S T A T E O F N E W Y O R K

6980

I N S E N A T E

April 9, 2014

Introduced by Sen. HANNON -- (at request of the Department of Health) -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law, in relation to general hospital inpatient reimbursement for annual rate periods and the effectiveness of certain provisions thereof; to amend the social services law, the state finance law, the insurance law and the workers' compensation law, in relation to technical conformity with changes to annual rate periods; to amend chapter 639 of the laws of 1996, constituting the "New York Health Care Reform Act of 1996", in relation to the effectiveness thereof; to amend chapter 1 of the laws of 1999, constituting the New York Health Care Reform act of 2000, in relation to the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; and repealing certain provisions of the public health law and the insurance law relating to making technical corrections

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Section 2807-c of the public health law, as amended by chapter 731 of the laws of 1993, paragraphs (a), (a-1), (b), (b-2), and (c) of subdivision 1, the opening paragraph of paragraph (a) of subdivision 3-a, paragraph (c), clauses (B) and (D) of subparagraph (i) and subparagraph (ii) of paragraph (f) of subdivision 11, paragraph (a) of subdivision 14, paragraph (c) of subdivision 14-a, subparagraph (v) of paragraph (a) of subdivision 14-b, paragraph (a) of subdivision 14-c, paragraphs (a) and (b) of subdivision 14-d, paragraph (b) of subdivision 16-a, the opening paragraph, and paragraphs (b) and (c) of subdivision 18, the opening paragraph, paragraphs (b) and (b-1), and the opening paragraph of subparagraph (ii) of paragraph (f) of subdivision 19, subdivision 19-a, paragraph (e) of subdivision 21 as amended by and paragraph (a-3) of subdivision 1, paragraph (d) of subdivision 2, paragraph (s) of subdivision 11, paragraph (e) of subdivision 12, paragraph (d) of subdivision 14-a, paragraph (e) of subdivision 14-d, and subdivi-

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

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sions 28 and 29 as added by chapter 639 of the laws of 1996, paragraph (g) of subdivision 16 as separately amended by chapters 474 and 639 of the laws of 1996, the opening paragraph of paragraph (a) of subdivision 1, paragraphs (f) and (k) of subdivision 4, subparagraph (vi) of paragraph (b) and paragraph (c) of subdivision 5, subparagraph (iii) of paragraph (c) of subdivision 6, the opening paragraph and clause (G) of subparagraph (i) of paragraph (f) of subdivision 11, paragraph (a) of subdivision 18, subdivision 19-b, and paragraphs (b), (c) and (d) of subdivision 21 as amended and paragraph (c) of subdivision 10 as added by chapter 1 of the laws of 1999, paragraph (a-2) of subdivision 1 as amended by section 6 of part OO of chapter 57 of the laws of 2008, the opening paragraph of subparagraph (i) of paragraph (a-3) of subdivision 1 as amended by section 15 of part C of chapter 63 of the laws of 2001, clauses (E) and (F) of subparagraph (i) of paragraph (a-3) of subdivision 1 as added by section 47-a of part B of chapter 58 of the laws of 2010, paragraph (b-1) of subdivision 1 as amended by section 10 of part C of chapter 58 of the laws of 2010, the opening paragraph of paragraph (i) of subdivision 1 as amended by section 36, the opening paragraph of paragraph (j) of subdivision 1 as amended by section 37, subparagraph (ii) of paragraph (k) of subdivision 1 as amended by section 40, the opening paragraph of paragraph (l) of subdivision 1 as amended by section 38, the opening paragraph and subparagraphs (i) and (ii) of paragraph (e-1) of subdivision 4 as amended by section 41, paragraph (a) of subdivision 32 as amended by section 39, clauses (A) and (B) of subparagraph (iii) of paragraph (g) of subdivision 35 as amended by section 44 and clause (E) of subparagraph (i) of paragraph (i) of subdivision 35 as amended by section 3-f of part B of chapter 58 of the laws of 2010, subparagraph (i) of paragraph (b-1) of subdivision 1 as amended by section 32, subparagraph (xi) as amended and subparagraphs (xii) and (xiii) of paragraph (b) of subdivision 35 as added by section 36 of part H, paragraphs (a) and (e) of subdivision 8 as amended by section 7 of part D and paragraph (e-1) of subdivision 21 as added by section 2 of part B of chapter 59 of the laws of 2011, clauses (B), (C) and (D) of subparagraph (iv) of paragraph (e) of subdivision 1, paragraph (q) of subdivision 11, paragraph (a) of subdivision 17, subparagraph (ii) of paragraph (a) of subdivision 25 and paragraph (b) of subdivision 27 as amended by chapter 255 of the laws of 1994, paragraph (h) of subdivision 1, clause (B) of subparagraph (iii) of paragraph (b) of subdivision 5, paragraphs (f) and (g) of subdivision 8, paragraph (r) of subdivision 11, subparagraph (iv) of paragraph (c) of subdivision 14, subparagraph (ii) of paragraph (b) of subdivision 17 as added and subparagraph (i) of paragraph (e) of subdivision 9, subparagraph (ii) of paragraph (e) and subparagraph (i) of paragraph (f) of subdivision 11, paragraph (d) of subdivision 14, paragraphs (a) and (d) of subdivision 14-b, paragraph (e) of subdivision 17 as amended by chapter 81 of the laws of 1995, subparagraph (i) of paragraph (b) of subdivision 17 as amended by chapter 255 of the laws of 1994 and as designated by chapter 81 of the laws of 1995, subparagraph (iii) of paragraph (h) of subdivision 1 as added by chapter 152 of the laws of 2003, paragraphs (i) and (j) of subdivision 1 as added by section 23, paragraph (k) of subdivision 1 as added by section 65-b, paragraph (l) of subdivision 1 as added by section 65-f and paragraph (f) of subdivision 30 as amended by section 44 of part A and paragraph (c) of subdivision 3 as amended by section 34, paragraph (e) of subdivision 3 as added by section 34-a and subparagraphs (i) and (ii) of paragraph (d) of subdivision 25 as amended by section 33 of part C of chapter 58 of the laws of 2007, subparagraph (i) of paragraph (i)

and subparagraph (i) of paragraph (j) of subdivision 1 as amended by chapter 500 of the laws of 2007, subparagraph (ii) of paragraph (i) of subdivision 1 as amended by section 19, subparagraph (ii) of paragraph (j) of subdivision 1 as amended by section 19-a of part B, paragraph (h) of subdivision 18 as added by section 41 and paragraphs (a) and (b) of subdivision 30 as amended by section 22-b of part B and subdivision 33 as added by section 12 of part C of chapter 58 of the laws of 2008, paragraph (e) of subdivision 4 as amended by section 30 and subdivision 31 as amended by section 24 of part J of chapter 82 of the laws of 2002, paragraph (e-1) of subdivision 4 as added by section 12, paragraph (e-2) of subdivision 4 as added by section 13, subdivision 35 as added by section 2 of part C, subparagraph (iii) of paragraph (f) of subdivision 4 as amended by section 16, subparagraph (iii) of paragraph (k) of subdivision 4 as amended by section 17, the opening paragraph of subparagraph (vi) of paragraph (b) of subdivision 5 as amended by section 18, the opening paragraph and subparagraph (i) of paragraph (c) of subdivision 5 as amended by section 19 and clause (B-1) of subparagraph (i) of paragraph (f) of subdivision 11 as amended by section 20 of part B, paragraph (l) of subdivision 4 as amended by section 11, paragraph (s-8) of subdivision 11 as amended by section 13-a, clause (A) of subparagraph (i) of paragraph (a) of subdivision 30 as amended by section 4, clause (A) of subparagraph (i) of paragraph (b) of subdivision 30 as amended by section 5 and subparagraph (ii) of paragraph (a) of subdivision 33 as amended by section 1-b of part C of chapter 58 of the laws of 2009, clause (D) of subparagraph (iv) of paragraph (e-2) of subdivision 4 as added by section 30, the opening paragraph of paragraph (l) of subdivision 4 as amended by section 25, subparagraphs (ii) and (x) of paragraph (b) of subdivision 35 as amended by section 33-a and paragraph (c) of subdivision 35 as amended by section 26 of part A, subparagraph (v) of paragraph (b) of subdivision 35 as amended by section 7 of part B, subdivision 14-f as amended by section 2 and the opening paragraph of subparagraph (i) of paragraph (i) of subdivision 35 as amended by section 4 of part C of chapter 56 of the laws of 2013, paragraphs (f) and (k) of subdivision 4 and clause (A) of subparagraph (iii) of paragraph (b) of subdivision 5 as separately amended by chapters 194 and 474 of the laws of 1996, subparagraph (iii) of paragraph (b) as amended by section 2, clause (A) of subparagraph (iii) as amended by section 3 and clause (C) of subparagraph (iii) of paragraph (b) of subdivision 5 as added by section 4 of chapter 593 of the laws of 2006, subparagraph (iv) of paragraph (b) of subdivision 5 as added by chapter 194 of the laws of 1996, subparagraphs (iv) and (v) of paragraph (b) of subdivision 5 as amended and paragraphs (s-1) and (s-2) of subdivision 11 as added by chapter 433 of the laws of 1997, subdivision 10 as amended by section 22 and paragraphs (s-3) and (s-4) of subdivision 11 as added by section 32-e of part F of chapter 412 of the laws of 1999, subparagraph (i) of paragraph (c) of subdivision 10 and paragraph (s-5) of subdivision 11 as amended by chapter 419 of the laws of 2000, subparagraph (vi) of paragraph (f) of subdivision 11 as added by chapter 170 of the laws of 1994, paragraph (s-6) of subdivision 11 as amended by section 6 of part H of chapter 686 of the laws of 2003, paragraph (s-7) of subdivision 11 as added by section 68 of part C, paragraph (c) of subdivision 16 as amended by section 64 and paragraph (f) of subdivision 31 as amended by section 7 of part B of chapter 58 of the laws of 2005, subparagraph (iv) of paragraph (b) of subdivision 5 as added and paragraph (b) of subdivision 14 as amended by chapter 474 of the laws of 1996, paragraph (e) of subdivision 16 as amended by chapter 484 of the laws of 2009, paragraph

(d) of subdivision 18 as amended by section 3-d and paragraph (i) of subdivision 35 as added by section 3-a of part B of chapter 109 of the laws of 2010, paragraph (f) of subdivision 18 as amended by section 46 and subparagraph (ii) of paragraph (b) of subdivision 20 as amended by section 48-c of part D of chapter 56 of the laws of 2012, paragraph (g) of subdivision 18 as added by section 22 and subparagraphs (iii) and (iv) of paragraph (e) of subdivision 30 as amended by section 10-i of part D of chapter 57 of the laws of 2006, paragraph (i) of subdivision 18 as added by chapter 319 of the laws of 2011, subparagraph (ii) of paragraph (f) of subdivision 19 as amended by chapter 311 of the laws of 1994, paragraph (b) of subdivision 20 as amended by section 26 of part A-3 of chapter 62 of the laws of 2003, subparagraph (i) of paragraph (c) of subdivision 20 as amended by section 23 of subpart D of part V-1 of chapter 57 of the laws of 2009, paragraphs (d) and (e) of subdivision 25 as added by section 7 of part B of chapter 58 of the laws of 2004, paragraph (c) of subdivision 27 as separately amended by chapter 922 of the laws of 1990 and chapter 731 of the laws of 1993, subdivision 30 as amended by section 3 of part E of chapter 63 of the laws of 2005 and subdivision 32 as amended by section 1 of part U of chapter 57 of the laws of 2007, is amended to read as follows:

S 2807-c. General hospital inpatient reimbursement [for annual rate periods beginning on or after January first, nineteen hundred eighty-eight. 1. Payor payments. Payments to general hospitals for inpatient hospital services provided to persons who are not eligible for payments as beneficiaries of title XVIII of the federal social security act (medicare) shall be determined pursuant to this section. Payor payments shall be as follows unless an alternative reimbursement methodology is authorized in accordance with paragraph (e), (f), (g), (h) or (i) of subdivision four of this section]. 1. (a) Payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments made by state governmental agencies [for patients discharged prior to January first, two thousand and on and after January first, two thousand; or for patients discharged prior to January first, nineteen hundred ninety-seven provided in accordance with policies written by corporations organized and operating in accordance with article forty-three of the insurance law, or payment by such a corporation on behalf of subscribers of a foreign corporation as described in paragraph (d) of subdivision twelve of this section, which provide for reimbursement on an expense incurred basis; or for patients discharged prior to January first, nineteen hundred ninety-seven provided to subscribers of organizations operating in accordance with the provisions of article forty-four of this chapter,] shall be [case based payments per discharge, for each diagnosis-related group] established in accordance with [paragraph (a) of subdivision three of] this section[, and shall include:

(i) a reimbursable inpatient operating cost component determined in accordance with subdivision five of this section;

(ii) capital related inpatient expenses determined in accordance with subdivision eight of this section;

(iii) for patients discharged prior to January first, nineteen hundred ninety-seven (A) a bad debt and charity care allowance determined in accordance with subdivision fourteen of this section, (B) a general health care services allowance determined in accordance with subdivision fourteen-b of this section, and (C) a bad debt and charity care allowance for financially distressed hospitals determined in accordance with subdivision fourteen-c of this section;

(iv) a projection of reimbursable inpatient operating costs to the rate year by the trend factor determined in accordance with subdivision ten of this section; and

(v) adjustments for any modifications to the case payments determined in accordance with paragraph (a), (b), (c) or (d) of subdivision four of this section].

[(a-1)] (B) Payments made by local governmental agencies to general hospitals for reimbursement of inpatient hospital services provided to inmates of local correctional facilities as defined in subdivision sixteen of section two of the correction law shall be at the rates of payment determined pursuant to this section for state governmental agencies, excluding adjustments pursuant to subdivision [fourteen-f] SIX of this section.

[(a-2)] (C) (i) With the exception of those enrollees covered under a payment rate methodology agreement negotiated with a general hospital, payments for inpatient hospital services provided to patients eligible for medical assistance pursuant to title eleven of article five of the social services law made by organizations operating in accordance with the provisions of article forty-four of this chapter or by health maintenance organizations organized and operating in accordance with article forty-three of the insurance law shall be the rates of payment that would be paid for such patients under the medical assistance program, (i) determined pursuant to this section, excluding adjustments pursuant to subdivision [fourteen-f] SIX of this section, and (ii) excluding medical education costs that are reimbursed directly to the general hospital in accordance with paragraph [(a-3)] (D) of this subdivision.

(ii) Effective July first, two thousand seven, with the exception of those enrollees covered under a payment rate methodology agreement negotiated with a general hospital, payment for inpatient hospital services provided to patients enrolled in the child health insurance program pursuant to title one-A of article twenty-five of this chapter made by organizations operating in accordance with the provisions of article forty-four of this chapter or by health maintenance organizations organized and operating in accordance with article forty-three of the insurance law shall be the rates of payment that would be paid under the medical assistance program determined pursuant to this section, excluding adjustments pursuant to subdivision [fourteen-f] SIX of this section.

