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

Subpart 86-1 of title 10 of NYCRR is amended by adding a new section 86-1.47 to read as follows:

86-1.47 Hospital indigent care pool payments.

(a) Effective for periods on and after January 1, 2013, payments pursuant to subdivision 5-d of section 2807-k of the Public Health Law shall be made in accordance with the provisions of this section.

(b) For the purposes of distributions in accordance with this section, each hospital’s relative uncompensated care need amount shall be determined in accordance with the following:

   (1) All uninsured inpatient units of service as reported in Exhibit 32 of the Institutional Cost Report from the cost reporting year two years prior to the distribution year, but excluding hospital-based residential health care facility (“RHCF”) and hospice units of
service, shall be multiplied by the average applicable Medicaid inpatient rate in effect for January 1 of the distribution year.

(2) All uninsured outpatient units of service as reported in Exhibit 33 of the Institutional Cost Report from the cost reporting year two years prior to the distribution year, but excluding referred ambulatory and home health services, shall be multiplied by the average applicable Medicaid outpatient rate in effect for January 1 of the distribution year.

(3) The inpatient amounts determined pursuant to paragraph (1) of this subdivision for each hospital shall be summed and adjusted by a statewide inpatient cost adjustment factor equivalent to the aggregate sum of the inpatient uninsured units multiplied by the step-down cost per unit for each applicable inpatient service, excluding hospital-based RHCF and hospice services, for all hospitals statewide, divided by the aggregate sum of the amounts determined pursuant to paragraph (1) of this subdivision for all hospitals statewide.

(4) The outpatient amounts determined pursuant to paragraph (2) of this subdivision for each hospital shall be summed and adjusted by a statewide outpatient cost adjustment factor equivalent to the aggregate sum of the outpatient uninsured units multiplied by the step-down cost per unit for each applicable outpatient service, excluding referred ambulatory and home health services, for all hospitals statewide, divided by the aggregate
sum of the amounts determined pursuant to paragraph (2) of this subdivision for all hospitals statewide.

(5) The adjusted inpatient and outpatient amounts determined pursuant to paragraphs (1) through (4) of this subdivision for each hospital shall be summed and reduced by the sum of all of the cash payments collected from such uninsured patients as reported in the Institutional Cost Report from the cost reporting year two years prior to the distribution year to determine each hospital’s net adjusted uncompensated care need.

(6) The uncompensated care nominal need for each hospital shall be calculated as the net adjusted uncompensated care need multiplied by the sum of: (i) 0.40, and (ii) the Medicaid inpatient utilization rate multiplied by 0.60. The Medicaid inpatient utilization rate shall be calculated based on discharge data reported in Exhibit 32 of the Institutional Cost Report from the cost reporting year two years prior to the distribution year and shall include fee-for-service and managed care discharges for acute and exempt services.

(c) For the 2013 calendar year, payments shall be made as follows:

(1) One hundred thirty nine million four hundred thousand dollars ($139,400,000) shall be distributed as Medicaid disproportionate share hospital (“DSH”) payments to major public general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital’s uncompensated care nominal need, as determined in accordance with the provisions of subdivision (b) of this section, as a share of the
aggregate uncompensated care nominal need for all major public general hospitals, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than two and a half percent less than the average distributions such hospitals received pursuant to §2807-k of the Public Health Law for the three year period January 1, 2010, through December 31, 2012.

(2) Nine hundred ninety four million nine hundred thousand dollars ($994,900,000) shall be distributed as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals, on the basis of each hospital’s uncompensated care need share, as determined in accordance with the provisions of subdivision (b) of this section, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than two and a half percent less than the average distributions such hospitals received pursuant to §2807-k and §2807-w of the Public Health Law, excluding academic medical center grants received pursuant to §2807-k(5-b)(b)(v) of the Public Health Law, and after any reductions made pursuant to §2807-k(17) of the Public Health Law, for the three year period January 1, 2010, through December 31, 2012.

(3) Payments made pursuant to paragraphs (1) and (2) of this subdivision shall be further adjusted such that such payments made to hospitals that experience increases in payments, as compared to the average of such payments made pursuant to this section for the three year period January 1, 2010 through December 31, 2012, shall be further
adjusted on a percentage basis, as determined by the Commissioner, sufficient to ensure, in conjunction with such other funding as may be made available, the full funding of the transition adjustments described in paragraphs (1) and (2) of this subdivision.

(d) For the 2014 calendar year, payments shall be made as follows:

(1) One hundred thirty nine million four hundred thousand dollars ($139,400,000) shall be distributed as Medicaid disproportionate share hospital (“DSH”) payments to major public general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital’s uncompensated care nominal need, as determined in accordance with the provisions of subdivision (b) of this section, as a share of the aggregate uncompensated care nominal need for all major public general hospitals, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than five percent less than the average distributions such hospitals received pursuant to §2807-k of the Public Health Law for the three year period January 1, 2010, through December 31, 2012.

