility as defined in the Mergers, Acquisitions, Consolidations, Restructurings and Closure Section [shall]will be reimbursed as follows:

   i. the facility which discharges the patient [shall]will receive the full DRG payment; and

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

b. A transferring facility [shall]will 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]will 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]will be reimbursed and assigned to the applicable APR-DRG upon admission or readmission.

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Alternate [l]Level of [c]Care [p]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.] For rates beginning on and after July 1, 2014, hospitals will be reimbursed for ALC days at the appropriate 2013 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]will be based on the combination of residential health care facilities as follows:

   a. The downstate group will consist[ing] of residential health care facilities located in the [five boroughs of New York City and Nassau, Suffolk, Westchester and Rockland counties]New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess.

   b. The upstate group will consist[ing] of all other residential health care facilities in the State.

2. Hospitals that convert medical/surgical beds to residential health care beds [shall] will be reimbursed for services provided in the converted beds in accordance with Attachment 4.19-D.

Attachment 4.19-A

Capital Expense Reimbursement.

1. The allowable costs of fixed capital, including but not limited to depreciation, rentals, interest on capital debt, 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 this section.

   a. The allowable capital expense will be adjusted to exclude such expenses related to the following:

      i. 44% of major moveable equipment;
      ii. staff housing costs.

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.

   a. The budgeted inpatient capital-related expense pertaining to the rate year will be decreased to reflect the percentage amount by which the budget for the applicable base year's capital-related expense exceeded the actual capital-related expense of that base year.

      i. The base year used in the budget to actual capital cost comparison will be 2-years prior to 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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d. Hospitals have 5 years to establish new programs. This time period is viewed as a 'ramp-up' period and year 1 of the program is defined as the first approved program year that the hospital received teaching status. Appeals for new teaching costs will only be accepted during this ramp-up period.

e. The hospital will provide the following data:

i. Documentation from the accrediting organization demonstrating the maximum number of approved positions eligible for the associated programs.

ii. Documentation from the new teaching hospital demonstrating the projected filled slots for the associated programs for the upcoming PGY. Documentation must include the resident name, residency program, program year, start date, and expected graduation date.

iii. Documentation from the new teaching hospital demonstrating the actual filled slots for the associated programs from the prior PGY if applicable. This includes resident name, residency program, program year, start date, and expected graduation date.

iv. Completion of the Department's New Teaching Hospital - Form (A), as of June 26, 2017, found on the APR-DRG website below:

https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/

v. Budgeted DGME costs must be included in the New Teaching Hospital Form (A) and must reflect calendar year costs based on the effective date of the rate adjustment. Budgeted DGME Costs must be discretely reported consistent with the standard cost centers provided for interns and residents, and supervising physicians within the annual institutional cost report.

4. Additional reimbursement will be received based on:

a. The initial effective date for a rate increase due to an appeal will be in accordance with subparagraph 4 (c)(ii)(3)(b). This provides for reimbursement effective July 1st.

b. Subsequent appeals after the initial effective date will be accepted during the ramp-up period and in accordance with subparagraph 4(c)(ii)(3)(c).

c. A Direct Graduate Medical Education (DGME) payment [per discharge]will be added [to the acute per discharge rate as stated in the Add-ons to the case payment rate per discharge section of this attachment]as follows.

i. For new teaching hospitals budgeted DGME costs will be submitted by the hospital and used until the first full year of actual DGME costs are available in a provider's Institutional Cost Report (ICR). The first full year of actual DGME costs for this purpose will be the first full year after the last ramp-up year. DGME budgeted costs can be submitted by a hospital for a rate revision each year during the ramp-up period.

1. If an appeal is not submitted with updated budgeted DGME costs, the budgeted DGME costs currently in the rate will continue.

ii. The DGME budgeted costs will be allocated between inpatient and outpatient services, however, there is no rate increase in the outpatient services for new teaching hospitals. Appeals for an initial rate adjustment are required to report the percentage of costs allocated to Inpatient and Outpatient services in section 6 of the New Teaching Hospital - (Form A). Once a full year of program costs have been included in an ICR submitted to the Department during the ramp up period, the total inpatient DGME traceback percentages for that year will be utilized for the remainder of the ramp-up period.

iii. At the time the Department updates the base year utilized for the DGME add-ons to the rate, if the provider is still in their ramp-up period, the new teaching costs will remain on budgeted costs.

iv. The DGME add-on to the Acute rate per discharge will be calculated by dividing the total inpatient DGME budgeted costs by the total reported Medicaid discharges as defined in [paragraph 3 (b of the Statewide base price section] the Definitions Section of this Attachment.

v. The DGME payment will be included in the exempt hospital rates for hospitals that are exempt from the Acute per discharge rate method, reimbursed in accordance with the Exempt units and hospitals section of this Attachment and the DGME costs are not included in the ceiling or price development. These DGME costs will be added to the base year total exempt hospital costs and reimbursed in accordance with the Exempt units and hospital section of this Attachment.

d. An Indirect Medical Education (IME) payment will be added to the acute per discharge rate as stated in the Add-ons to the case payment rate per discharge section of this attachment.

i. An IME percentage will be calculated for new teaching hospitals as follows and applied to the adjusted statewide base price to determine the per case add-on payment.

1. For IME rate adjustments, effective July 1st for program year, the IME Payment percentage will be calculated based on the formula [1.03*(((1+(r)) ^0.405)-1)] where "r" equals the ratio of residents for the upcoming PGY, as provided with the appeal, to inpatient acute staff beds as reported in the base [period]year defined in [paragraph 3 of the statewide base price section] the Definitions Section of this Attachment.