[(a-3)] (D) Notwithstanding any inconsistent provision of law:

(i) the commissioner shall establish, subject to the approval of the director of the budget, discrete rates of payment for general hospitals for the period July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-nine and periods on and after January first, two thousand for payments under the medical assistance program pursuant to title eleven of article five of the social services law for persons eligible for medical assistance who are enrolled in health maintenance organizations and for payments under the family health plus program for persons enrolled in approved organizations pursuant to title eleven-D of article five of the social services law based on the components of rates of payment established pursuant to this section for persons eligible for medical assistance who are not enrolled in health maintenance organizations for a general hospital for such rate period that reflect the estimated reimbursable costs of direct medical education expenses and indirect medical education expenses in the determination of:

(A) [the hospital-specific average reimbursable inpatient operating cost per discharge pursuant to subdivision six of this section, and

(B) group category average inpatient reimbursable operating cost per discharge pursuant to subdivision seven of this section, and

(C) the operating cost component of rates of payment pursuant to paragraphs (f) and (k) of subdivision four of this section, and

(D) the operating cost component of rates of payment in accordance with paragraphs (e), (g) and (i) of subdivision four of this section for general hospitals or distinct units of general hospitals not reimbursed on the basis of case based payments per discharge; and

(E) notwithstanding clauses (A) through (D) of this subparagraph, for periods on and after December first, two thousand nine,] the operating cost component of rates of payment subject to subdivision [thirty-five] SEVENTEEN of this section, and

[(F) notwithstanding clauses (A) through [(D)] (C) of this subparagraph, for periods on and after December first, two thousand nine,]

(B) the operating cost component of rates of payment subject to paragraphs [(e-1), (e-2) and (1) of subdivision four] (B), (C) AND (F) OF SUBDIVISION TWO of this section for general hospitals or distinct units of general hospitals not reimbursed on the basis of case based payments per discharge; and

(ii) such rates of payment may be established by the commissioner on any appropriate payment basis, including a case mix adjusted per discharge basis.

[(b) For patients discharged prior to January first, nineteen hundred ninety-seven, payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments pursuant to the comprehensive motor vehicle insurance reparations act; or enrolled in a self-insured fund which provides for reimbursement directly to general hospitals on an expense incurred basis, with the exception of those enrollees covered under a payment rate methodology agreement in accordance with the provisions of paragraph (a) of subdivision two of this section; or insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis; or receiving inpatient hospital services pursuant to an out-of-plan benefits system authorized pursuant to section four thousand four hundred six of this chapter, except where such out-of-plan, inpatient hospital services are offered by an organization organized pursuant to the not-for-profit corporation law or which meets the qualifications of section 501(c) of the internal revenue code, shall be case based payments per discharge, for each diagnosis-related group established in accordance with paragraph (a) of subdivision three of this section, and equal to the case payments to general hospitals provided in accordance with paragraph (a) of this subdivision for services provided to subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, adjusted for uncovered services, and increased by thirteen percent or, for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law and the volunteer ambulance workers' benefit law, increased by five percent. Funds received by a general hospital based on the payment differential applied pursuant to this paragraph shall be hospital funds for patient care purposes. Without due cause general hospitals shall not refuse to accept direct payments from a payor who would otherwise be eligible to reimburse hospitals for inpatient

services on a case based payment per discharge in accordance with this subdivision.

(b-1)] (E) (i) For patients discharged on and after January first, nineteen hundred ninety-seven and prior to January first, two thousand and on and after January first, two thousand, payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law, and the comprehensive motor vehicle insurance reparations act shall be at the rates of payment determined pursuant to this section for state governmental agencies, excluding adjustments pursuant to subdivision [fourteen-f] SIX of this section and subdivision [thirty-three] SIXTEEN of this section, excluding such further reductions to such payments as are enacted as part of the state budget for the state fiscal year commencing April first, two thousand ten and excluding such further reductions to such payments as are enacted as part of the state budget for state fiscal years commencing on and after April first, two thousand eleven.

(ii) The provisions of paragraph [(d)] (A) of subdivision [eleven] FIVE of this section shall continue to apply to such payors for payments determined pursuant to this paragraph.

[(b-2)] (F) A payor included in the payor categories specified in paragraph (a) [or (b-1)] of this subdivision shall not be provided the option of payment to a general hospital for inpatient services based on the lower of hospital charges or the case based payment per discharge determined in accordance with this section for a patient or apportioning the appropriate case based payment per discharge for a patient by excluding payment for a preexisting condition or acquired condition which has to be treated along with the reason for the admission [or, except as may affect qualification for payments in accordance with paragraph (b) or (d) of subdivision four of this section, for days within the inlier stay determined to be medically unnecessary].

[(c) Charge based payments. For patients discharged prior to January first, nineteen hundred ninety-seven, payments to general hospitals for reimbursement of inpatient hospital services provided to those for whom a case based payment per discharge system is not authorized by paragraph (a) or (b) of this subdivision, or who are not covered under the provisions of paragraph (a) of subdivision two of this section, shall be on the basis of the hospital's charges; provided, however, for these patients the definition of a short stay patient pursuant to paragraph (d) of subdivision four of this section shall apply, and reimbursement to hospitals for such patients shall be at payments developed in accordance with paragraph (d) of subdivision four of this section, increased by thirteen percent. The maximum amount to be charged to any charge paying patient for a case shall be one hundred twenty percent of the case based payment per discharge as determined under paragraph (b) of this subdivision for the diagnosis-related group with which the patient is identified. Each general hospital shall establish a charge schedule and inpatient charges from this schedule shall be applied uniformly for all inpatient charge based payments made in accordance with this section.

(d) The components of rates of payment calculated in accordance with this section related to inpatient operating costs shall be based on general hospital reimbursable inpatient operating costs used in determining payments for services pursuant to section twenty-eight hundred seven-a of this article during the rate period January first, nineteen

hundred eighty-seven through December thirty-first, nineteen hundred eighty-seven (or for a distinct unit of a general hospital excluded from case based payments pursuant to paragraph (e) or (g) of subdivision four of this section such distinct unit reimbursable inpatient operating costs), excluding inpatient operating costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare) in accordance with paragraph (g) of subdivision eleven of this section and adjusted to reflect the annualized cost impact of rate revisions or adjustments, including the volume adjustment and case mix adjustment for the nineteen hundred eighty-seven rate period, made with respect to such services, which shall be defined as a general hospital's or distinct unit's reimbursable inpatient operating cost base; a projection to the nineteen hundred eighty-eight rate period by the trend factor determined in accordance with subdivision ten of this section; and an increase to reflect special additional inpatient operating costs determined and allocated in accordance with paragraph (e) of this subdivision.

(e) General hospital special additional inpatient operating costs shall be determined and allocated among general hospitals in accordance with subparagraphs (i), (iii) and (iv) of this paragraph. For purposes of computing group category average inpatient reimbursable operating costs in accordance with paragraph (a) of subdivision seven of this section and an equivalent cost component for general hospitals that are excluded from the case based payment per diagnosis-related group system in accordance with paragraph (e) or (g) of subdivision four of this section special additional inpatient operating costs shall include an additional increase determined and allocated among general hospitals in accordance with subparagraph (ii) of this paragraph.

(i) The total cost increases pursuant to this subparagraph for all general hospitals shall in the aggregate be one hundred thirty million dollars for the nineteen hundred eighty-eight rate period to reflect nineteen hundred eighty-five costs incurred in excess of the trend factor between nineteen hundred eighty-one and nineteen hundred eighty-five, such cost increases to be projected from nineteen hundred eighty-eight to subsequent annual rate periods by the applicable trend factor, and shall be allocated among general hospitals in accordance with the following methodology:

Five hundred dollars per bed shall be allocated to costs of each general hospital based on the total number of inpatient beds for which the hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on January first, nineteen hundred eighty-eight.

A factor of one quarter of one percent of a general hospital's reimbursable inpatient operating cost base as defined in paragraph (d) of this subdivision, trended through nineteen hundred eighty-eight, shall be allocated to costs of general hospitals for technology advances and a further one quarter of one percent of such costs shall be allocated to costs of general hospitals for increased activities related to quality assurance and patient discharge planning.

The balance of one hundred thirty million dollars after deducting the dollar value of the per bed cost enhancement and the dollar value of the percentage cost enhancements shall be allocated to costs of general hospitals based on the ratio of each general hospital's nineteen hundred eighty-five cost incurred in excess of the trend factor between nineteen hundred eighty-one and nineteen hundred eighty-five in the following

discrete areas, summed, to the total sum of such cost over trend of all general hospitals applied to such balance: malpractice insurance costs, infectious and other waste disposal costs, water charges, direct medical education expenses, working capital interest costs of hospitals that qualified for distributions made in accordance with paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-a of this article, costs of distinct psychiatric units excluded from case based payments per diagnosis-related group, and ambulance costs. For purposes of this subparagraph, nineteen hundred eighty-five cost incurred in excess of the trend factor between nineteen hundred eighty-one and nineteen hundred eighty-five shall be calculated for each such discrete area based on a general hospital's inpatient operating costs for the fiscal year ending in nineteen hundred eighty-five, after excluding inpatient operating costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), for such discrete area in excess of the hospital's comparable component of reimbursable inpatient operating costs for its fiscal year ending in nineteen hundred eighty-one, after excluding inpatient operating costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), trended through nineteen hundred eighty-five by the appropriate component of the trend factors and adjusted to reflect approved decreases or increases in inpatient operating costs resulting from all rate adjustments.

(ii) The total additional cost increases pursuant to this subparagraph for all general hospitals shall in the aggregate be forty million dollars for the nineteen hundred eighty-eight rate period, such additional cost increases to be projected from nineteen hundred eighty-eight to the rate period by the applicable trend factor, to be allocated among general hospitals in accordance with the following methodology:

The additional increase of forty million dollars shall be allocated to costs of general hospitals that are included in group categories established pursuant to paragraph (b) of subdivision seven of this section based on the ratio of the nineteen hundred eighty-eight intermediate group operating costs of each such general hospital, and to costs of general hospitals that are excluded from the case based payment per diagnosis-related group system in accordance with paragraph (e) or (g) of subdivision four of this section based on the ratio of the nineteen hundred eighty-eight intermediate operating costs of each such general hospital, to the total sum of such intermediate group operating costs and intermediate operating costs applied to the forty million dollars. For purposes of this subparagraph, intermediate group operating costs of a general hospital shall be calculated in accordance with rules and regulations adopted by the council and approved by the commissioner based on the reimbursable inpatient operating cost base determined in accordance with paragraph (d) of this subdivision of such general hospital; adjusted to exclude operating costs related to specialized hospital services for which an alternative reimbursement methodology is adopted pursuant to paragraph (e) or (g) or, if effective, (i) of subdivision four of this section; and trended to the nineteen hundred eighty-eight rate period by the trend factor determined in accordance with subdivision ten of this section; and increased to reflect special additional inpatient operating costs determined and allocated in accordance with subparagraph (i) of this paragraph; and adjusted to exclude a factor for operating costs of patients who required an alternate level of care in accordance with paragraph (h) of subdivision four of this section; and adjusted to exclude the components of the trended reimbursable inpatient

operating cost base related to education, physician, ambulance services and organ acquisition costs determined in accordance with subparagraphs (i), (iii) and (iv) of paragraph (c) of subdivision seven of this section and malpractice insurance costs, and the components of special additional inpatient operating costs determined and allocated in accordance with subparagraph (i) of this paragraph associated with cost increases in such costs. For purposes of this subparagraph, intermediate operating costs of a general hospital excluded from the case based payment per diagnosis-related group system shall be calculated in accordance with rules and regulations adopted by the council and approved by the commissioner based on the reimbursable inpatient operating cost base determined in accordance with paragraph (d) of this subdivision of such general hospital; trended to the nineteen hundred eighty-eight rate period by the trend factor determined in accordance with subdivision ten of this section; and increased to reflect special additional inpatient operating costs determined and allocated in accordance with subparagraph (i) of this paragraph; and adjusted to exclude a factor for operating costs of patients who required an alternate level of care developed consistent with the provisions of paragraph (h) of subdivision four of this section; and adjusted to exclude the components of the trended reimbursable inpatient operating cost base related to education, physician, ambulance services and organ acquisition costs determined consistent with the provisions of subparagraphs (i), (iii) and (iv) of paragraph (c) of subdivision seven of this section and malpractice insurance costs, and the components of special additional inpatient operating costs determined and allocated in accordance with subparagraph (i) of this paragraph associated with cost increases in such costs.

(iii) Cost increases pursuant to this subparagraph shall be made for the nineteen hundred ninety-one rate period to reflect cost increases incurred in excess of the trend factor and not included in the costs used in determining payments in accordance with paragraph (d) of this subdivision and subparagraphs (i) and (ii) of this paragraph. Such costs shall in the aggregate be three hundred twenty-nine million dollars exclusive of costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare). Such costs increases shall be projected from nineteen hundred ninety-one to subsequent annual rate periods by the applicable trend factor, and shall be allocated among general hospitals, except those general hospitals whose base year for determining payments for services in such facilities is nineteen hundred eighty-seven, in accordance with the following methodology:

(A) Up to two hundred twenty-two million dollars shall be allocated for labor adjustments. If the total of the adjustments is less than two hundred twenty-two million dollars, then the adjustments shall be fully funded. If the total of the adjustments is more than two hundred twenty-two million dollars, then the adjustment specified in accordance with item (II) of this clause shall be funded at the lower of twenty percent of the total amount allocated for labor adjustments or its proportional share of the labor adjustments unless the labor adjustment specified in item (I) of this clause is less than eighty percent of the total amount allocated for labor adjustments in which case the adjustment specified in item (II) of this clause shall be equal to the difference between two hundred twenty-two million dollars and the total amount of the adjustment specified in item (I) of this clause.

(I) A portion of the amount allocated for labor adjustments shall be for labor cost increases related to registered nurses' salaries and fringes (twenty percent of salaries) and an add-on for the ripple effect on other health care professionals of at least thirty-five percent. Such adjustment shall cover both inpatient and outpatient cost incurred, based on costs reported in a survey conducted by the department for the period January first, nineteen hundred ninety through June thirtieth, nineteen hundred ninety on forms specified by the commissioner and received by the department no later than November first, nineteen hundred ninety, annualized, in excess of nineteen hundred eighty-five labor costs related to registered nurses' salaries and fringes trended to nineteen hundred ninety and the nineteen hundred eighty-eight statewide nurse salary adjustment trended to nineteen hundred ninety by the appropriate components of the trend factors adjusted to reflect the effect of the annualization of nineteen hundred ninety data and the result trended to nineteen hundred ninety-one and shall be based exclusively on regional experience. Such regional adjustment shall not be less than zero. Each individual hospital within a region shall receive a portion of the regional adjustment equal to its share of the total inpatient and outpatient reimbursable operating costs for the region excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare) and excluding direct medical education costs.