(2) Nine hundred ninety four million nine hundred thousand dollars ($994,900,000) shall be distributed as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals, on the basis of each hospital’s uncompensated care need share, as determined in accordance with the provisions of subdivision (b) of this section, further adjusted by a transition factor that shall be calculated such that no hospital shall
experience a reduction in payments pursuant to this section that is greater than five percent less than the average distributions such hospitals received pursuant to §2807-k and 2807-w of the Public Health Law, excluding academic medical center grants received pursuant to §2807-k(5-b)(b)(v) of the Public Health Law, and after any reductions made pursuant to §2807-k(17) of the Public Health Law, for the three year period January 1, 2010, through December 31, 2012.

(3) Payments made pursuant to paragraphs (1) and (2) of this subdivision shall be further adjusted such that such payments made to hospitals that experience increases in payments, as compared to the average of such payments made pursuant to this section for the three year period January 1, 2010 through December 31, 2012, shall be further adjusted on a percentage basis, as determined by the Commissioner, sufficient to ensure, in conjunction with such other funding as may be made available, the full funding of the transition adjustments described in paragraphs (1) and (2) of this subdivision.

(e) For the 2015 calendar year, payments shall be made as follows:

(1) One hundred thirty nine million four hundred thousand dollars ($139,400,000) shall be distributed as Medicaid disproportionate share hospital (“DSH”) payments to major public general hospitals, including the hospitals operated by public benefit corporations, on the basis of each hospital’s uncompensated care nominal need, as determined in accordance with the provisions of subdivision (b) of this section, as a share of the aggregate uncompensated care nominal need for all major public general hospitals,
further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than seven and a half percent less than the average distributions such hospitals received pursuant to §2807-k of the Public Health Law for the three year period January 1, 2010, through December 31, 2012.

(2) Nine hundred ninety four million nine hundred thousand dollars ($994,900,000) shall be distributed as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals, on the basis of each hospital’s uncompensated care need share, as determined in accordance with the provisions of subdivision (b) of this section, further adjusted by a transition factor that shall be calculated such that no hospital shall experience a reduction in payments pursuant to this section that is greater than seven and a half percent less than the average distributions such hospitals received pursuant to §2807-k and §2807-w of the Public Health Law, excluding academic medical center grants received pursuant to §2807-k(5-b)(b)(v) of the Public Health Law, and after any reductions made pursuant to §2807-k(17) of the Public Health Law, for the three year period January 1, 2010, through December 31, 2012.

(3) Payments made pursuant to paragraphs (1) and (2) of this subdivision shall be further adjusted such that such payments made to hospitals that experience increases in payments, as compared to the average of such payments made pursuant to this section for the three year period January 1, 2010 through December 31, 2012, shall be further adjusted on a percentage basis, as determined by the Commissioner, sufficient to ensure,
in conjunction with such other funding as may be made available, the full funding of the transition adjustments described in paragraphs (1) and (2) of this subdivision.

(f) (1) Funds reserved in the Financial Assistance Compliance Pool (“FACP”) pursuant to §2807-k(5-d)(b)(iv) of the Public Health Law for the calendar years 2014 and 2015 shall be distributed to hospitals which demonstrate substantial compliance, as determined by the Commissioner, with the provisions of §2807-k(9-a) of the Public Health Law (the “financial assistance law” or “FAL”).

(2) Hospitals which are determined to be in substantial FAL compliance by the end of the 2013 calendar year shall receive their 2014 FACP payments as soon as practical in 2014 in accordance with subdivision (b) of this section. Hospitals which are determined to be in substantial FAL compliance by the end of the 2014 calendar year shall receive their 2015 FACP funds as soon as practical in 2015 in accordance with subdivision (b) of this section, provided, however, that those hospitals which were determined to be not in such substantial compliance by the end of 2013, but which are determined to be in such substantial compliance by the end of 2014, shall receive both their 2014 and 2015 FACP payments as soon as practical in 2015.
REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authority for this regulation is contained in Section 2807-k (5-d) of the Public Health Law (PHL), as enacted by Section 1 of Part C of Chapter 56 of the Laws of 2013, which authorizes the Commissioner to promulgate regulations, including emergency regulations, with regard to the establishment of a distribution methodology to make annual indigent care pool payments to general hospitals for the three-year period January 1, 2013 through December 31, 2015. The distribution methodology will be set forth in Section 86-1.47 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulation of the State of New York.

