Hospital Indigent Care Pool Payment Methodology

Effective date: 12/18/20

Pursuant to the authority vested in the Commissioner of Health by section 2807-k (5-d) of the Public Health Law, Section 86-1.47 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon filing with the Secretary of State, to read as follows:

Subdivision (i) of section 86-1.47 is repealed.

Subdivision (a) of section 86-1.47 is amended by adding paragraphs (1) and (2) to read as follows:

(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.

(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 through 2022 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 each calendar year shall receive the following year's FACP funds as soon as practical in such year, in accordance with subdivision (b) of this section.

Section 86-1.47 is amended by adding subdivisions (i) and (j) to read as follows:

(i) For the 2019 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 seventeen 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 seventeen 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 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 sufficient, as determined by the Commissioner, 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.

(j) For the 2020 through 2022 calendar years, 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.

(2) The nine hundred sixty-nine million nine hundred thousand dollars ($969,900,000) shall be 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, excluding any reductions made pursuant to §2807-k(17) of the Public Health Law.

(3) Payments made pursuant to paragraph (2) of this subdivision shall be further adjusted such that such payments made to hospitals shall be subject to an aggregate reduction of one hundred fifty million dollars ($150,000,000), provided that eligible general hospitals, other than major public general hospitals, that qualify as enhanced safety net hospitals under §2807-c(34) of the Public Health Law for state fiscal year 2019-2020 shall not be subject to such reduction. The methodology to allocate the reduction shall take into account the payor mix of each voluntary hospital, including the percentage of inpatient days paid by Medicaid. Such methodology will calculate the total public payor mix of each facility and calculate an average public payor mix.

For the purposes of this subparagraph, public payor mix means the percentage of total reported Medicaid and Medicare inpatient days, as reported in Exhibit 32 of the Institutional Cost Report (ICR) for the reporting period two years prior to the distribution year, where Medicaid and Medicare were the primary payors, out of total reported inpatient days which includes all inpatient services but excludes Alternate Level of Care days.

Hospitals exceeding the calculated average of public payor mix will be exempt from reductions pursuant to this subparagraph. Hospitals that fall below the calculated average of public payor mix will be subject to a proportionate reduction pursuant to this subparagraph.

(4) Payments made pursuant to paragraph (2) shall be further adjusted such that sixty-four million six hundred thousand dollars ($64,600,000) shall be distributed to eligible general hospitals, other than major public general hospitals, that qualify as Enhanced Safety Net Hospitals under §2807-c(34) of the Public Health Law as of April 1, 2020, and that experience a reduction in indigent care pool payments pursuant to this subdivision when compared to their 2019 ICP payments. Such additional payments shall be calculated to equal the proportional reduction experienced by the facility out of the total decrease experienced by all qualifying Enhanced Safety Net Hospitals multiplied by the sixty-four million six hundred thousand dollars ($64,600,000).

REGULATORY IMPACT STATEMENT

Statutory Authority:

The statutory authorities for this regulation for calendar year (CY) 2019 are contained in Section 2807-k(5-d) of the Public Health Law (PHL), as amended by Section 2 of Part A of Chapter 57 of the Laws of 2018, and Section 3 of Part KK of Chapter 56 of the Laws of 2020. Such section of the Public Health Law requires the Commissioner to promulgate regulations, including emergency regulations, regarding the extension of a distribution methodology to make annual indigent care pool payments to general hospitals for the four-year period January 1, 2019 through December 31, 2022.

Legislative Objectives:

The legislative objective of PHL 2807-k(5-d) is to establish methodologies for the distribution of certain pools of funds to certain hospitals, including an indigent care pool.

Needs and Benefits:

The current regulation contains, for calendar years through 2018, the methodology required to determine a hospital's relative uncompensated care need. It incorporates both uninsured and Medicaid inpatient and outpatient volume, which form the basis for the allocation of a proportional share of the total available pool funds. The proposed amendment would extend this methodology to calendar years 2019 through 2022, in conformance with amendments to PHL Section 2807-k (5-d).