(II) A portion of the amount allocated for labor adjustments shall be for personnel costs other than those related to registered nurses' salaries and fringes and the ripple effect on other health care professionals. Such adjustment shall cover both inpatient and outpatient costs incurred, based on costs reported in a survey conducted by the department for the period January first, nineteen hundred ninety through June thirtieth, nineteen hundred ninety on forms specified by the commissioner and received by the department no later than November first, nineteen hundred ninety, annualized, in excess of nineteen hundred eighty-five personnel costs covered by this adjustment trended to nineteen hundred ninety and the annualized rate adjustments approved in nineteen hundred eighty-nine for personnel costs covered by this adjustment for increased hospital costs to meet additional state requirements that became effective July first, nineteen hundred eighty-nine trended to nineteen hundred ninety by the appropriate components of the trend factors adjusted to reflect the effect of the annualization of nineteen hundred ninety data and the result trended to nineteen hundred ninety-one and shall be based exclusively on regional data.

(III) In the event that federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allocation and adjustment specified in items (I) and (II) of this clause related to outpatient costs as a component of such payments is not approved by the federal government then such outpatient costs shall not be considered in calculating such adjustment.

(B) Health personnel development.

Four million five hundred thousand dollars shall be allocated for labor adjustments to be made available for health occupation development and workplace demonstration programs authorized pursuant to section twenty-eight hundred seven-h of this article. The commissioner is directed to make rate adjustments subject to the approval of the director of the budget to cover the cost of such programs, which shall be made available for the duration of such programs.

(C) Thirty-three million dollars shall be allocated for technology advances and changes in medical practice. A fixed amount per bed shall be allocated to the costs of each general hospital based on the total number of inpatient beds for which the general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety.

(D) Thirty-four million dollars shall be allocated to those general hospitals providing comprehensive health care to the communities they serve as determined by the commissioner pursuant to regulations approved by the council. Comprehensive health care includes providing and/or accommodating patients' health care needs at the appropriate levels and settings of care, and reaches outside of traditional inpatient services to outpatient and other services. Factors to be considered in deciding which general hospitals are providing comprehensive health care and the size of the adjustment shall include but not be limited to: clinic and emergency room volume compared to inpatient volume (measured using total volume and/or volume related to medicaid and medically indigent patients); number and type of clinic services offered; availability of services; whether the general hospital is an AIDS designated center, prenatal care assistance program provider, home health care provider, trauma center, burn center; whether the general hospital offers neonatal intensive care services, dialysis services, birthing center backup agreements, AIDS outpatient programs, specific mental health, drug and alcohol programs including outpatient and emergency services and those designated pursuant to section 9.39 of the mental hygiene law; and whether the general hospital's emergency room is designated as a 911 receiving hospital. In the event that federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the adjustment specified in this clause as a component of such payments is not approved by the federal government because of the inclusion of outpatient services then such outpatient services shall not be considered in calculating such adjustment. If such exclusion results in the allocation for this adjustment not being spent, then any unspent portion shall be reallocated to further fund the adjustments specified in clauses (D) and (E) of this subparagraph in the same proportion as their original funding.

(E)(I) Twenty-six million dollars shall be allocated to the costs of general hospitals based on the ratio of each general hospital's nineteen hundred eighty-nine cost incurred in excess of the trend factor between nineteen hundred eighty-five and nineteen hundred eighty-nine in the certain discrete areas, summed, to the total sum of such cost over trend of all general hospitals applied to the total funds under this allocation. Such discrete cost areas shall include but not be limited to: infectious and other waste disposal costs, universal precautions, working capital interest costs, costs for asbestos removal, costs of low osmolality contrast media, malpractice costs, water and sewer charges, ambulance costs and costs related to designation as a trauma center. For purposes of this clause, nineteen hundred eighty-nine cost incurred in excess of the trend factor between nineteen hundred eighty-five and nineteen hundred eighty-nine shall be calculated for each such discrete area based on a general hospital's inpatient operating costs for the fiscal year ending in nineteen hundred eighty-nine, after excluding inpatient operating costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), for such discrete area in excess of the hospital's comparable component of reim-

bursable inpatient operating costs for its fiscal year ending in nineteen hundred eighty-five, after excluding inpatient operating costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), trended through nineteen hundred eighty-nine by the appropriate component of the trend factors and adjusted to reflect approved decreases or increases in inpatient operating costs resulting from all rate adjustments.

(II) Any funds allocated under this clause and not distributed pursuant to item (I) of this clause shall be allocated for the following: to reimburse for a portion of the cost increases incurred above the trend factor between nineteen hundred eighty-one and nineteen hundred eighty-five for those discrete cost areas specified in the last paragraph of subparagraph (i) of paragraph (e) of this subdivision as added by chapter two of the laws of nineteen hundred eighty-eight and not reimbursed in accordance with such paragraph. Such funds shall be allocated to general hospitals in the same manner as specified in such paragraph.

(F) Seven million two hundred thousand dollars shall be allocated to account for the increase in the number of patients admitted through the emergency room and the high costs of treating such patients which has resulted in an increase in severity within diagnosis related groups. Such funds shall be allocated to general hospitals based on the nineteen hundred eighty-nine hospital-specific data on increased admissions through the emergency room since nineteen hundred eighty-one, excluding those admissions related to providing services to beneficiaries of title XVIII of the federal social security act (medicare).

(G) Two hundred fifty dollars per bed shall be allocated to the costs of each general hospital having two hundred or less certified acute care beds and classified as a rural hospital for purposes of determining payment for inpatient acute care services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, for recruiting and retaining health care personnel, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety.

(H) One million dollars shall be allocated to assist general hospitals involved in a merger, acquisition, or consolidation in meeting the costs associated with such merger, acquisition, or consolidation on or after January first, nineteen hundred ninety-one. The commissioner shall make rate adjustments for such allocations.

(I) Five hundred thousand dollars shall be allocated for a practitioner placement program to assist general hospitals in the placement of physicians and other health care practitioners to practice primary health care and/or dentistry in underserved areas, to serve the medically needy, and including services with affiliated community based providers. The commissioner shall make rate adjustments for such allocations. Notwithstanding any inconsistent provision of this subdivision, this clause shall not apply in rate periods commencing on or after January first, nineteen hundred ninety-four.

(iv) Cost increases pursuant to this subparagraph shall be made for the nineteen hundred ninety-four rate period to reflect cost increases incurred in excess of the trend factor and not included in the costs used in determining payments in accordance with paragraph (d) of this subdivision and subparagraphs (i), (ii) and (iii) of this paragraph. Such costs shall in the aggregate be one hundred seventy-three million

dollars exclusive of costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare). Such cost increases shall be projected from nineteen hundred ninety-four to subsequent annual rate periods by the applicable trend factor, and shall be allocated among general hospitals in accordance with the following methodology:

(A) Forty-six million dollars shall be allocated to the costs of general hospitals for treating tuberculosis patients. Each general hospital shall receive a portion of this total equal to its share of the statewide total of inpatient tuberculosis discharges based on the most recent twelve month period for which data is available.

(B) Sixty-three million dollars shall be allocated for labor adjustments in accordance with the following methodology:

(I) Fifty-five million dollars shall be for labor cost increases incurred prior to June thirtieth, nineteen hundred ninety-three. Each general hospital shall receive a portion of this total equal to its share of the statewide total of inpatient and outpatient reimbursable operating costs based on nineteen hundred ninety data excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare) and excluding direct medical education costs.

(II) Eight million dollars of the amount to be allocated for labor adjustments pursuant to this clause shall be distributed to general hospitals located in the counties of Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland, Columbia, Delaware and Westchester, to account for prior disproportionate increases in unreimbursed labor costs. Each individual hospital shall receive a portion of the eight million dollars equal to its share of the total inpatient and outpatient reimbursable operating costs based on nineteen hundred ninety data for all hospitals located in the above-referenced counties excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare) and excluding direct medical education costs.

(C) Fifty-five million dollars shall be allocated to the costs of increased activities related to regulatory compliance, universal precautions and infection control related to AIDS, tuberculosis, and other infectious diseases, including the training of employees with regard to infection control, and for infectious and other waste disposal costs. A fixed amount per bed shall be allocated to the costs of each general hospital based on the total number of inpatient beds for which the general hospital is certified pursuant to the operating certificate issued for each general hospital in accordance with section twenty-eight hundred five of this article in effect on August twenty-fourth, nineteen hundred ninety-three.

(D) Three million dollars shall be allocated as follows:

(I) Two hundred fifty dollars per bed shall be allocated to the costs of each general hospital having two hundred or less certified acute care beds and classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, in recognition of the unique costs incurred by these facilities in complying with state regulations, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on August twenty-fourth, nineteen hundred ninety-three.

(II) The remainder shall be allocated on a proportional basis to the costs of each general hospital classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, in recognition of the unique costs incurred by these facilities to provide hospital services in remote or sparsely populated areas, according to the following methodology:

(1) the net income, or the net loss expressed as a negative, as a proportion of the net patient revenue, of each such hospital, based on operating results for the nineteen hundred ninety and nineteen hundred ninety-one rate years, shall be computed and averaged, and expressed as a percentage;

(2) each such resulting percentage average shall be multiplied by each such hospital's number of inpatient beds for which such hospital is certified pursuant to the operating certificate issued for such hospital in accordance with section two thousand eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety, and such resulting products for all such hospitals shall be summed, and such sum shall be divided by the total of all such beds for all such hospitals, and the resulting quotient shall be the weighted average rural operating margin expressed as a percentage; and

(3) one percentage point shall be subtracted from each such hospital's average net operating margin, and the resulting difference shall be divided by the weighted average rural operating margin; and

(4) (a) if the quotient resulting from the computation in subitem three above is less than zero, then the absolute value of such quotient shall be multiplied by each such hospital's number of inpatient beds for which such hospital is certified pursuant to the operating certificate issued for such hospital in accordance with section two thousand eight hundred five of this chapter in effect on June thirtieth, nineteen hundred ninety, such product shall be multiplied by one hundred fifty dollars, and such resulting amount shall be such hospital's adjustment pursuant to this clause;

(b) if the quotient resulting from the computation in subitem three above is zero or greater, such hospital's adjustment pursuant to this clause shall be zero; and

(c) provided, however, that if the total of all such adjustments so computed exceeds the amount to be allocated in accordance with this item, each such hospital's adjustment shall be proportionately reduced.

(E) Three million dollars shall be allocated to assist general hospitals involved in a merger, acquisition, or consolidation in meeting the costs associated with such merger, acquisition, or consolidation on or after January first, nineteen hundred ninety-four. The commissioner shall make rate adjustments for such allocations.

(F) (I) One million five hundred thousand dollars shall be allocated for enhanced rates for general hospitals participating within a rural health network as defined in subdivision two of section twenty-nine hundred fifty-one of this chapter. Such rate enhancements shall be established only for inpatient services provided by such hospitals through the written rural health network agreement, where such services have been approved for enhanced rates by the commissioner. Notwithstanding any inconsistent provision of law, such enhanced rates shall be subject to the availability of federal financial participation pursuant to title XIX of the federal social security act in expenditures made for eligible patients, including pooling arrangements and volume adjustments, provided, however that such enhanced rates shall not affect the

calculation for any other general hospital of the group price component calculated pursuant to subparagraph (i) of paragraph (a) of subdivision seven of this section.

(II) One million five hundred thousand dollars shall be allocated for enhanced rates for general hospitals participating within a central services facility rural health network as defined in subdivision three of section twenty-nine hundred fifty-one of this chapter. Such rate enhancements shall be established only for inpatient services provided by such hospitals through the network operational plan, where such services have been approved for enhanced rates by the commissioner. Notwithstanding any inconsistent provision of law, such enhanced rates shall be subject to the availability of federal financial participation pursuant to title XIX of the federal social security act in expenditures made for eligible patients, including pooling arrangements and volume adjustments, provided, however that such enhanced rates shall not affect the calculation for any other general hospital of the group price component calculated pursuant to subparagraph (i) of paragraph (a) of subdivision seven of this section.

(f) The commissioner and the state director of the budget shall consider providing a supplementary increase to general hospital reimbursable inpatient operating costs for purposes of computing rates of payment for annual rate periods beginning on or after January first, nineteen hundred eighty-nine in accordance with this section for reasonable and necessary supplementary cost increases in general hospital operating costs for such rate period or periods based on increased minimum standards and procedures relating to general hospital operating certificates adopted by the council and approved by the commissioner or state initiatives related to recruitment or maintenance of an appropriate level of personnel providing professional services to patients. Any such supplementary increase shall be allocated to costs of general hospitals in accordance with rules and regulations adopted by the council and approved by the commissioner.

(g) Hospital discharges for purposes of computing case based payments per discharge pursuant to this section shall be based on the number of patient discharges during the rate period from January first, nineteen hundred eighty-seven through December thirty-first, nineteen hundred eighty-seven excluding discharges of beneficiaries of title XVIII of the federal social security act (medicare) and adjusted as provided in specific provisions of this section, or the number of such patient discharges during a recent twelve month period prior thereto established by regulation for which data are available subsequently reconciled by an adjustment to reflect nineteen hundred eighty-seven discharge data.

(h) Notwithstanding any inconsistent provision of this section, commencing April first, nineteen hundred ninety-five:

(i) rates of payment for patients eligible for payments made by state governmental agencies shall be reduced by the commissioner to reflect an exclusion from reimbursable inpatient operating costs commencing April first, nineteen hundred ninety-five of the special additional inpatient operating costs determined and allocated among general hospitals in accordance with clause (C) of subparagraph (iii) and clause (C) of subparagraph (iv) of paragraph (e) of this subdivision and the factor of one quarter of one percent of general hospitals' reimbursable inpatient operating cost base allocated to costs of general hospitals for technology advances in accordance with subparagraph (i) of paragraph (e) of this subdivision; and

(ii) general hospitals may not request and the commissioner shall not consider any pending or further appeals for an adjustment to rates of payment based on costs associated with technology advances and changes in medical practice and such adjustments to reimbursable inpatient operating costs pursuant to clause (C) of subparagraph (iv) of paragraph (e) of this subdivision.

(iii) Notwithstanding the foregoing, or any other provision of this section, the commissioner may establish pass through payments, or other appropriate methodologies, for the period ending December thirty-first, two thousand three for innovative medical device advances for which the federal centers for medicare and medicaid services adopts new codes to the hospital inpatient prospective payment system prior to the federal food and drug administration's approval of such medical device.

(i) For the rate period July first, two thousand seven through March thirty-first, two thousand eight and for rates applicable to the state fiscal year commencing April first, two thousand eight, and each state fiscal year thereafter through March thirty-first, two thousand nine, and for the period April first, two thousand nine through November thirtieth, two thousand nine, provided, however, that for the period April first, two thousand nine through November thirtieth, two thousand nine the aggregate rate adjustments calculated pursuant to subparagraph (ii) of this paragraph shall not exceed four million dollars, and contingent upon the availability of federal financial participation:

(i) The commissioner shall adjust inpatient medical assistance rates of payment calculated pursuant to this section for public hospitals other than non-state public hospitals located in a city with a population of more than one million persons, that meet the targeted medicaid discharge percentage in accordance with the methodology set forth in subparagraph (ii) of this paragraph. For purposes of this paragraph, "targeted medicaid discharge percentage" shall mean that at least seventeen and one-half percent of a public hospital's total discharges were patients eligible for payments under the medical assistance program pursuant to title eleven of article five of the social services law, including those enrolled in health maintenance organizations, and patients eligible for payments under the family health plus program pursuant to title eleven-D of article five of the social services law, based on data reported in such hospital's institutional cost report submitted for the two thousand four period and filed with the department by November first, two thousand six. Any hospital that meets the filing deadline shall have until June first, two thousand seven to submit revised and corrected data schedules in such institutional cost report which established eligibility for such adjusted rate.