Legislative Objectives:

The legislation requires the Department of Health to develop an indigent care distribution methodology which conforms to federal DSH (“Disproportionate Share Hospital”) reform guidelines by targeting payments to hospitals which provide a disproportionate share of uncompensated care to the uninsured and Medicaid inpatient population and also to strengthen hospital compliance with the Financial Aid Law contained in Section 2807-k (9-a) of the Public Health Law. The legislation further requires that the distribution methodology be set forth in a regulation with an effective date of January 1, 2013.

The State provides over $1.1 billion annually in hospital indigent care (DSH) payments which are funded through a fifty percent federal match. Beginning in October 2013, the federal government will begin reducing DSH payments to states that don’t target their DSH payments solely to hospitals with high uncompensated care provided to the uninsured and Medicaid population. To minimize the State’s share of these federal cuts and to respond to industry and
public pressure to tie indigent care payments directly to care provided to the poor, the Department developed the new distribution methodology set forth in the proposed regulation.

**Needs and Benefits:**

The proposed regulation establishing the new indigent care distribution methodology replaces an outdated and complex distribution methodology which expired December 31, 2012.

The proposed regulation contains the detailed calculations required to determine a hospital’s relative uncompensated care need, incorporating both uninsured and Medicaid inpatient volume, which forms the basis for allocation of a proportional share of the total available pool funds.

The proposed regulation also provides for a transition payment, in each of the three years 2013-2015, to ensure that no hospital experiences severe financial instability resulting from the redistribution of funding among the hospitals as a result of the change in methodology. This transition payment will establish a minimum payment as a set percentage of the average indigent care pool payments received by the hospital in the previous three years (2010-2012). Hospitals which experience gains will have their distributions similarly capped by a set percentage of the average indigent care pool payments received in the previous three years (2010-2012).

In addition, the proposed regulation grants the Commissioner the authority to withhold one percent of the total indigent care pool funds available for years 2014 and 2015 in order to strengthen hospital compliance with the Financial Aid Law contained in Section 2807-k (9-a) of the Public Health Law. Hospitals must demonstrate compliance with the provisions of the Financial Aid Law to receive their share of the one percent withheld funds for years 2014 and 2015.
The benefits of the regulatory changes include a simpler, more transparent methodology which relates indigent care pool payments directly to care of low-income patients and incentives for hospitals to comply with the provisions of the Financial Aid Law. Further, federal DSH matching funds are optimized by the State’s conformance with federal guidelines.

Costs:

Costs to Private Regulated Parties:

There will be no additional costs to private regulated parties. The proposed regulation utilizes information contained in the Institutional Cost Reports which hospitals are already required to submit to the Department on an annual basis.

Costs to State Government:

There is no increase in Medicaid expenditures anticipated as a result of this regulation.

Costs to Local Government:

Local districts’ share of Medicaid costs is statutorily capped; therefore, there will be no additional costs to local governments as a result of this proposed regulation.

Costs to the Department of Health:

There will be no additional administrative costs to the Department of Health as a result of this proposed regulation.
Local Government Mandates:

The proposed regulation does not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

There are no new reporting requirements, forms or additional paperwork as a result of this amendment.

Duplication:

This proposed regulation does not duplicate any existing federal, state or local regulations.

Alternatives:

No significant alternatives are available. The Department developed the distribution methodology with extensive input from the industry associations representing the hospitals subject to the proposed regulation. The regulations are mandated by the terms of the recently enacted § 2807-k(5-d) of the Public Health Law.

Federal Standards:

State statutory provisions contained in PHL § 2807-k(5-d) establish a system of hospital indigent care payments, that exceed the minimum requirement for such payments established in federal law and the proposed regulations reflects those enhanced payment levels.
Compliance Schedule:

The proposed regulation grants the Commissioner of Health the authority to withhold one percent of the total indigent care pool funds available for years 2014 and 2015. Hospitals must demonstrate compliance with the provisions of the Financial Aid Law contained in Section 2807-k (9-a) of the Public Health Law to receive their share of the one percent withheld funds for years 2014 and 2015. There are no additional compliance efforts required by the hospitals.

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REGULATORY FLEXIBILITY ANALYSIS
FOR
SMALL BUSINESSES AND LOCAL GOVERNMENTS

Effect of Rule:

For the purpose of this regulatory flexibility analysis, small businesses were considered to be general hospitals with 100 or fewer full time equivalents. Based on recent financial and statistical data extracted from the Institutional Cost Reports, five hospitals were identified as employing fewer than 100 employees.

Some hospitals subject to this regulation may see a decrease in their indigent care payments as a result of this regulation but, as noted above, transition payments will help minimize the impact so that no hospital experiences severe financial instability as a result of the change in methodology.

