Attachment 4.19-A
___Part I

Section 86-1.10 Effective period of reimbursement rates. Certification of reimbursement rates of payment by governmental agencies shall be for a 12-month calendar year period or for such other period as may be prescribed. Certification of reimbursement rates by article IX-C corporations shall be for the periods specified in the reimbursement formula approved by the Commissioner of Health.

OFFICIAL

85-34
supersedes
81-36

Approval Date JUL. 23 1987 Effective Date JAN. 1 1986

Section 86-1.11 Computation of basic rate.—

OFFICIAL

*
*
*

(b) Payment rates for the period January 1, 1983 through December 31, 1983 shall be established on a prospective basis. Such payments shall be computed on the basis of allowable historical inpatient expense based on the fiscal and statistical data submitted by the medical facility for the fiscal year ended at least six months prior to January 1, 1983 and upon the data described below. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days, except as stated in subdivision (1) of this section and section 86-1.41 of this Subpart. Total allowable costs of a facility shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the Federal Social Security Act and article IX-C of the New York State Insurance Law and other patients, so that the share borne by each program is based upon actual services received by that program's beneficiaries. To accomplish this apportionment, for each program the ratio of beneficiary charges to total patient charges for the services of each ancillary department shall be applied to the cost of the department; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem.

(1) Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diems, unless the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(2) After July 1, 1984 the apportionment computed in this section will be revised to reflect 1982 charge data and patient day data received by the Commissioner pursuant to section 86-1.3 of this Subpart.

(3) In 1983, costs of malpractice insurance premiums and self-insurance fund contributions must be separately accumulated and directly apportioned among programs on the basis of average cost. In 1984 and 1985, one-third and two-thirds, respectively, of malpractice costs will be apportioned on the basis of payor experience. Apportionment on the basis of experience shall be based on the dollar ratios for each payor of the facility's malpractice losses paid by that payor to its total paid malpractice losses for the current cost reporting period and the preceding four-year period. If a facility has no malpractice loss experience for the five-year period, the costs of malpractice insurance premiums or self-insurance fund contributions must be apportioned among the programs based on the national ratio of malpractice awards paid to program beneficiaries to malpractice awards paid to all patients. If a facility pays allowable uninsured malpractice losses incurred by program beneficiaries, either through allowable deductible or coinsurance provisions, or as a result of an award in excess of reasonable coverage limits, or as

85-34 supersedes 81-36 + new

a governmental provider, such losses and related direct costs must be directly assigned to a respective program for reimbursement.

(c) (1) To the allowable basic rate, computed in accordance with ceiling limitations and to the discrete alternate level of care rate if applicable, and prior to the addition of capital costs (depreciation, leases and interest), there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. This factor shall be developed in accordance with section 86-1.15 of this Subpart. The allowances specified in subdivisions (e)-(g) of this section shall be computed on the basis of, and added to, the trended basic rate plus capital costs.

(2) reserved

(d) **General hospital inpatient revenue cap.** (1) An inpatient revenue cap for each general hospital for each of the rate years 1984 and 1985 shall be established as follows and shall include only the revenues set forth below. An initial inpatient revenue cap shall be calculated for each general hospital by first trending to each rate year the allowable historical inpatient operational expenses reimbursed in 1983. The initial allowable historical inpatient operational expenses to be trended shall reflect all closed appeals and audit adjustments pursuant to this Subpart. The trend factors used shall be developed in accordance with section 86-1.15 of this Subpart. The following revenues shall then be added to trended allowable historical inpatient operational expenses for each rate year:

(i) capital related inpatient expenses determined in accordance with sections 86-1.29 and 86-1.30 of this Subpart;

(ii) the allowances provided for in subdivisions (e)-(g) of this section, calculated for each rate year utilizing the sum of trended allowable historical inpatient operational expenses and capital related inpatient expenses; and

(iii) any anticipated additional revenues generated by a general hospital's charge schedule, developed in accordance with section 86-1.2 of the Subpart, for each respective rate year.