(ii) The aggregate amount of rate adjustments calculated pursuant to this paragraph shall not exceed six million dollars for each rate period. Such amount shall be allocated proportionally based on the relative numbers of medicaid discharges among those public hospitals eligible for rate adjustments in accordance with subparagraph (i) of this paragraph based on each such hospital's reported medical assistance data specified in subparagraph (i) of this paragraph. Such amounts shall be included as an add-on to medical assistance inpatient rates of payment, excluding exempt unit rates, and shall not be reconciled to reflect changes in medical assistance utilization between two thousand four and the current rate year.

(j) For the rate period July first, two thousand seven through March thirty-first, two thousand eight and for rates applicable to the state fiscal year commencing April first, two thousand eight, and each state

fiscal year thereafter through March thirty-first, two thousand nine and for the period April first, two thousand nine through November thirtieth, two thousand nine, provided, however, that for the period April first, two thousand nine through November thirtieth, two thousand nine the aggregate rate adjustments calculated pursuant to subparagraph (ii) of this paragraph shall not exceed twenty-eight million dollars, and contingent upon the availability of federal financial participation:

(i) The commissioner shall adjust inpatient medical assistance rates of payment calculated pursuant to this section for voluntary hospitals other than voluntary hospitals located in a city with a population of more than one million persons that meet the targeted medicaid discharge percentage in accordance with the methodology set forth in subparagraph (ii) of this paragraph. For purposes of this paragraph, "targeted Medicaid discharge percentage" shall mean between seventeen and one-half percent and thirty-five percent of a voluntary hospital's total discharges were patients eligible for payments under the medical assistance program pursuant to title eleven of article five of the social services law, including those enrolled in health maintenance organizations, and patients eligible for payments under the family health plus program pursuant to title eleven-D of article five of the social services law, based on data reported in such hospital's institutional cost report submitted for the two thousand four period and filed with the department by November first, two thousand six. Any hospital that meets the filing deadline shall have until June first, two thousand seven to submit revised and corrected data schedules in such institutional cost report which established eligibility for such adjusted rate.

(ii) The aggregate amount of rate adjustments calculated pursuant to this paragraph shall not exceed forty-two million dollars for each rate period. Such amount shall be allocated proportionally based on relative numbers of medicaid discharges among those voluntary hospitals eligible for rate adjustments in accordance with subparagraph (i) of this paragraph based on each such hospital's reported medical assistance data specified in subparagraph (i) of this paragraph. Such amounts shall be included as an add-on to medical assistance inpatient rates of payment, excluding exempt unit rates, and shall not be reconciled to reflect changes in medical assistance utilization between two thousand four and the rate year.

(k) Subject to the availability of federal financial participation, the commissioner shall adjust inpatient rates of payment for non-public general hospitals located in a city with a population of more than one million persons for the following periods and in the following amounts in order to ensure meaningful access to the hospital's services and reasonable accommodation for all medicaid patients who require language assistance:

(i) for the period July first, two thousand seven through December thirty-first, two thousand seven, thirty-eight million dollars shall be allocated proportionally to such hospitals based on fifty percent of each such hospital's reported general clinic medicaid visits and fifty percent on each such hospital's reported medicaid inpatient discharges, as reported in each hospital's two thousand four institutional cost report, as submitted to the department prior to November first, two thousand six, to the total of all such general clinic visits reported by all such hospitals.

(ii) for the period April first, two thousand eight through March thirty-first, two thousand nine, and each state fiscal year thereafter through November thirtieth, two thousand nine, thirty-eight million

dollars shall be allocated on an annualized basis for such purpose to such hospitals in accordance with the methodology set forth in subparagraph (i) of this paragraph, provided, however, that thirty percent of such funds shall be allocated proportionally, based on the number of foreign languages utilized by one or more percent of the residents in each hospital total service area population, provided, however, that for the period April first, two thousand nine through November thirtieth, two thousand nine, such allocation shall be reduced to twenty-five million three hundred thirty-three thousand dollars.

(l) Effective for periods on and after July first, two thousand seven through November thirtieth, two thousand nine:

(i) Subject to the availability of federal financial participation, the commissioner shall adjust inpatient medical assistance rates of payment calculated pursuant to this section for general hospitals located in the counties of Nassau and Suffolk in accordance with the methodology set forth in subparagraph (ii) of this paragraph. For purposes of this paragraph, "medicaid inpatient discharges" shall mean the total number of such general hospital's discharges where the patients were eligible for payments under the medical assistance program pursuant to title eleven of article five of the social services law, including those enrolled in health maintenance organizations, and patients eligible for payments under the family health plus program pursuant to title eleven-D of article five of the social services law, based on data reported in such hospital's institutional cost report submitted for the two thousand four period and filed with the department by November first, two thousand six.

(ii) The amount of rate adjustments calculated pursuant to this paragraph shall not exceed five million dollars in the aggregate annually. Such amount shall be allocated proportionally based on the relative numbers of medicaid discharges among those general hospitals eligible for rate adjustments in accordance with subparagraph (i) of this paragraph based on each such hospital's reported medical assistance data specified in subparagraph (i) of this paragraph. Such amounts shall be included as an add-on to medical assistance inpatient rates of payment, excluding exempt unit rates, and shall not be reconciled to reflect changes in medical assistance utilization between two thousand four and the current rate year.

2. Special payment rate methodology agreements, negotiated rates. (a) Any payment rate methodology agreement negotiated between a self-insured and self-administered fund and a specific general hospital or its successor which was in effect on May first, nineteen hundred eighty-five shall be permitted to continue with such fund, or a self-insured and self-administered fund related in interest to such fund through merger, consolidation or corporate reorganization subsequent to May first, nineteen hundred eighty-five, as long as any revision to such methodology does not provide more of an economic advantage to the fund than the previous agreement. A general hospital which has any such agreement shall file with the commissioner information regarding each such agreement, as may be required by regulations adopted by the council and approved by the commissioner.

(b)(i) Nothing in this section shall prohibit the establishment of special payment rate methodologies in arrangements between general hospitals and health maintenance organizations operating in accordance with the provisions of article forty-three of the insurance law or article forty-four of this chapter, provided the commissioner has been notified of the proposed arrangement, has reviewed such proposed arrangement

and has issued his written approval of the arrangement. The commissioner shall not approve such an arrangement if it would result in payments to a general hospital for inpatient services provided to subscribers of health maintenance organizations which in the aggregate are less than what otherwise would have been paid under the provisions of this section, unless the health maintenance organization demonstrates that such lower payments are justified because the arrangement will result in lower costs to the general hospital, and the payments approximate costs. Such arrangements may be approved by the commissioner to: integrate the medical delivery functions of the health maintenance organization with the medical delivery functions of the hospital, including but not limited to joint staffing arrangements or pre-admission testing arrangements; or integrate the method of payment and financial incentives to the hospital with the method of payment and financial incentives to physicians or other providers in the health maintenance organization; or integrate the method of payment and financial incentives to the hospital with the health maintenance organization, including, but not limited to, bed leasing or capitation payments. Notwithstanding any inconsistent provision of this section, for periods beginning on or after January first, nineteen hundred ninety-four, negotiated agreements between health maintenance organizations and general hospitals which were approved by the commissioner and which were in effect on December thirty-first, nineteen hundred ninety-three, may continue.

(ii) Notwithstanding any inconsistent provisions of this section, health maintenance organizations operating in accordance with the provisions of article forty-three of the insurance law or article forty-four of this chapter, having enrollees eligible for inpatient general hospital payments as beneficiaries of title XVIII of the federal social security act (medicare) shall reimburse general hospitals for inpatient services for these enrollees in accordance with the provisions contained in title XVIII of the federal social security act (medicare).

(c) Special payment rate methodology agreements other than those permitted in accordance with the provisions of paragraphs (a) and (b) of this subdivision shall not be authorized, and no other arrangements with a general hospital for inpatient rates of payment other than those established in accordance with this section shall be negotiated.

(d) Notwithstanding any inconsistent provision of law, the provisions of paragraphs (a), (b) and (c) of this subdivision shall not apply to payments for patients discharged on or after January first, nineteen hundred ninety-seven.

3. Diagnosis-related groups and weights. (a) The commissioner shall establish as a basis for case classification for case based rates of payment the same system of diagnosis-related groups for classification of hospital discharges as established for purposes of reimbursement of inpatient hospital service pursuant to title XVIII of the federal social security act (medicare) in effect on the first day of July in the year preceding the rate period. However, the council may adopt rules and regulations, subject to the approval of the commissioner, to adjust such diagnosis-related groups or establish additional diagnosis-related groups to reflect subsequent revisions applicable to reimbursement for discharges of beneficiaries of title XVIII of the federal social security act (medicare) effective subsequent to the first day of July in the year preceding the rate period, or to identify medically appropriate patterns of health resource use efficiently and economically provided. No such regulations, however, except those to reflect subsequent revisions applicable to reimbursement for discharges of beneficiaries of

title XVIII of the federal social security act (medicare) or for changes made to diagnosis-related groups for neonatal services and services to acquired immune deficiency syndrome (AIDS) patients shall apply to the rate period beginning January first, nineteen hundred eighty-eight. For subsequent rate periods regulations other than those to reflect subsequent revisions applicable to reimbursement for discharges of beneficiaries of title XVIII of the federal social security act (medicare) may in addition apply to changes to the diagnosis-related groups for other services, including but not limited to, pediatric services; provided, however, that psychiatric and rehabilitation services shall not be included.

Notwithstanding section one hundred twelve or one hundred seventy-four of the state finance law or any other law, rule or regulation to the contrary, the commissioner may contract with a vendor for nominal consideration to develop the specifications for the adjusted or additional diagnosis-related groups if the commissioner certifies to the comptroller that such contract is in the best interest of the health of the people of the state. Notwithstanding that such specifications shall be available pursuant to article six of the public officers law, such contract may provide that the specifications for such adjusted or additional diagnosis-related groups provided by the vendor shall be subject to copyright protection pursuant to federal copyright law.

(b) The methodology for assignment of patient discharges within diagnosis-related groups applicable for purposes of determining payments for discharges of beneficiaries of title XVIII of the federal social security act (medicare) in effect on the first day of July in the year preceding the rate period, revised to reflect such adjustments as may be made to the diagnosis-related group classification system pursuant to paragraph (a) of this subdivision, shall be applied to assign specific patient discharges within the diagnosis-related groups established pursuant to paragraph (a) of this subdivision. The council may adopt rules and regulations, subject to the approval of the commissioner, to revise the methodology for the assignment of specific patient discharges within the diagnosis-related groups to reflect revisions to the methodology applicable for purposes of determining payments for discharges of beneficiaries of title XVIII of the federal social security act (medicare) effective subsequent to the first day of July in the year preceding the rate period.

(c) (i) The commissioner shall determine an appropriate weighting factor for each diagnosis-related group which reflects the relative general hospital resources used by all patients, other than beneficiaries of title XVIII of the federal social security act (medicare), with respect to discharges classified within that diagnosis-related group compared to discharges classified within other diagnosis-related groups. For rate periods during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety, the appropriate weighting factor for each diagnosis-related group shall be determined using nineteen hundred eighty-five costs and statistics for a representative sample of general hospitals. For rate periods during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three, the appropriate weighting factor for each diagnosis-related group shall be determined using nineteen hundred eighty-nine costs and statistics for a representative sample of general hospitals. For rate periods during the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand

through December thirty-first, two thousand seven, the appropriate weighting factor for each diagnosis-related group shall be determined using nineteen hundred ninety-two costs and statistics for a representative sample of general hospitals. For rate periods on and after January first, two thousand eight, the appropriate weighting factor for each diagnosis-related group shall be determined using two thousand four costs and statistics for a representative sample of general hospitals, and, further, the computation of the group average arithmetic inlier length-of-stays for each diagnostic related group, as otherwise determined in accordance with applicable regulations, shall utilize two thousand four data as reported to the department, and, be based on a representative sample of general hospitals, and further, the short-stay and long-stay length-of-stay trimpoints, as otherwise determined in accordance with applicable regulations, shall be computed utilizing two thousand four data as reported to the department and based on a representative sample of general hospitals. Provided however, that if the department does not release updated data and documentation described in subparagraph (iii) of this paragraph, the effective rate period shall be April 1, 2008. Discharges and costs related to the exceptions to case payment provided in accordance with paragraphs (e), (g) and (i) of subdivision four of this section shall be eliminated from the costs and statistics used in determining the appropriate weighting factors, while the cost factor related to the exception provided in paragraph (h) of subdivision four of this section shall be eliminated. The costs and statistics for the case payment modifications calculated pursuant to paragraphs (a), (b), (c) and (d) of subdivision four of this section shall be eliminated in accordance with paragraph (c) of subdivision six of this section. Costs related to education, physician, ambulance services and organ acquisition identified consistent with the provisions of paragraph (c) of subdivision seven of this section and costs related to malpractice insurance shall also be eliminated. The council may adopt rules and regulations, subject to the approval of the commissioner, to prospectively adjust weighting factors determined in accordance with this paragraph to reflect changes in medical technology. After the commissioner issues rate certifications pursuant to subdivision four of section twenty-eight hundred seven of this article the commissioner shall expeditiously make available for inspection by general hospitals and payors the data, consistent with appropriate department procedures for the release and protection of confidential data, and the methodology utilized to determine the appropriate weighting factors.

(ii) Notwithstanding any contrary provision of law, the case mix adjustment to the operating component of per diem rates of payment paid to general hospitals or units of general hospitals that are exempt from case based payments, as determined in accordance with subdivision four of this section and as otherwise computed in accordance with applicable regulations, shall, for periods on and after January first, two thousand eight, be computed utilizing the diagnosis-related group classification system in effect for the rate year for inpatient case based medicaid rates of payment and the related per day cost weights calculated using two thousand four data as reported to the department and based on a representative sample of general hospitals. For rate periods on and after the two thousand eleven rate period, such case mix adjustment shall utilize the same base period data as determined in accordance with paragraph (e) of this subdivision.

(iii) The department shall, by no later than June first, two thousand seven, make available to hospital industry representatives relevant

updated data and documentation that the department will utilize, in accordance with this paragraph, in developing appropriate service intensity weights for each diagnosis-related group for the two thousand eight rate period. The department will thereafter consult with hospital industry representatives in developing regulations to implement the utilization of such updated service intensity weight data applicable to rate periods on and after two thousand eight. If it is deemed appropriate by the commissioner, in consultation with hospital industry representatives, such regulations may provide for the phase-in over a period of time of the application of such updated data in determining Medicaid rates on and after two thousand eight, provided, however, that the application of such updated data shall be fully reflected in such rates by no later than January first, two thousand ten.