Hospitals operated by local governments will be impacted in the same manner as other hospitals, but this rule will have no direct effect on local governments.

Compliance Requirements:

The proposed regulation grants the Commissioner of Health the authority to withhold one percent of the total indigent care pool funds available for years 2014 and 2015. All hospitals must demonstrate compliance with the provisions of the Financial Aid Law as set forth in Section 2807-k (9-a) of the Public Health Law to receive their share of the funds held in this pool for years 2014 and 2015. No other compliance efforts are required.

A small business regulation guide is not required.

The rule will have no direct effect on local governments.
Professional Services:

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

Compliance Costs:

No additional compliance costs are anticipated as a result of this rule.

Economic and Technological Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this rule because there are no technological requirements other than the use of existing technology, and the overall economic aspect of complying with the requirements is expected to be minimal.

Minimizing Adverse Impact:

A transition payment will be provided, in each of the three years, to ensure that no hospital experiences severe financial instability resulting from the change in methodology. This transition payment will establish a minimum payment as a set percentage of the average indigent care pool payments received by the hospital in the previous three years (2010-2012).

Local districts’ share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

Small Business and Local Government Participation:

The State filed a Federal Public Notice, published in the State Register on December 26,
2012, prior to the effective date of the change. The Notice provided a summary of the action to be taken and instructions as to where the public, including small businesses and local governments, could locate copies of the corresponding proposed State Plan Amendment. The Notice further invited the public to review and comment on the related proposed State Plan Amendment. In addition, contact information for the Department of Health was provided for anyone interested in further information.

Draft regulations, prior to filing with the Secretary of State, were shared with the industry associations representing hospitals and comments were solicited from all affected parties. Such associations include hospitals with 100 or fewer FTEs.
RURAL AREA FLEXIBILITY ANALYSIS

Effect on Rural Areas:

Rural areas are defined as counties with populations less than 200,000 and, for counties with populations greater than 200,000, include towns with population densities of 150 persons or less per square mile. The following 43 counties have populations of less than 200,000:

- Allegany
- Cattaraugus
- Cayuga
- Chautauqua
- Chemung
- Chenango
- Clinton
- Columbia
- Cortland
- Delaware
- Essex
- Franklin
- Fulton
- Genesee
- Greene
- Hamilton
- Herkimer
- Jefferson
- Lewis
- Livingston
- Madison
- Montgomery
- Ontario
- Orleans
- Oswego
- Otsego
- Putnam
- Rensselaer
- St. Lawrence
- Schenectady
- Schoharie
- Schuyler
- Seneca
- Steuben
- Sullivan
- Tioga
- Tompkins
- Ulster
- Warren
- Washington
- Wayne
- Wyoming
- Yates

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

- Albany
- Broome
- Dutchess
- Erie
- Monroe
- Niagara
- Oneida
- Orange
- Saratoga
- Suffolk
- Onondaga

Compliance Requirements:

The proposed regulation grants the Commissioner of Health the authority to withhold one percent of the total indigent care pool funds available for years 2014 and 2015. All hospitals must demonstrate compliance with the provisions of the Financial Aid Law as set forth in
Section 2807-k (9-a) of the Public Health Law to receive their share of the funds held in this pool for years 2014 and 2015. No other compliance efforts are required.

**Professional Services:**

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

**Compliance Costs:**

No additional compliance costs are anticipated as a result of this rule.

**Minimizing Adverse Impact:**

A transition payment will be provided, in each of the three years, to ensure that no hospital experiences severe financial instability resulting from the change in methodology. This transition payment will establish a minimum payment as a set percentage of the average indigent care pool payments received by the hospital in the previous three years (2010-2012).

Local districts’ share of Medicaid costs is statutorily capped; therefore, there will be no adverse impact to local governments as a result of this proposal.

**Rural Area Participation:**

The State filed a Federal Public Notice, published in the State Register on December 26, 2012, prior to the effective date of the change. The Notice provided a summary of the action to be taken and instructions as to where the public, including rural area members and local governments, could locate copies of the corresponding proposed State Plan Amendment. The Notice further invited the public to review and comment on the related proposed State Plan
Amendment. In addition, contact information for the Department of Health was provided for anyone interested in further information.

Draft regulations, prior to filing with the Secretary of State, were shared with the industry associations representing hospitals and comments were solicited from all affected parties. Such associations include members from rural areas.
JOB IMPACT STATEMENT

A Job Impact Statement is not required pursuant to Section 201-a(2)(a) of the State Administrative Procedure Act. The proposed regulation establishes the hospital indigent care pool payment methodology for the three-year period January 1, 2013 through December 31, 2015. It is apparent, from the nature and purpose of the proposed rule, that it will not have a substantial adverse impact on jobs or employment opportunities.