[2. For IME rate adjustments, effective January 1st for calendar year, the IME Payment percentage will be calculated based on the formula [1.03*(((1+(r)) ^0.405)-1)] where "r" equals the ratio of calendar year residents as defined in paragraph 3 of this section to]

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2. For IME rate adjustments, effective January 1st for calendar year, the IME Payment percentage will be calculated based on the formula [1.03*(((1+(r))^0.405)-1)] where "r" equals the ratio of calendar year residents as defined in paragraph 3 of this section to inpatient acute staff beds as reported in the base [period]year defined in [paragraph 3 of the Statewide base price section] the Definitions Section of this Attachment.

3. Calendar year residents are calculated as follows:

i. Upcoming PGY Resident counts as provided in paragraph 4(c)(ii)(3)(e)(ii) are multiplied by six months

ii. Prior PGY Resident counts as provided in 4(c)(ii)(3)(e)(iii) are multiplied by six months

iii. The calendar year residents equal the sum of i and ii divided by twelve months.

ii. IME residents will be calculated each ramp-up year until the final year ramp-up.

[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.]

d. i. Beginning on and after July 1, 2014, direct graduate medical education (DGME) and indirect medical education (IME) costs, as defined in the Definitions Section of this Attachment, for Graduate Medical Education for displaced residents due to the closure of a teaching hospital.

ii. Rate appeals for rate adjustments may be submitted for displaced residents subsumed by a hospital that is approved as a teaching facility and receiving a payment in their rate for DGME and IME. If the displaced residents are subsumed by a new teaching hospital, as described in paragraph (4)(c) of this section, the rate adjustments are in accordance with paragraph (4)(c) of this section.

1. Eligible for reimbursement.

a. Displaced residents due to the closing of a teaching hospital.

i. Hospitals that take in residents from a closed hospital after Jan 1st of the base year, as defined in the Definitions Section, and before the subsequent rebasing effective date, and

ii. The hospital takes in the residents for 6 months or more of needed training to complete the program from which they were displaced.

b. A facility is not limited to a one-time receipt of a displaced residents rate adjustment and is eligible to submit appeals for future hospital closures if they meet the appeal requirements. However, only one rate adjustment will be approved for each closure.

2. Not eligible for reimbursement:

a. Displaced residents due to the closing of a residency program in a teaching hospital that has remained open.

b. Displaced residents, due to a teaching hospital closing, requiring less than six months of training to complete the program from which they were displaced.

3. Appeal requirements:

a. A hospital is required to submit a written request to the Department for additional reimbursement due to displaced residents.

i. The rate adjustment will be effective the first day of the month following the later of:
1. The Department's receipt of the written notification and documentation requesting a rate adjustment, or
2. The date the hospital has taken in the displaced residents.

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b. The hospital will provide the following data:

i. Completion of the Department's standardized template - Form (B), as of June 26, 2017, found on the APR-DRG website below:

https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/

c. The Department will obtain information from the closing hospital pertaining to placement of the displaced residents.

4. Additional reimbursement will be received based on:

a. The revised FTE count based on the added displaced residents.

b. The maximum resident count will be filled slots at the time the existing resident program closed limited by the number of filled slots actually entering the program at the time the hospital takes in the residents from the closed teaching hospital. No additional adjustment will be received if slots are subsequently filled after the hospital takes in the displaced residents.

c. Direct Graduate Medical Education (DGME) Acute rate cost calculation:

i. Using the receiving hospital's Institutional Cost Report (ICR), a cost per resident will be calculated as follows:

1. DGME costs from the base year, as defined in the Definitions Section of this Attachment, that are used in the DGME add-on calculated per the Add-On to the Acute Rate Per Discharge Section of this Attachment.

2. Total Acute Residents used in the Indirect Medical Education (IME) calculation per the Add-On to the Acute Rate Per Discharge Section of this Attachment.

3. The DGME costs will be divided by the Total Acute Residents to determine a cost per resident.

ii. The cost per resident will be applied to the maximum allowed additional FTE displaced resident count, as described in paragraph (4)(d)(ii)(4)(b), to determine the additional DGME costs. These additional costs will be added to the DGME costs, described in paragraph (4)(d)(ii)(4)(c)(i)(1) of this section, for the development of the DGME add-on that is developed per the Acute Rate Per Discharge section of this Attachment.

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d. The DGME payment will be included in the exempt hospital rates for hospitals that are exempt from the Acute per discharge rate method, reimbursed in accordance with the Exempt units and hospitals section of this Attachment and the DGME costs are not included in the ceiling or price development.

i. Using the receiving hospital's ICR, a cost per resident will be calculated as follows:

1. A DGME cost per resident will be developed by dividing the total DGME costs from the base year, per the Exempt units and hospitals section of this Attachment, by the total residents as reported in the same base year.

2. The cost per resident will be applied to the maximum allowed additional FTE displaced resident count, as described in paragraph (4)(d)(ii)(4)(b), to determine the additional DGME costs. These additional costs will be added to the base year total exempt hospital costs and reimbursed in accordance with the Exempt units and hospital section of this Attachment.

e. Indirect Medical Education (IME) for the Acute rate per discharge:

i. The maximum allowed additional FTE displaced resident count, as described in paragraph (4)(d)(ii)(4)(b), will be added to the receiving hospital's Total Acute Residents, described in paragraph (4)(d)(ii)(4)(c)(i)(2) of this section, for the development of the IME payment per discharge calculation per the Add-On to the Acute Rate Per Discharge section of this Attachment.

f. The receiving hospital will receive no further adjustment for this specific hospital closure until the time the base year, as defined in the Definitions Section, is subsequently updated.

g. Receiving a Medicare cap increase is not a requirement for submitting a Medicaid rate appeal.

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.

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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.