(iv) By no later than December first, two thousand seven, the commissioner shall issue a report to the governor and the legislature describing the updated data utilization applicable, in accordance with the provisions of this paragraph, to periods on and after two thousand eight and setting forth the factors considered in developing it.

(d) The commissioner shall consult with technical advisory groups as necessary in establishing diagnosis-related groups and weights in accordance with paragraphs (a), (b) and (c) of this subdivision and in making adjustments in accordance with paragraphs (b) and (c) of subdivision six of this section.

(e) The appropriate weighting factor for each diagnosis-related group, the group average arithmetic inlier length-of-stays for each diagnosis-related group, and the short-stay and long-stay length-of-stay trimpoints shall, by no later than the two thousand eleven rate period, be based on reported costs and statistics from a representative sample of general hospitals from a base period no earlier than two thousand seven. Thereafter, the base period reported costs and statistics utilized for such purposes shall be updated no less frequently than every four years and the new base periods utilized shall be no more than four years prior to the applicable rate period.

3-a. Dispute resolution system. (a) The commissioner shall establish, in accordance with rules and regulations adopted by the council and approved by the commissioner, a payment dispute resolution system to resolve disputes between payors of inpatient hospital services and general hospitals for patients discharged on or after January first, nineteen hundred ninety-one and prior to January first, nineteen hundred ninety-seven. The commissioner shall designate the use of a uniform set of guidelines for determining the application of particular diagnosis-related group categories to particular patients which may include guidelines published by associations, universities or other organizations. The dispute resolution process shall apply to all payors of hospital services described in paragraphs (a), (b) and (c) of subdivision one of this section, including patients or payors which pay hospitals' charges or coinsurance, provided, however, such process shall not include payments made for persons eligible for payments as beneficiaries of title XVIII of the federal social security act (medicare) as a patients' primary payor or payments made pursuant to title eleven of article five of the social services law, provided that this exception shall not include payments for medical assistance participants in health maintenance organizations or prepaid health services plans. A payor of hospital services included in paragraph (a) of subdivision one of this section may serve as, or designate, the review agent for their subscribers, beneficiaries or enrolled members for an initial review and a

reconsideration review but the final step in such dispute resolution process shall be an independent party unrelated to the payor which party shall be approved by the commissioner pursuant to this section.

In the event a third party payor or patient desires to challenge the appropriateness of a bill for hospital services rendered by a general hospital for a particular patient, or in the event a general hospital desires to challenge the appropriateness of a payment by a third party payor on behalf of a particular patient, then either the hospital or the payor may submit the question to the dispute resolution process established pursuant to this subdivision. The disputes submitted for resolution may include the appropriateness of the application of a particular diagnosis-related group category, as described in subdivision three of this section, to a particular patient; the appropriate classification and payment of an inpatient stay as a modification of a case payment pursuant to paragraph (a), (b), (c), or (d) of subdivision four of this section, including whether payment for services should be, based on medical necessity or other reasons, made as a case payment or payment as a modification of a case payment; whether payment should appropriately be made pursuant to an alternative reimbursement methodology authorized in accordance with paragraph (e) or (h) of subdivision four of this section and the payment for such services; whether payment for services rendered by a general hospital should be appropriately, based on medical necessity or other reasons, made as payment for inpatient care or payment for outpatient care and the payment for such services; or whether the hospital stay should be classified as a readmission as defined in accordance with regulations adopted pursuant to paragraph (l) of subdivision eleven of this section and the payment for such stay.

The dispute resolution system established shall provide for an initial review and a reconsideration review. The council shall adopt necessary rules and regulations, subject to the approval of the commissioner, including but not limited to those for determining the parties to a dispute resolution review and any reconsideration review; the procedures and time limits to initiate a dispute resolution review or any reconsideration review; the procedures for notification of all parties involved in the dispute upon initiation of a dispute resolution review or any reconsideration review; time limits for resolving disputes; the establishment of dispute resolution and reconsideration fees; and required documents to be submitted including the hospital bill in dispute, a copy of the patient medical record, or so much thereof as may be required, and a statement of issues including the basis for the dispute. During a dispute resolution review or any reconsideration review, a party may present documentation or evidence in support of its position regarding the appropriate diagnosis-related group to which the patient discharge should be assigned or the proper payment for the case. The commissioner shall approve a statewide utilization review organization or regional utilization review organization to conduct and determine such dispute resolution reviews including any reconsideration reviews in accordance with paragraph (b) of this subdivision. Every general hospital bill issued for a patient discharged on or after January first, nineteen hundred ninety-one other than for discharges of patients eligible for medical assistance pursuant to title eleven of article five of the social services law subject to case based payments determined pursuant to this section based on diagnosis-related group assigned or maximum hospital charges for a case determined pursuant to this section based on diagnosis-related group assigned shall include or be accompanied by a notice of the payment dispute resolution system; provided, however, that

a general hospital issuing bills to a payor for twenty-five or more patients per year may send such notice to such payor on an annual basis. The form and content of such notice shall be determined in accordance with rules and regulations adopted by the council and approved by the commissioner.

(b) The commissioner shall approve a statewide utilization review organization or regional utilization review organizations to conduct and determine dispute resolution reviews, including reconsideration reviews, pursuant to this subdivision. To be approved as a utilization review organization in accordance with this subdivision such organization must meet the following criteria: the organization shall employ or otherwise secure the services of adequate personnel, including medical personnel, qualified to review such disputes, the organization shall demonstrate the ability to render decisions in a timely manner, the organization shall agree to provide ready access by the commissioner to all data, records and information it collects and maintains concerning its review activities under this subdivision, the organization shall agree to provide to the commissioner such data, information and reports as the commissioner determines necessary to evaluate the review process provided pursuant to this subdivision, the organization shall provide assurances that review personnel shall not have a conflict of interest in conducting a review based on payor, hospital or professional affiliation, and the organization meets such other performance and efficiency criteria regarding the conduct of reviews pursuant to this subdivision established by the commissioner. The commissioner may withdraw approval of a utilization review organization where such organization fails to continue to meet approval criteria established pursuant to this paragraph. A utilization review organization approved pursuant to this paragraph shall be authorized to receive and review patient medical records and shall develop and implement appropriate procedures to maintain confidentiality of such patient medical records.

(c) Upon resolution of a payment dispute in accordance with this paragraph, the parties involved in the dispute shall be notified of the reason for the decision and the hospital bill in dispute shall be adjusted to reflect such resolution.

(d) The party initiating a payment dispute resolution review or any reconsideration review must submit to the utilization review organization a dispute resolution fee established to recover the costs related to the conduct of the initial dispute resolution reviews or a reconsideration review fee established to recover the costs related to the conduct of such reconsideration reviews, except that for payors in paragraph (a) of subdivision one of this section which serve as or designate the review agent for their subscribers, beneficiaries, or enrolled members a fee shall be charged only for the final step in the dispute resolution process. Upon resolution of a payment dispute in accordance with this subdivision in favor of the payor, the amount due to the hospital by a payor based upon the hospital bill shall be reduced by the amount of any fee paid pursuant to this paragraph by such payor. Upon resolution of a payment dispute in accordance with this subdivision in favor of the general hospital, the amount due to the hospital based upon the hospital bill shall be increased by the amount of any fee paid pursuant to this paragraph by such general hospital.

(e) Nothing herein shall relieve the responsibilities of the payors as set forth in paragraphs (a), (b) and (c) of subdivision one of this section.

(f)(i) Whenever the amount of payment made by a payor to a general hospital is less than the amount of payment due determined by a utilization review organization in accordance with this subdivision, general hospitals in accordance with paragraph (d) of subdivision eleven of this section may include financing or working capital charges on such balance owed to the general hospital by a payor.

(ii) Whenever the amount of payment made by a payor to a general hospital is in excess of the amount of payment due determined by a utilization review organization in accordance with this subdivision, interest shall be due on such excess owed by the general hospital to a payor of two percent for the first thirty days and one percent per month thereafter from the date of payment of such excess amount. Interest shall not be applied to excess amounts owed to third party payors participating in an advance payment system.

(g) For payment amounts eligible for payment dispute resolution pursuant to this subdivision, a general hospital shall not bill a patient or pursue collection efforts against a patient for the difference between a hospital bill and the payment made on such bill by a payor within the payor categories specified in paragraph (a), (b) or (c) of subdivision one of this section, except for uncovered services by a payor, deductibles and coinsurance based on maximum hospital charges calculated based on the undisputed amount of the hospital bill, until final decision of the utilization review organization. Nothing in this subdivision shall be construed to prohibit a general hospital from issuing an informational bill to a patient regarding such difference between the hospital bill and the payment made on such bill to advise the patient of the amount in dispute.

(h) The formal written decision of a utilization review organization approved by the commissioner to conduct and determine dispute resolution reviews in accordance with paragraph (b) of this subdivision upon a reconsideration review, or if there is no reconsideration review upon an initial review, or for a payor of hospital services included in paragraph (a) of subdivision one of this section which serves as or designates the review agent for their subscribers, beneficiaries or enrolled members upon the final step in the dispute resolution process as to the questions of the appropriateness of a bill for hospital services or the calculation of the proper payment for such hospital services shall be admissible in evidence at any subsequent trial upon the request of any party to the action. The decision shall not be binding upon the jury or, in a case tried without a jury, upon the trial court, but shall be considered prima facie evidence to establish the facts resolved by the utilization review organization.

4.] 2. Modifications and exceptions to case payment rates. Case based rates of payment shall be modified and per diem or other unit of service payments shall be provided, or exceptions shall be made to case payments, in accordance with rules and regulations adopted by the council and approved by the commissioner, in the following circumstances:

(a) where a case that is eligible for payment under the case based payment system is transferred between general hospitals, the receiving hospital shall be reimbursed its total case payment amount for the diagnosis-related group (including any payments made in accordance with this subdivision), and the transferring hospital shall receive reimbursement on a basis consistent with the methodology developed for the elimination of transfer patient costs [in accordance with subparagraph (i) of paragraph (c) of subdivision six of this section plus additions contained in subparagraph (ii) of paragraph (a) of subdivision one of this section on

a per diem basis]. The payment to a transferring general hospital shall not exceed the case payment amount for the diagnosis-related group computed in accordance with this section;

[(b) where the cost per case for a patient that does not qualify for payment pursuant to paragraph (a) or (d) of this subdivision is in excess of the basic case payment rate for the diagnosis-related group multiplied by two and the overall hospital-specific average cost per case multiplied by six, the payment to the general hospital in addition to the basic case payment rate will be one hundred percent, or such percentage as computed in accordance with subparagraph (ii) of paragraph (c) of subdivision six of this section, multiplied by the difference between the general hospital's cost for the case and the greater of the basic case payment rate for the diagnosis-related group multiplied by two or the overall hospital-specific cost per case multiplied by six. In determining whether a case qualifies for payment under this paragraph, prospective rate adjustments made in accordance with paragraph (c) of subdivision eleven of this section to reflect the retroactive impact of an adjustment on prior rates, shall be excluded. Where a case qualifies for payment pursuant to both this paragraph and paragraph (c) of this subdivision then payment shall be made in accordance with this paragraph if such payment exceeds that which would be made in accordance with paragraph (c) of this subdivision. The general hospital's costs per case shall be computed by adjusting the general hospital's actual charges for the case by the general hospital's inpatient cost to charge ratio;

(c) where a patient is identified as a long stay patient, payment to the general hospital in addition to the basic case payment rate shall be on a basis consistent with the methodology developed for the elimination of long stay patient costs in accordance with subparagraph (iii) of paragraph (c) of subdivision six of this section. Where a case qualifies for payment pursuant to both this paragraph and paragraph (b) of this subdivision then payment shall be made in accordance with paragraph (b) of this subdivision if such payment exceeds that which would be made in accordance with this paragraph. A long stay patient is defined as an inpatient whose hospital stay exceeds the long stay outlier threshold for the diagnosis-related group;

(d) where a patient is identified as a short stay patient, payment to the general hospital shall be on a basis consistent with the methodology developed for the elimination of short stay patient costs in accordance with subparagraph (iv) of paragraph (c) of subdivision six of this section plus additions contained in subparagraph (ii) of paragraph (a) of subdivision one of this section on a per diem basis. A short stay patient is defined as an inpatient discharged from the hospital on the same day of admission, or the day after admission except for those stays where the statewide mean length of stay for the diagnosis-related group is less than three days, or whose hospital stay is not greater than twenty percent of the statewide mean length of stay for the diagnosis-related group with which the patient is identified, excluding normal newborn cases and normal deliveries;

(e) in cases where a general hospital or distinct unit of a general hospital is not or would not have been reimbursed on a case based payment per diagnosis-related group for inpatient services provided on or before December thirty-first, two thousand one, to beneficiaries of title XVIII of the federal social security act (medicare), reimbursement shall be on a per diem basis computed for excluded general hospitals based on the hospital's reimbursable inpatient operating cost base, or for excluded distinct units of general hospitals based on the distinct

unit's reimbursable inpatient operating cost base, determined in accordance with paragraph (d) of subdivision one of this section, projected to the applicable rate period by the trend factor determined in accordance with subdivision ten of this section, and increased in accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of subdivision one of this section to reflect special additional inpatient operating costs, and adjusted to exclude a factor for operating costs of patients who required an alternate level of care developed consistent with the provisions of paragraph (h) of this subdivision, and increased for excluded general hospitals to reflect the product of the group category percentage amount applicable for purposes of determining group category average inpatient reimbursable operating cost per discharge (price) in the rate period pursuant to paragraph (b) of subdivision five of this section for general hospitals reimbursed on a case based payment per diagnosis-related group applied to such excluded general hospital's additional cost increases determined in accordance with subparagraph (ii) of paragraph (e) of subdivision one of this section, and adjusted on a payor category basis to reflect allocation of malpractice insurance costs in accordance with the methodology developed pursuant to subparagraph (ii) of paragraph (h) of subdivision eleven of this section, for those patients included in the payor categories pursuant to the provisions of paragraph (a) or (b) of subdivision one of this section; provided, however, for those patients included in the payor categories pursuant to the provisions of paragraph (b) of subdivision one of this section payment shall be at the per diem payment to the hospital or distinct unit of the hospital for services provided to subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, adjusted for uncovered services, and increased by thirteen percent or by five percent, as the case may be; provided further, however, for those general hospitals that are not reimbursed on a case-based payment per diagnosis-related group for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) as a result of their designation by the secretary of health and human services as a comprehensive cancer hospital or as a result of their status as an acute care exempt children's hospital, the base year for determining payments for services in such facilities shall be nineteen hundred eighty-seven, provided, however, such hospitals shall be allowed adjustments in rates of payment to reflect costs incurred subsequent to nineteen hundred eighty-seven but not reflected in such base. Funds received by a general hospital based on the payment differential in accordance with paragraph (b) of subdivision one of this section applied pursuant to this paragraph shall be hospital funds for patient care purposes. For those patients not covered under the provisions of paragraph (a) or (b) of subdivision one of this section, or who are not covered under the provisions of paragraph (a) of subdivision two of this section, payment shall be on the basis of the hospital's charge schedule, limited to one hundred twenty percent of the total per diem payment that would have been made if the patient were included in the payor categories pursuant to the provisions of paragraph (b) of subdivision one of this section. Rates of payment for excluded general hospitals and excluded distinct units of general hospitals for a rate period shall be increased on a per diem basis by additions and allowances specified in subparagraphs (ii) and (iii) of paragraph (a) of subdivision one of this section. In adopting regulations for purposes of determining rates of payment for psychiatric services pursuant to this paragraph, the council and the commissioner shall consider the advice of

the commissioner of mental health and may include case mix and other adjustments for such rates of payment. The commissioner of mental health shall study and report on alternative procedures for the development of rates of payment for inpatient psychiatric care. Such report shall be submitted to the governor, the legislature and the commissioner of health by January first, nineteen hundred ninety-three. Recommendations for alternative financing shall take into consideration methods to improve access to inpatient care for seriously mentally ill persons.