Further, for calendar years through 2022, the new methodology makes necessary spending amendments that conform to federal Disproportionate Share Hospital (DSH) reform guidelines by targeting payments to hospitals that provide a disproportionate share of

uncompensated care to the uninsured and Medicaid inpatient and outpatient population. The reform guidelines also aim to strengthen hospital compliance with the Financial Aid Law contained in Section 2807-k (9-a) of the Public Health Law.

The current regulation also includes, for calendar year 2019 only, $25M in transition payments. This transition payment establishes a minimum payment as a set percentage of the average indigent care pool payments received by the hospital in the years 2010-2012. Hospitals that experience gains have their distributions similarly capped by a set percentage of the average indigent care pool payments received in the years 2010-2012. The proposed amendment would extend the transition payments for another calendar year, in conformance with amendments to PHL Section 2807-k (5-d).

For calendar years 2020-2022, the proposed regulation eliminates the previously utilized transition collar and the corresponding $25 million used to fund that transition collar. The Voluntary Pool will be reduced by an aggregate $150 million based on hospitals with a low relative proportion of hospitals covered by public payors. Hospitals defined as Enhanced Safety Net Hospitals (ESNH) under Section 2807-c of the Public Health Law are exempt from this reduction. Additionally, beginning in CY 2020, the establishment of a new $64.6 million Enhanced Safety Net Transition Collar Pool will ensure that no ESNH experiences severe financial instability resulting from the removal of the transition collar and its associated funding through the Voluntary hospital pool as a result of the updated indigent care distribution methodology for these years. This transition payment will be distributed by taking each voluntary ESNH and comparing its distribution year allocation to their CY 2019 allocation. ESNHs experiencing a reduction will receive a proportional distribution of the total $64.6 million in funds available. The proposed amendment would extend the ESNH transition

payments to calendar years 2020 through 2022, in conformance with amendments to PHL Section 2807-k (5-d).

The current regulation also requires, for calendar years 2019 through 2022, the Commissioner to withhold one percent of the total indigent care pool funds available to distribute to hospitals who demonstrate substantial compliance with the Financial Aid Law in accordance with PHL Section 2807-k (9-a). The proposed amendment would extend the one percent withholding and distribution to hospitals for calendar years 2019 through 2022, in conformance with amendments to PHL Section 2807-k (5-d).

This regulation amendment is necessary to preserve the integrity of the Medicaid program and maintain the Global Cap, while still protecting the facilities that provide necessary services to poor and uninsured patients.

Costs:

Costs to Private Regulated Parties:

There will be no additional costs to private regulated parties. The Department utilizes audited information contained in hospitals' Institutional Cost Reports, which the 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 proposed amendment. This proposal results in a net savings of $110.4 million gross ($55.2 million State share) for calendar years 2020 through 2022.

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 amendment.

Costs to the Department of Health:

There will be no additional administrative costs to the Department of Health as a result of this proposed amendment.

Local Government Mandates:

The proposed amendment 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 proposed amendment.

Duplication:

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

Alternatives:

The Department of Health could have chosen a different method; however, the Department developed the distribution methodology and incorporated recommendations from the ICP workgroup (including representatives from the industry associations representing the hospitals subject to the proposed amendment).

Federal Standards:

The proposed amendment does not exceed any minimum standards of the federal government for the same or similar subject area.

Compliance Schedule:

The proposed amendment grants the Commissioner of Health the authority to withhold one percent of the total indigent care pool funds available for years 2019 through 2022. 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. 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 are general hospitals with 100 or fewer full-time equivalents. Based on recent financial and statistical data extracted from the Institutional Cost Report, 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.

This rule will have no direct effect on local governments.

Compliance Requirements:

The proposed amendment requires the Commissioner of Health to withhold one percent of the total indigent care pool funds available for years 2019 through 2022. 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. No other compliance efforts are 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 amendment.