(2) The initial revenue caps for rate years 1984 and 1985 shall be adjusted to reflect the following:

(i) case mix changes pursuant to the provisions of subdivision (s) of this section and volume changes;

(ii) appeals filed and/or adjustments made pursuant to sections 86-1.16 and 86-1.17 of this Subpart; and

OFFICIAL

(iii) any adjustments made in payments under title XVIII of the Federal Social Security Act (Medicare) pursuant to section 86-1.43 of this Subpart.

(3)(i) The commissioner shall require direct repayment or adjust a subsequent year's inpatient revenue cap to reflect actual inpatient revenues received for inpatient services provided by a general hospital that exceed a previous year's inpatient revenue cap initially established or adjusted in accordance with this Subpart. A general hospital determined to have such excess revenues shall be subject to direct repayment or adjustment of a subsequent revenue cap when such excess is due to establishment of a charge schedule that is not in compliance with section 86-1.2(c) of this Subpart. Revenue received established as a result of the provisions of title XVIII of the Federal Social Security Act (Medicare) phase-in policies or from charges authorized under section 86-1.17(h) of this Subpart in excess of the revenue cap shall not be included in the adjustment.

(ii) A facility that maintains charge schedules less than the maximums set forth in section 86-1.2(c) of this Subpart such that it results in it receiving less than the maximum allowable charge paying rate shall not be compensated by other payors for the amount by which its charge revenues are less than the maximum amount allowed.

(4) That portion of the revenue cap that is related to utilization of inpatient services shall be apportioned among beneficiaries of programs administered under titles XVIII and XIX of the Federal Social Security Act and article IX-C of the New York State Insurance Law, and those enrolled in organizations operating in accordance with the provisions of article 44 of the Public Health Law, so that the share borne by each program is based upon actual services received by that program's beneficiaries. To accomplish this apportionment, for each ancillary department, the ratio of total department costs to total department charges will be applied to program beneficiary charges for the services of that ancillary department to develop an ancillary cost per day for beneficiaries of that program; to this shall be added the cost of routine services for program beneficiaries, determined on the basis of an average cost per diem.

(i) Any adjustment in the overall revenue cap in accordance with this Subpart shall be reflected in an appropriate adjustment to this portion of the revenue cap and payment levels by these programs.

85-34 supersedes 81-36 & new

(ii) After such adjustments, the portion of the revenue cap initially established, or as adjusted, that is related to the actual utilization of covered inpatient services of the above programs, shall constitute guaranteed revenue to the general hospital.

Approval Date JUL. 23 1987 Effective Date JAN. 1 1986

(iii) Hospitals with charge structures from which an apportionment of costs cannot be determined will be paid only on the basis of total average cost per diem, unless the hospital can provide adequate and verified statistical data to apportion ancillary costs among beneficiaries.

(e) reserved

(f) reserved

(g) Bad debt and charity care regional pools and allowances. Regional pools will be established from which allowances will be added to hospital rates to help pay for the costs of bad debt and charity care for the three year period commencing January 1, 1983, and ending December 31, 1985. Such pools shall receive funds from hospitals pursuant to this subdivision and section 86-1.37 of this Subpart. For the rates established in 1983, the resources available for purposes of establishing the bad debt and charity care pools shall be calculated on the basis of two percent of the total statewide general hospital (including both major public hospitals and all other hospitals) reimbursable inpatient operating costs after application of the trend factor plus the addition of capital costs. For the rates established in 1984 and 1985, the resources available for establishing these pools shall be calculated on the basis of three percent and four percent, respectively of total statewide general hospital reimbursable inpatient operating costs in the respective rate year after application of the trend factor plus the addition of capital costs.

(1) To be eligible to receive an allowance from the bad debt and charity care pool funded by paragraph (4) of this subdivision and the financially distressed hospital pool funded by subdivision (g)(8) of this section, a facility must meet the following criteria. Compliance with these criteria shall be subject to audit.

(i) The costs of bad debt and charity care must be determined according to the following definitions and must be reported in the appropriate sections of the facility's Institutional Cost Report.