(e-1)] (B) Notwithstanding any inconsistent provision [of paragraph (e)] of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, per diem rates of payment by governmental agencies for a general hospital or a distinct unit of a general hospital for inpatient psychiatric services [that would otherwise be subject to the provisions of paragraph (e) of this subdivision] shall, with regard to days of service associated with admissions occurring on and after April first, two thousand ten, be in accordance with the following:

(i) For rate periods on and after April first, two thousand ten, the commissioner, in consultation with the commissioner of the office of mental health, shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for determining the operating cost components of rates of payments for services described in this paragraph. Such regulations shall utilize two thousand five operating costs as submitted to the department prior to July first, two thousand nine and shall provide for methodologies establishing per diem inpatient rates that utilize case mix adjustment mechanisms. Such regulations shall contain criteria for adjustments based on length of stay.

(ii) Rates of payment established pursuant to subparagraph (i) of this paragraph shall reflect an aggregate net statewide increase in reimbursement for such services of up to twenty-five million dollars on an annual basis.

(iii) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this paragraph shall remain subject to the provisions of subdivision [eight] THREE of this section.

[(e-2)] (C) Notwithstanding any inconsistent provision [of paragraph (e)] of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, per diem rates of payment by governmental agencies for inpatient services provided by a general hospital or a distinct unit of a general hospital for services, as described below, [that would otherwise be subject to the provisions of paragraph (e) of this subdivision,] shall, with regard to days of service occurring on and after December first, two thousand nine, be in accord with the following:

(i) For physical medical rehabilitation services and for chemical dependency rehabilitation services, the operating cost component of such rates shall reflect the use of two thousand five operating costs for each respective category of services as reported by each facility to the department prior to July first, two thousand nine and as adjusted for inflation pursuant to paragraph (c) of subdivision [ten] FOUR of this section, as otherwise modified by any applicable statute, provided, however, that such two thousand five reported operating costs, but not including reported direct medical education cost, shall, for rate-setting purposes, be held to a ceiling of one hundred ten percent of the average of such reported costs in the region in which the facility is located[, as determined pursuant to clause (E) of subparagraph (iii) of paragraph (1) of this subdivision].

(ii) For services provided by rural hospitals designated as critical access hospitals in accordance with title XVIII of the federal social security act, the operating cost component of such rates shall reflect the use of two thousand five operating costs as reported by each facility to the department prior to July first, two thousand nine and as adjusted for inflation pursuant to paragraph (c) of subdivision [ten] FOUR of this section, as otherwise modified by any applicable statutes, provided, however, that such two thousand five reported operating costs shall, for rate-setting purposes, be held to a ceiling of one hundred ten percent of the average of such reported costs for all such designated hospitals statewide.

(iii) For inpatient services provided by specialty long term acute care hospitals and for inpatient services provided by cancer hospitals as so designated as of December thirty-first, two thousand eight, the operating cost component of such rates shall reflect the use of two thousand five operating costs for each respective category of facility as reported by each facility to the department prior to July first, two thousand nine and as adjusted for inflation pursuant to paragraph (c) of subdivision [ten] FOUR of this section, as otherwise modified by any applicable statutes.

(iv) For facilities designated by the federal department of health and human services as exempt acute care children's hospitals as of December thirty-first, two thousand eight, for which a discrete institutional cost report was filed for the two thousand seven calendar year, and which has reported Medicaid discharges greater than fifty percent of total discharges in such cost report, shall be determined in accordance with the following:

(A) The operating cost component of such rates shall reflect the use of two thousand seven operating costs as reported by each facility to the department prior to July first, two thousand nine and as adjusted for the inflation pursuant to paragraph (c) of subdivision [ten] FOUR of this section, as otherwise modified by any applicable statutes, and as further adjusted as the commissioner deems appropriate, including transition adjustments. Such rates shall be determined on a per case basis or per diem basis, as set forth in regulations promulgated by the commissioner.

(B) The operating component of outpatient specialty rates of hospitals subject to this subparagraph shall reflect the use of two thousand seven operating costs as reported to the department prior to December first, two thousand eight, and shall include such adjustments as the commissioner deems appropriate.

(C) The base period reported operating costs used to establish inpatient and outpatient rates determined pursuant to this subparagraph shall be updated no less frequently than every two years and each such hospital shall submit such additional data as the commissioner may require to assist in the development of ambulatory patient groups (APGs) rates for such hospitals' outpatient specialty services.

(D) Notwithstanding any other provisions of law to the contrary and subject to the availability of federal financial participation, for all rate periods on and after April first, two thousand fourteen, the operating component of outpatient specialty rates of hospitals subject to this subparagraph shall be determined by the commissioner pursuant to regulations, including emergency regulations, and in consultation with such specialty outpatient facilities, provided however, that for the period beginning October first, two thousand thirteen through September thirtieth, two thousand fourteen, services provided to patients enrolled

in medicaid managed care shall be paid by the medicaid managed care plans at no less than the otherwise applicable medicaid fee-for-service rates, as computed in accordance with clause (B) of this subparagraph for the period beginning October first, two thousand thirteen through March thirty-first, two thousand fourteen and as computed in accordance with this clause for the period beginning April first, two thousand fourteen through September thirtieth, two thousand fourteen.

(v) Rates established pursuant to this paragraph shall be deemed as excluding reimbursement for physician services for inpatient services and claims for Medicaid fee payments for such physician services for such inpatient care may be submitted separately from the rate in accordance with otherwise applicable law.

(vi) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this paragraph shall remain subject to the provisions of subdivision [eight] THREE of this section.

(vii) The commissioner may promulgate regulations, including emergency regulations, implementing the provisions of this paragraph.

(viii) The operating cost component of rates of payment pursuant to this paragraph for a general hospital or distinct unit of a general hospital without adequate cost experience shall be based on the lower of the facility's or unit's inpatient budgeted operating costs per day, adjusted to actual, or the applicable regional ceiling, if any.

(ix) The operating cost component of inpatient medicaid rates subject to subparagraphs (i), (ii) and (iii) of this paragraph shall, with regard to alternative level of care (ALC) days of care be subject to computation pursuant to paragraph [(h)] (D) of this subdivision[.

(f) where a general hospital having two hundred or less certified acute care beds, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety, is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, such general hospital may at its option have its reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group based one hundred percent on the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with subdivision six of this section; provided however, commencing April first, nineteen hundred ninety-six the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group for patients eligible for payments made by state governmental agencies shall be reduced by five percent to encourage improved productivity and efficiency. Such election shall not alter the calculation of the group price component calculated pursuant to subparagraph (i) of paragraph (a) of subdivision seven of this section;

(f) where a general hospital having two hundred or less certified acute care beds, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety, is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, such general hospital may at its option have its

reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group based one hundred percent on the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with subdivision six of this section; provided however,

(i) commencing April first, nineteen hundred ninety-six through July thirty-first, nineteen hundred ninety-six, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by state governmental agencies shall be reduced by five percent; and

(ii) commencing August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by state governmental agencies shall be reduced by two and five-tenths percent; and

(iii) commencing April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and commencing July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and for periods commencing April first, two thousand five through March thirty-first, two thousand six and for periods commencing on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods commencing on and after April first, two thousand seven through March thirty-first, two thousand nine, and for periods commencing on and after April first, two thousand nine through March thirty-first, two thousand eleven, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by state governmental agencies shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. Such election shall not alter the calculation of the group price component calculated pursuant to subparagraph (i) of paragraph (a) of subdivision seven of this section;

(g) in cases where general hospitals or distinct units of general hospitals, other than those specified in paragraphs (e) and (f) of this subdivision, may be excluded from case based payments or receive an adjustment to case based payment rates. An exclusion or adjustment shall be provided only where the council, subject to the approval of the commissioner, determines that the case based rates of payment determined in accordance with this section would not reflect medically appropriate patterns of health resource use for such general hospital services efficiently and economically provided. If an exclusion is provided, then the reimbursement provisions contained in paragraph (e) of this subdivision shall apply. The commissioner shall provide to the council an analysis of the effect of case based payments on rural general hospitals and the council, subject to the above criteria and the approval of the commissioner, may exclude for any of the annual rate periods beginning on or after January first, nineteen hundred eighty-eight any of these general hospitals from case based payments or provide an adjustment to the case based payments in addition to that authorized in accordance with paragraph (f) of this subdivision];

[(h)] (D) where alternate level of care (ALC) days are provided, a factor as determined in [subparagraph (i) of] this paragraph for the costs of these patients in a general hospital shall not be included in computations relating to the determination of general hospital case based rates of payment pursuant to this section. Alternate level of care days shall be days of care provided by a general 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 and are being provided by the general hospital. Separate rates of payment shall be established for such patients based on the level of care required and shall reflect[: (i)] operating costs based on the nineteen hundred eighty-seven regional average operating cost component of rates of payment for hospital based residential health care facilities determined in accordance with section twenty-eight hundred eight of this article and trended to the rate period[, and (ii) additions contained in subparagraph (iii) of paragraph (a) of subdivision one of this section]. In the event that federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the rates calculated in accordance with this paragraph is not approved by the federal government, the council subject to the approval of the commissioner shall adopt regulations for such payments;

[(i) if diagnosis-related groups are not adjusted or established in accordance with paragraph (a) of subdivision three of this section for services to acquired immune deficiency syndrome (AIDS) patients, then general hospitals shall receive separate payments for these patients based on regulations adopted by the council and approved by the commissioner;

(j)] (E) where general hospitals or distinct units of general hospitals are excluded from or receive an adjustment to case based payments per diagnosis-related group in accordance with [paragraph (e), (f) or (g) of] this subdivision, reimbursement shall continue to be calculated in accordance with [such paragraph] THIS SUBDIVISION until the beginning of the rate period immediately following the date when the general hospital or the distinct unit of the general hospital is no longer excluded from or no longer receives an adjustment to case based payments per diagnosis-related group for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare), or until appropriate diagnosis-related groups have been developed for the specialized service provided by the general hospital or distinct unit of the general hospital[, pursuant to paragraph (a) of subdivision three of this section]; and

[(k) for facilities designated by the federal department of health and human services as an exempt acute care children's hospital, payment effective January first, nineteen hundred ninety-four will be based upon a hospital specific case payment amount inclusive of high cost and high length of stay outlier costs. The nineteen hundred eighty-seven base year cost, trended, volume adjusted and case mix adjusted where applicable to nineteen hundred ninety-two, trended will be utilized to determine the rate of payment effective January first, nineteen hundred ninety-four. Commencing April first, nineteen hundred ninety-six, the operating cost component of rates of payment for patients eligible for payments made by a state governmental agency shall be reduced by five percent to encourage improved productivity and efficiency. The facility will be eligible to receive the financial incentives for the physician

specialty weighting incentive towards primary care pursuant to subparagraph (ii) of paragraph (a) of subdivision twenty-five of this section.

(k) for facilities designated by the federal department of health and human services as an exempt acute care children's hospital, payment effective January first, nineteen hundred ninety-four will be based upon a hospital specific case payment amount inclusive of high cost and high length of stay outlier costs. The nineteen hundred eighty-seven base year cost, trended, volume adjusted and case mix adjusted where applicable to nineteen hundred ninety-two, trended will be utilized to determine the rate of payment effective January first, nineteen hundred ninety-four.

(i) Commencing April first, nineteen hundred ninety-six through July thirty-first, nineteen hundred ninety-six, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by a state governmental agency shall be reduced by five percent; and

(ii) commencing August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by a state governmental agency shall be reduced by two and five-tenths percent; and

(iii) commencing April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and commencing July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and commencing April first, two thousand five through March thirty-first, two thousand six, and for periods commencing on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods commencing on and after April first, two thousand seven through March thirty-first, two thousand nine, and for periods commencing on and after April first, two thousand nine through March thirty-first, two thousand eleven, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by a state governmental agency shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. The facility will be eligible to receive the financial incentives for the physician specialty weighting incentive towards primary care pursuant to subparagraph (ii) of paragraph (a) of subdivision twenty-five of this section.

(l)] (F) Notwithstanding any inconsistent provision of this section and subject to the availability of federal financial participation, rates of payment by governmental agencies for general hospitals which are certified by the office of alcoholism and substance abuse services to provide inpatient detoxification and withdrawal services and, with regard to inpatient services provided to patients discharged on and after December first, two thousand eight and who are determined to be in diagnosis-related groups as defined by the commissioner and published on the New York state department of health website, shall be made on a per diem basis in accordance with the following:

(i) for the period December first, two thousand eight through March thirty-first, two thousand nine, seventy-five percent of the operating cost component of such rates of payments shall reflect the operating cost component of rates of payment effective for December thirty-first,

two thousand seven, as adjusted for inflation pursuant to paragraph (c) of subdivision [ten] FOUR of this section, as otherwise modified by any applicable statutes, and twenty-five percent of such rates shall reflect the use of two thousand six operating costs as reported by each facility to the department prior to two thousand eight and as computed in accordance with the provisions of subparagraph (iv) of this paragraph;

(ii) for the period April first, two thousand nine through March thirty-first, two thousand ten, thirty-seven and five tenths percent of the operating cost component of such rates of payment shall reflect the operating cost component of rates of payment effective December thirty-first, two thousand seven, as adjusted for inflation pursuant to paragraph (c) of subdivision [ten] FOUR of this section, as otherwise modified by any applicable statutes, and sixty-two and five tenths percent of such rates of payment shall reflect the use of two thousand six operating costs as reported by each facility to the department prior to two thousand eight and as computed in accordance with the provisions of subparagraph (iv) of this paragraph;

(iii) for periods on and after April first, two thousand ten, one hundred percent of the operating cost component of such rates of payment shall reflect the use of two thousand six operating costs as reported to the department prior to two thousand eight and as computed in accordance with the provisions of subparagraph (iv) of this paragraph.

(iv) rates of payment computed in accordance with this paragraph and reflecting the use of two thousand six base year operating costs shall be in accord with the following, provided, however that the commissioner may establish criteria under which reimbursement may be provided at higher percentages and for longer periods.