Compliance Costs:

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

Economic and Technological Feasibility:

Small businesses will be able to comply with the economic and technological aspects of this proposed amendment 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 for calendar year 2019 to ensure that no hospital experiences severe financial instability resulting from the methodology. Changes made in calendar years 2020-2022 exclude hospitals defined as Enhanced Safety Net Hospitals and exclude hospitals which serve a high burden of public payor patients from the $150 million reduction. Additionally, for calendar years 2020 through 2022, the Enhanced Safety Net Transition Collar provides funding to qualifying hospitals to mitigate funding reductions resulting from the removal of the transition collar.

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:

These proposed regulations arise from a change in State law pursuant to Chapter 56 of the Laws of 2020, Part MM. The initiatives were recommended by the MRT II, a group comprised with representatives of LDSS and MMCOs among others, following a series of public meetings where stakeholders had the opportunity to comment and collaborate on ideas to address the efficacy of these services. The State filed Federal Public Notices which were published in the State Register on May 8, 2019 and June 3, 2020, which served as clarifications of State Plan Amendment (SPA) 19-0001 and for SPA 20-0040, respectively. These Notices provide 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 Amendments. The Notices further invited the public to review and comment on the related proposed State Plan Amendments. In addition, contact information for the Department of Health was provided for anyone interested in further information.

RURAL AREA FLEXIBILITY ANALYSIS

Types and Estimated Numbers of Rural Areas:

This rule applies uniformly throughout the state, including rural areas. Rural areas are defined as counties with a population less than 200,000 and counties with a population of 200,000 or greater that have towns with population densities of 150 persons or fewer per square mile. The following 43 counties have a population of less than 200,000 based upon the United States Census estimated county populations for 2010 (https://www.census.gov/quickfacts/). Approximately 17% of small health care facilities are located in rural areas.

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

The following counties have a population of 200,000 or greater and towns with population densities of 150 persons or fewer per square mile. Data is based upon the United States Census estimated county populations for 2010.

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

Reporting, Recordkeeping and Other Compliance Requirements; and Professional Services:

No new additional professional services are required for providers in rural areas to comply with the proposed amendment. The proposed amendment requires the Commissioner of Health to withhold one percent of the total indigent care pool funds available for years 2019 through 2022. 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. No other compliance efforts are required.

Costs:

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

Minimizing Adverse Impact:

A transition payment will be provided for calendar year 2019 to ensure that no hospital experiences severe financial instability resulting from the methodology. Changes made in calendar years 2020 through 2022 exclude hospitals defined as Enhanced Safety Net Hospitals and exclude hospitals which serve a high burden of public payor patients from the $150 million reduction. Additionally, for calendar years 2020-2022, the Enhanced Safety Net Transition Collar provides funding to qualifying hospitals to mitigate funding reductions resulting from the removal of the transition collar.

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 has filed Federal Public Notices, published in the State Register on May 8, 2019, April 1, 2020, and June 3, 2020. The Notices 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 Amendments. The Notices further invited the public to review and comment on the related proposed State Plan Amendments. In addition, contact information for the Department of Health was provided for anyone interested in further information.

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 rule extends the hospital indigent care pool payment methodology for the four-year period January 1, 2019 through December 31, 2022 and will not have a substantial adverse impact on jobs or employment opportunities, nor does it have adverse implications for job opportunities.

EMERGENCY JUSTIFICATION

The proposed amendments implement an extension to the methodology that the Department of Health uses to determine the Indigent Care Pool payments, eliminates the transition payment afforded to all hospitals receiving the pool payments, and creates a transition payment pool for Enhanced Safety Net Hospitals as enacted in Public Health Law Sections 2807-k(5-d). Public Health Law Section 2807-k(5-d)(b) provide the Commissioner of Health with authority to issue emergency regulations in order to implement these amendments.