(a) Bad debt. Bad debts are the amounts which are considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services, and are collectable in money in the next operating cycle. Bad debts shall be determined in accordance with generally accepted accounting principles which recognize the direct charge-off method, the reserve method, or a combination of the direct charge-off method and the reserve method. Additionally, the debt must be related to a service which the facility has been authorized by the commissioner to provide. If an amount previously written off as a bad debt is recovered in a subsequent accounting period, the amount written off must be used to reduce the cost of bad debt for the period in which the collection is made.

(b) Charity care. Charity care is the reduction in charges made by the provider of services because the patient is indigent or medically indigent. Reductions in charge for employees which are accounted for as fringe benefits, such as hospitalization and personnel health programs, are not considered charity care. Courtesy allowances, such as free or reduced-charge services provided to other than the indigent or medically indigent, are not considered charity care.

(ii) The facility must maintain reasonable collection efforts and procedures.

(a) The hospital must utilize commonly accepted business methods and practices to collect unpaid amounts from all classes of payors. Such methods may differ for inpatient and outpatient services. The hospital shall utilize good business judgment and practices in determining the amounts to be collected.

(b) The hospital must determine the patient's ability to pay for the services rendered and document the method under which the determination was made.

(c) The hospital must generate and maintain written documentation of requests for payment for services provided.

(d) The hospital must take any subsequent actions as appropriate within good business practice such as subsequent billings, collection letters or telephone calls. These subsequent actions must be documented.

(e) The hospital may turn accounts over to a collection agency. Amounts so turned over may be written off as a bad debt at the time of turnover. Amounts collected by the facility after write-off

constitute a recovery of bad debts in the period collected.

(f) The hospital shall not be required to pursue judgment claims before the account can be written off.

(g) A policy which is consistent and follows commonly accepted business methods and practices concerning the time period that must elapse between initial billing and the determination that an unpaid bill is a bad debt must be maintained from January 1, 1981 to December 31, 1985. A finding of inconsistency may be waived upon demonstration by the facility that a policy change served to make bad debt determination policies consistent with the requirements of this subdivision.

(iii) The facility shall submit by October 1, 1983 and thereafter within 120 days from the beginning of a rate year, a report containing an opinion by its independent certified public accountant or independent licensed public accountant in a form approved by the commissioner after consultation with the New York State Society of Certified Public Accountants, as to whether the facility meets the criteria of this subdivision for eligibility for a distribution from the bad debt and charity pool. The commissioner may accept a report containing an opinion that the facility is in compliance with the criteria of this subdivision as establishing initial eligibility as of the first day of each rate year for distribution from the pool. Thereafter if the commissioner determines that the facility is not in compliance, such noncompliance shall be applicable for the entire rate year. The facility may appeal this noncompliance determination pursuant to the provisions of section 86-1.17(i) of this Subpart. If the facility chooses to appeal the commissioner's determination, the facility will continue to receive payments from its regional pools, if otherwise eligible, until a final determination has been made. If it is finally determined that the facility is not in compliance or if the facility chooses not to appeal the commissioner's determination that it is out of compliance, the facility shall repay to its regional pools all monies received from these pools for the period during which it was out of compliance. If a facility fails to repay such monies to its regional pools within a reasonable period of time, major third-party payors shall adjust the facility's rate as directed by the commissioner to reflect money owed to the pools and shall pay these monies to the pool administrator.

(2) For the purposes of this subdivision only, the following words or phrases shall be defined as follows:

(i) Major public sector shall mean all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospitals Corporation as established in chapter 1016 of the Laws of 1969, as amended and all other

public general hospitals having annual inpatient operating costs in excess of $25 million.

(ii) Voluntary sector shall mean all voluntary nonprofit, private proprietary and public general hospitals other than major public general hospitals.

(3) reserved

(4) reserved

OFFICIAL

Reserved

(g)(5) reserved

(g)(6) reserved

(g)(7) reserved

OFFICIAL

Reserved