(A) For each of the regions within the state as described in clause (E) of this subparagraph the commissioner shall determine the average per diem cost incurred by general hospitals in that region subject to the provisions of this paragraph with regard to inpatients requiring medically managed detoxification services, as defined by applicable regulations promulgated by the office of alcoholism and substance abuse services. In determining such costs the commissioner shall utilize two thousand six costs and statistics as reported by such hospitals to the department prior to two thousand eight.

(B) Per diem payments for inpatients requiring medically managed inpatient detoxification services shall reflect one hundred percent of the per diem amounts computed pursuant to clause (A) of this subparagraph for the applicable region in which the facility is located and as trended forward to adjust for inflation, provided however, that such payments shall be reduced by fifty percent for any such services provided on or after the sixth day of services through the tenth day of services, and further provided that no payments shall be made for any services provided on or after the eleventh day.

(C) Per diem payments for inpatients requiring medically supervised withdrawal services, as defined by applicable regulations promulgated by the office of alcoholism and substance abuse services, shall reflect one hundred percent of the per diem amounts computed pursuant to clause (A) of this subparagraph for the applicable region in which the facility is located for the period January first, two thousand nine through December thirty-first, two thousand nine, and as trended forward to adjust for inflation, and shall reflect seventy-five percent of such per diem amounts for periods on and after January first, two thousand ten, as trended forward to adjust for inflation, provided, however, that such payments shall be reduced by fifty percent for any services provided on

or after the sixth day of services through the tenth day of services, and further provided that no payments shall be made for any services provided on and after the eleventh day.

(D) Per diem payments for inpatients placed in observation beds, as defined by applicable regulations promulgated by the office of alcoholism and substance abuse services, shall be at the same level as would be paid pursuant to clause (A) of this paragraph, provided, however, that such payments shall not apply for more than two days of care, after which payments for such inpatients shall reflect their designation as requiring either medically managed detoxification services or medically supervised withdrawal services, and further provided that days of care provided in such observation beds shall, for reimbursement purposes, be fully reflected in the computation of the initial five days of care as set forth in clauses (A) and (B) of this subparagraph.

(E) For the purposes of this paragraph, the regions of the state shall be as follows:

(I) New York city, consisting of the counties of Bronx, New York, Kings, Queens and Richmond;

(II) Long Island, consisting of the counties of Nassau and Suffolk;

(III) Northern metropolitan, consisting of the counties of Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester;

(IV) Northeast, consisting of the counties of Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington;

(V) Utica/Watertown, consisting of the counties of Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida;

(VI) Central, consisting of the counties of Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga and Tompkins;

(VII) Rochester, consisting of Monroe, Ontario, Livingston, Wayne and Yates;

(VIII) Western, consisting of the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

(F) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this paragraph shall remain subject to the provisions of subdivision [eight] THREE of this section.

[5. Reimbursable inpatient operating cost component. (a) The reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group for general hospital inpatient hospital services shall be the product of the average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (b) of this subdivision, adjusted by a third-party payor of hospital services for uncovered services by such payor, and the weighting factors determined in accordance with paragraph (c) of subdivision three of this section.

(b) (i) For the rate year January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred eighty-eight, average reimbursable inpatient operating cost per discharge shall be a composite sum of no less than ninety percent of the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (a) of subdivision six of this section and a percentage amount not to exceed ten percent of the general hospital's group category average inpatient reimbursable operating cost per discharge (price) determined in accordance with paragraph (a) of

subdivision seven of this section such that the composite sum equals one hundred percent.

(ii) For the rate year commencing January first, nineteen hundred eighty-nine, average reimbursable inpatient operating cost per discharge shall be a composite sum of no less than seventy-five percent of the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (a) of subdivision six of this section and a percentage amount not to exceed twenty-five percent of the general hospital's group category average inpatient reimbursable operating cost per discharge (price) determined in accordance with paragraph (a) of subdivision seven of this section, such that the composite sum equals one hundred percent.

(iii) Except as provided in clause (C) of this subparagraph, for annual rate years commencing on or after January first, nineteen hundred ninety, average reimbursable inpatient operating cost per discharge shall be a composite sum of no less than forty-five percent of the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (a) of subdivision six of this section and a percentage amount not to exceed fifty-five percent of the general hospital's group category average inpatient reimbursable operating cost per discharge (price) determined in accordance with paragraph (a) of subdivision seven of this section, such that the composite sum equals one hundred percent.

(A) Except as provided in clause (B) of this subparagraph and subparagraph (iv) of this paragraph, for annual rate years commencing on or after January first, nineteen hundred ninety, average reimbursable inpatient operating cost per discharge shall be a composite sum of no less than forty-five percent of the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (a) of subdivision six of this section and a percentage amount not to exceed fifty-five percent of the general hospital's group category average inpatient reimbursable operating cost per discharge (price) determined in accordance with paragraph (a) of subdivision seven of this section, such that the composite sum equals one hundred percent.

(A) Except as provided in clauses (B) and (C) of this subparagraph and subparagraphs (iv), (v) and (vi) of this paragraph, for annual rate years commencing on or after January first, nineteen hundred ninety, average reimbursable inpatient operating cost per discharge shall be a composite sum of no less than forty-five percent of the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined in accordance with paragraph (a) of subdivision six of this section and a percentage amount not to exceed fifty-five percent of the general hospital's group category average inpatient reimbursable operating cost per discharge (price) determined in accordance with paragraph (a) of subdivision seven of this section, such that the composite sum equals one hundred percent.

(B) For discharges on or after April first, nineteen hundred ninety-five for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies assigned to one of the twenty most common diagnosis-related groups for all general hospitals, the average reimbursable inpatient operating cost per discharge of a general hospital shall be the lower of (I) the amount determined in accordance with clause (A) of this subparagraph or (II) the average amount determined in accordance with clause (A) of this subparagraph for all general hospitals in the group category to which

the hospital is assigned. The twenty most common diagnosis-related groups shall be determined using discharge data for the year two years prior to the rate year for all general hospitals, excluding beneficiaries of title XVIII of the federal social security act (medicare) and patients assigned to diagnosis related groups for human immunodeficiency virus (HIV) infection, acquired immune deficiency syndrome, alcohol/drug use or alcohol/drug induced organic mental disorders, and exempt unit or exempt hospital patients.

(C) (I) For discharges on or after July first, two thousand six through December thirty-first, two thousand six, and subject to the availability of federal financial participation, rates of payment by state governmental agencies to Westchester medical center shall be increased by an aggregate amount of twenty-five million dollars to assist the medical center to maintain critically needed health care services.

(II) For discharges on or after January first, two thousand seven through December thirty-first, two thousand seven, and subject to the availability of federal financial participation, rates of payment by state governmental agencies to Westchester medical center shall be increased by an aggregate amount of twenty-five million dollars to assist the medical center to maintain critically needed health care services.

(III) For discharges on or after January first, two thousand eight through December thirty-first, two thousand eight, and subject to the availability of federal financial participation, rates of payment by state governmental agencies to Westchester medical center shall be increased by an aggregate amount of twenty-five million dollars to assist the medical center to maintain critically needed health care services.

(iv) for discharges on or after April first, nineteen hundred ninety-six for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average reimbursable inpatient operating cost per discharge of a general hospital shall be the sum of:

(A) the amount determined in accordance with clause (B) of subparagraph (iii) of this paragraph, excluding the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge, and excluding the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital specific average reimbursable inpatient operating cost per discharge, and excluding the value of fifty-five percent of the indirect medical education expenses reflected in a general hospital's group category average inpatient reimbursable operating cost per discharge in accordance with subdivision twenty-five of this section as amended;

(B) minus five percent of the amount determined in accordance with clause (A) of this subparagraph;

(C) plus the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge;

(D) minus five percent of the costs of hospital based physicians reflected in the direct medical education amount determined in accordance with clause (C) of this subparagraph;

(E) plus the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge; and

(F) plus the value of fifty-five percent of the indirect medical education expenses reflected in the general hospital's group category average inpatient operating cost per discharge in accordance with subdivision twenty-five of this section as amended.

(iv) for discharges on or after April first, nineteen hundred ninety-six for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average reimbursable inpatient operating cost per discharge of a general hospital shall to encourage improved productivity and efficiency be the sum of:

(A) the amount determined in accordance with clause (B) of subparagraph (iii) of this paragraph, excluding the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge, and excluding the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital specific average reimbursable inpatient operating cost per discharge, and excluding the value of fifty-five percent of the indirect medical education expenses reflected in a general hospital's group category average inpatient reimbursable operating cost per discharge in accordance with subdivision twenty-five of this section as amended;

(B) minus five percent of the amount determined in accordance with clause (A) of this subparagraph;

(C) plus the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge;

(D) minus five percent of the costs of hospital based physicians reflected in the direct medical education amount determined in accordance with clause (C) of this subparagraph;

(E) plus the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge; and

(F) plus the value of fifty-five percent of the indirect medical education expenses reflected in the general hospital's group category average inpatient operating cost per discharge in accordance with subdivision twenty-five of this section as amended.

(iv) for discharges on or after April first, nineteen hundred ninety-six through July thirty-first, nineteen hundred ninety-six for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average reimbursa-

ble inpatient operating cost per discharge of a general hospital shall, to encourage improved productivity and efficiency, be the sum of:

(A) the amount determined in accordance with clause (B) of subparagraph (iii) of this paragraph, excluding the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge, and excluding the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital specific average reimbursable inpatient operating cost per discharge, and excluding the value of fifty-five percent of the indirect medical education expenses reflected in a general hospital's group category average inpatient reimbursable operating cost per discharge in accordance with subdivision twenty-five of this section as amended;

(B) minus five percent of the amount determined in accordance with clause (A) of this subparagraph;

(C) plus the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge;

(D) minus five percent of the costs of hospital based physicians reflected in the direct medical education amount determined in accordance with clause (C) of this subparagraph;

(E) plus the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge; and

(F) plus the value of fifty-five percent of the indirect medical education expenses reflected in the general hospital's group category average inpatient operating cost per discharge in accordance with subdivision twenty-five of this section as amended.

(v) for discharges on or after August first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average reimbursable inpatient operating cost per discharge of a general hospital shall, to encourage improved productivity and efficiency, be the sum of:

(A) the amount determined in accordance with clause (B) of subparagraph (iii) of this paragraph, excluding the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge, and excluding the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital specific average reimbursable inpatient operating cost per discharge, and excluding the value of fifty-five percent of the indirect medical education expenses reflected in a general hospital's group category average inpatient reimbursable operating

cost per discharge in accordance with subdivision twenty-five of this section as amended;

(B) minus two and five-tenths percent of the amount determined in accordance with clause (A) of this subparagraph;

(C) plus the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge;

(D) minus two and five-tenths percent of the costs of hospital based physicians reflected in the direct medical education amount determined in accordance with clause (C) of this subparagraph;

(E) plus the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge; and

(F) plus the value of fifty-five percent of the indirect medical education expenses reflected in the general hospital's group category average inpatient operating cost per discharge in accordance with subdivision twenty-five of this section as amended.

(vi) for discharges on or after April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and for discharges on or after July first, nineteen hundred ninety-nine through March thirty-first, two thousand and for discharges on or after April first, two thousand through March thirty-first, two thousand five and for discharges on or after April first, two thousand five through March thirty-first, two thousand six, and for discharges on or after April first, two thousand six through March thirty-first, two thousand seven, and for discharges on or after April first, two thousand seven through March thirty-first, two thousand nine, and for discharges on or after April first, two thousand nine through March thirty-first, two thousand eleven, for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average reimbursable inpatient operating cost per discharge of a general hospital shall, to encourage improved productivity and efficiency, be the sum of:

(A) the amount determined in accordance with clause (B) of subparagraph (iii) of this paragraph, excluding the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge, and excluding the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge, and excluding the value of fifty-five percent of the indirect medical education expenses reflected in a general hospital's group category average inpatient reimbursable operating cost per discharge in accordance with subdivision twenty-five of this section as amended;

(B) minus three and thirty-three hundredths percent of the amount determined in accordance with clause (A) of this subparagraph;

(C) plus the value of direct medical education expenses, as defined in subparagraph (i) of paragraph (c) of subdivision seven of this section,

reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge and group category average inpatient reimbursable operating cost per discharge;

(D) minus three and thirty-three hundredths percent of the costs of hospital based physicians reflected in the direct medical education amount determined in accordance with clause (C) of this subparagraph;

(E) plus the value of forty-five percent of the indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, reflected in the general hospital's hospital-specific average reimbursable inpatient operating cost per discharge; and

(F) plus the value of fifty-five percent of the indirect medical education expenses reflected in the general hospital's group category average inpatient operating cost per discharge in accordance with subdivision twenty-five of this section as amended.

(c) Notwithstanding any inconsistent provision of this section, commencing July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and for periods on and after April first, two thousand five through March thirty-first, two thousand six, and for periods on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods on and after April first, two thousand seven through March thirty-first, two thousand nine, and for periods on and after April first, two thousand nine through March thirty-first, two thousand eleven, rates of payment for a general hospital for patients eligible for payments made by state governmental agencies shall be further reduced by the commissioner to encourage improved productivity and efficiency by providers by a factor determined as follows:

(i) an aggregate reduction shall be calculated for each general hospital commencing July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and for periods on and after April first, two thousand five through March thirty-first, two thousand six, and for periods on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods on and after April first, two thousand seven through March thirty-first, two thousand nine, and for periods on and after April first, two thousand nine through March thirty-first, two thousand eleven, as the result of (A) eighty-nine million dollars on an annualized basis for each year, multiplied by (B) the ratio of patient days for patients eligible for payments made by state governmental agencies provided in a base year two years prior to the rate year by a general hospital, divided by the total of such patient days summed for all general hospitals; and

(ii) (A) the result for each general hospital shall be allocated to units within such hospital exempt from case based rates of payment based on the ratio of such patient days provided in the exempt unit to the total of such patient days provided by the general hospital, and (B) the result divided by such patient days provided in the exempt unit, for a per diem unit of service reduction in rates of payment for such exempt unit for patients eligible for payments made by state governmental agencies for such general hospital; and

(iii) any amount not allocated to exempt units shall be divided by case based discharges (or for exempt hospitals by patient days) in the base year two years prior to the rate year for patients eligible for payments made by state governmental agencies, for a per case (or for exempt hospitals a per diem) unit of service reduction in rates of payment for patients eligible for payments made by state governmental agencies for such general hospital.

6. Operating costs. (a) A general hospital's hospital-specific average reimbursable inpatient operating cost per discharge shall be determined in accordance with rules and regulations adopted by the council and approved by the commissioner based on the hospital's reimbursable inpatient operating cost base determined in accordance with paragraph (d) of subdivision one of this section; adjusted in accordance with paragraph (b) of this subdivision to reflect exceptions to case payments; and projected to the applicable rate period by a trend factor determined in accordance with subdivision ten of this section; and increased in accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of subdivision one of this section to reflect special additional inpatient operating costs; and adjusted in accordance with subparagraphs (i), (ii) and (iv) of paragraph (c) of this subdivision to reflect modifications to case payments; and standardized to reflect nineteen hundred eighty-seven hospital case mix. A general hospital's hospital-specific average reimbursable inpatient operating cost per discharge shall be adjusted on a payor category basis to reflect allocation of malpractice insurance costs in accordance with the methodology developed pursuant to subparagraph (ii) of paragraph (h) of subdivision eleven of this section.

(b) In accordance with rules and regulations adopted by the council and approved by the commissioner, the commissioner shall adjust reimbursable inpatient operating costs and discharges to exclude operating costs and statistics related to specialized hospital services for which an alternative reimbursement methodology is adopted pursuant to paragraph (e) or (g) of subdivision four of this section, a factor for operating costs of patients who required an alternate level of care in accordance with paragraph (h) of subdivision four of this section and the operating costs and statistics of AIDS patients pursuant to paragraph (i) of subdivision four of this section if effective.

(c) In accordance with rules and regulations adopted by the council and approved by the commissioner, the commissioner shall adjust weighting factors developed pursuant to paragraph (c) of subdivision three of this section and reimbursable inpatient operating costs and statistics on which case payment rates are based to take into account the provisions for additional payments in accordance with paragraph (a), (b), (c) or (d) of subdivision four of this section. The rules and regulations are to be designed to identify an estimate of costs and statistics as if the payment methodology effective for the applicable rate period including payment based on the higher of high-cost outliers or long-stay outliers was in effect during the period used to establish such costs and statistics to accomplish the following:

(i) an estimate of costs for inpatient services to patients transferred to another general hospital receiving case payment rates pursuant to paragraph (a) of subdivision four of this section shall be eliminated from reimbursable inpatient operating costs considering a transfer patient cost conversion factor determined based on nineteen hundred eighty-five data from a representative sample of general hospitals; a case mix neutral acute care cost component of a general hospital's reimbursable inpatient operating cost base per day after application of the

trend factor and the addition of special additional inpatient operating costs; transfer patient days incurred by such general hospital in nineteen hundred eighty-seven or the number of such transfer patient days during a recent twelve month period prior thereto established by regulation for which data are available subsequently reconciled by an adjustment to reflect nineteen hundred eighty-seven data; and the specific diagnosis-related groups with which the transfer patients are identified. Such costs shall be eliminated in accordance with rules and regulations adopted by the council and approved by the commissioner which shall contain the specific methodology to adequately identify the costs related to transfer cases. Transfer cases shall be eliminated in computing discharges of the transferring hospital. The costs and discharges for transfer cases for each general hospital participating in the determination of the weighting factors shall be removed before calculating the weighting factors;

(ii) an estimate of costs for the outlier portion of inpatient services which would qualify for additional payments as cost outliers in accordance with paragraph (b) of subdivision four of this section shall be eliminated from reimbursable inpatient operating costs based on a general hospital's high cost percentage outlier factor, applied to an acute care cost component of such general hospital's reimbursable inpatient operating cost base after application of the trend factor and the addition of special additional inpatient operating costs. The high cost percentage outlier factor shall be calculated based on a determination of the percentage of nineteen hundred eighty-seven discharges of patients other than beneficiaries of title XVIII of the federal social security act (medicare) for which the commissioner has complete hospital bill submissions or such discharges during a recent twelve month period prior thereto established by regulation for which hospital bills are available, as follows, (a) for general hospitals that have complete hospital bill submissions for at least ninety percent of their discharges, a high cost percentage outlier factor based on such data, and (b) for general hospitals that have complete hospital bill submissions for at least eighty percent but less than ninety percent of their discharges, a high cost percentage outlier factor based on such data plus an additional one-quarter of one percent, and (c) for general hospitals that have complete bill submissions for less than eighty percent of their discharges, a high cost percentage outlier factor determined based on nineteen hundred eighty-five data from a representative sample of general hospitals plus an additional one-quarter of one percent. The calculation of the high cost percentage outlier factor shall be subsequently reconciled by an adjustment to reflect the percentage of such complete hospital bill submissions for such nineteen hundred eighty-seven discharges as submitted to the commissioner prior to August first, nineteen hundred eighty-eight.

The minimum percentage threshold applicable pursuant to clause (a) of the first paragraph of this subparagraph may be increased to "at least ninety-five percent" and the percentage ceiling applicable pursuant to clause (b) of the first paragraph of this subparagraph increased to "less than ninety-five percent" pursuant to rules and regulations adopted by the council and approved by the commissioner based upon a study and a report by the commissioner of a sample of incomplete discharge records which showed that there was a significant difference in the value of high cost outlier cases potentially reflected in incomplete records from the value of high cost outlier cases reflected in

records for which the commissioner has complete hospital bill submissions.

The maximum amount to be eliminated on a statewide basis shall be three percent of the total of nineteen hundred eighty-eight acute care cost components of general hospital reimbursable inpatient operating costs reimbursed on the case payment system. In the event that the total amount as calculated exceeds three percent, the calculated amount will be reduced to three percent by the application of a percentage computed by dividing expected outlier costs based on the three percent by actual outlier costs, which shall also be the percentage of outlier costs to be reimbursed in the payment year. The costs for the outlier portion of cost outliers for general hospitals participating in the determination of the weighting factors shall be removed from each diagnosis-related group before determining the weighting factors;

(iii) an estimate of inpatient costs which are related to a hospital stay in excess of the long stay threshold for long stay patients as defined in paragraph (c) of subdivision four of this section shall be eliminated from reimbursable inpatient operating costs in determining group category average inpatient reimbursable operating costs considering a long stay patient cost conversion factor, which shall be established at sixty percent provided, however, such long stay patient cost conversion factor may be revised for an annual rate period or periods beginning on or after January first, nineteen hundred eighty-nine in accordance with rules and regulations adopted by the council and approved by the commissioner; a case mix neutral acute care cost component of a general hospital's reimbursable inpatient operating cost base per day after application of the trend factor and the addition of special additional inpatient operating costs; long stay patient days incurred by such general hospital in nineteen hundred eighty-seven or the number of such long stay patient days during a recent twelve month period prior thereto established by regulation for which data are available subsequently reconciled by an adjustment to reflect nineteen hundred eighty-seven data; and the specific diagnosis-related groups with which the long stay patients are identified. The long stay outlier thresholds shall be determined by adding a sufficient number of standard deviations to the mean length of stay for each diagnosis-related group such that it is estimated for rates of payment during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety based upon nineteen hundred eighty-five data from a representative sample of general hospitals and for rates of payment during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three based upon nineteen hundred eighty-nine data from a representative sample of general hospitals and for rates of payment during the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-nine and periods on and after January first, two thousand based upon nineteen hundred ninety-two data from a representative sample of general hospitals that the costs associated with the portion of hospital stays in excess of the long stay outlier thresholds do not exceed three percent of the total of the acute care cost components of reimbursable inpatient operating costs related to the determination of case based rates of payment. The costs associated with the outlier portion of long stay outliers for each general hospital participating in the determination of the weighting factors shall be removed from each diagnosis-related group before calculating the weighting factors;

(iv) an estimate of inpatient costs which are related to short stay patients as defined in paragraph (d) of subdivision four of this section shall be eliminated from reimbursable inpatient operating costs considering a short stay patient cost conversion factor determined based on nineteen hundred eighty-five data from a representative sample of general hospitals; a case mix neutral acute care cost component of a general hospital's reimbursable inpatient operating cost base per day after application of the trend factor and the addition of special additional inpatient operating costs; short stay patient days incurred by such general hospital in nineteen hundred eighty-seven or the number of such short stay patient days during a recent twelve month period prior thereto established by regulation for which data are available subsequently reconciled by an adjustment to reflect nineteen hundred eighty-seven data; and the specific diagnosis-related groups with which the short stay patients are identified. Such costs shall be eliminated in accordance with rules and regulations adopted by the council and approved by the commissioner which shall contain the specific methodology to adequately identify the costs related to short stay patients. Short stay cases shall be eliminated in computing discharges of a general hospital. The costs and discharges for short stay cases for each general hospital participating in the determination of the weighting factors shall be removed before calculating the weighting factors.

7. Operating cost group component. (a) A general hospital's group category average inpatient reimbursable operating cost per discharge (price) shall be a composite factor determined in accordance with rules and regulations adopted by the council and approved by the commissioner based on a group price component determined in accordance with subparagraph (i) of this paragraph, a hospital-specific price component determined in accordance with subparagraph (ii) of this paragraph, and an adjustment in accordance with subparagraph (iii) of this paragraph.

(i) The group price component shall be based on the costs and statistics of general hospitals in the group category established pursuant to paragraph (b) of this subdivision to which the hospital is assigned by the commissioner to compute a group based average inpatient reimbursable operating cost per discharge for the group category. General hospital costs and statistics shall be determined consistent with the methodology to determine hospital-specific average reimbursable inpatient operating cost per discharge pursuant to subdivision six of this section; adjusted to reflect additional cost increases in accordance with subparagraph (ii) of paragraph (e) of subdivision one of this section; and adjusted to exclude the components of hospital-specific inpatient reimbursable operating costs related to education, physician, ambulance services and organ acquisition costs determined in accordance with paragraph (c) of this subdivision and malpractice insurance costs, and the components of special additional inpatient operating costs determined and allocated in accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of subdivision one of this section associated with cost increases in such costs; and adjusted to exclude the components of special additional inpatient operating costs determined and allocated in accordance with clauses (B), (D), (H), and (I) of subparagraph (iii) and clauses (A), (E) and (F) of subparagraph (iv) of paragraph (e) of subdivision one of this section; and adjusted to reflect additional modifications to case payments in accordance with subparagraph (iii) of paragraph (c) of subdivision six of this section. The group based average inpatient reimbursable operating costs computed for a general hospital shall be adjusted to reflect the hospital-specific indirect medical education

costs percentage of such hospital determined in accordance with subparagraph (ii) of paragraph (c) of this subdivision.

Hospital costs shall be standardized for comparison purposes considering differences in wage and wage-related costs levels and such other economic factors, such as a power equalization factor, as may be determined in accordance with rules and regulations adopted by the council and approved by the commissioner.

(ii) A hospital-specific price component shall be determined for each general hospital based on such hospital's hospital-specific education, physician, ambulance services and organ acquisition costs determined in accordance with subparagraphs (i), (iii) and (iv) of paragraph (c) of this subdivision and malpractice insurance costs, and the components of special additional inpatient operating costs determined and allocated in accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of subdivision one of this section associated with cost increases in such costs, and special additional inpatient operating costs determined and allocated in accordance with clauses (B), (D), (H) and (I) of subparagraph (iii) and clauses (A), (E) and (F) of subparagraph (iv) of paragraph (e) of subdivision one of this section, as excluded pursuant to subparagraph (i) of this paragraph, per discharge, standardized to reflect nineteen hundred eighty-seven hospital case mix.

(iii) A general hospital's group category average inpatient reimbursable operating cost per discharge shall be adjusted on a payor category basis to reflect allocation of malpractice insurance costs in accordance with the methodology developed pursuant to subparagraph (ii) of paragraph (h) of subdivision eleven of this section.

(b) General hospital group categories shall be established in accordance with rules and regulations adopted by the council and approved by the commissioner for purposes of computing group category average inpatient reimbursable operating cost per discharge considering, but not limited to, factors such as hospital size, hospital medical education activity, teaching status and geographic divisions of the state.

(c) Education, physician, ambulance services and organ acquisition costs shall include:

(i) direct medical education expenses, defined as the reimbursable costs of residents, fellows, and supervising physicians, combined with the costs of hospital based physicians;

(ii) indirect medical education expenses, defined as an estimate of the costs, other than direct costs, of educational activities in teaching hospitals attributable to factors including but not limited to increased overhead, more severely ill patients and the tendency of residents to provide more tests than experienced licensed physicians. For the rate period beginning January first, nineteen hundred eighty-eight and ending December thirty-first, nineteen hundred eighty-eight, an estimate of indirect medical education costs shall be determined in accordance with the methodology applicable for purposes of determining an estimate of indirect medical education costs for reimbursement for inpatient hospital service pursuant to title XVIII of the federal social security act (medicare) in effect on the first day of July in the year preceding the rate period. The council may adopt rules and regulations, subject to the approval of the commissioner, to revise the methodology for the determination of an estimate of indirect medical education costs to reflect revisions to the methodology applicable for purposes of determining reimbursement for inpatient hospital service pursuant to title XVIII of the federal social security act (medicare) effective subsequent to the first day of July in the year preceding the rate peri-

od. For annual rate periods beginning on or after January first, nineteen hundred eighty-nine an estimate of indirect medical education costs shall be determined in accordance with rules and regulations adopted by the council and approved by the commissioner;

(iii) the reimbursable costs of schools of nursing, allied professional programs and ambulance services; and

(iv) the reimbursable costs of organ acquisition services not reimbursed pursuant to the methodology applicable for purposes of reimbursement pursuant to title XVIII of the federal social security act (medicare).

(d) The commissioner shall establish, in accordance with rules and regulations adopted by the council and approved by the commissioner, the methodology to determine the hospital's group category average inpatient reimbursable operating cost per discharge (price) and the percentage amounts, pursuant to subparagraphs (i), (ii) and (iii) of paragraph (b) of subdivision five of this section, of the group category average inpatient reimbursable operating cost per discharge to be used to determine the inpatient reimbursable operating cost component of case based rates for annual rate periods beginning on or after January first, nineteen hundred eighty-eight.

8.] 3. Capital related inpatient expenses. (a) Capital related inpatient expenses including but not limited to straight line depreciation on buildings and non-movable equipment, accelerated depreciation on major movable equipment if requested by the hospital, rentals and interest on capital debt (or for hospitals financed pursuant to article twenty-eight-B of this chapter, such expenses, including amortization in lieu of depreciation, as determined pursuant to the reimbursement regulations promulgated pursuant to such article and THIS article [twenty-eight of this chapter]), shall be included in rates of payment determined pursuant to this section based on a budget for capital related inpatient expenses and subsequently reconciled to actual expenses and statistics through appropriate audit procedures. General hospitals shall submit to the commissioner, at least one hundred twenty days prior to the commencement of each year, a schedule of capital related inpatient expenses for the forthcoming year. Any capital expenditure which requires or required approval pursuant to this article must have received such approval for any capital related expense generated by such capital expenditure to be included in rates of payment. The basis for determining capital related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for the construction of the capital asset. The submitted budget may include the capital related inpatient expenses for all existing capital assets as well as estimates of capital related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the rate year or during the rate year provided all required approvals have been obtained.

The council shall adopt, with the approval of the commissioner, regulations to:

(i) identify by type the eligible capital related inpatient expenses;

(ii) safeguard the future financial viability of voluntary, non-profit general hospitals by requiring funding of inpatient depreciation on building and fixed and movable equipment;

(iii) provide authorization to adjust inpatient rates by advancing payment of depreciation as needed, in instances of capital debt related financial distress of voluntary, non-profit general hospitals; and

(iv) provide a methodology for the reimbursement treatment of sales.

(b) Capital related inpatient expenses shall be included in case based payments based on the hospital's average capital related inpatient expenses per discharge. Adjustments shall be made to capital related costs and statistics to reflect capital related inpatient expenses reimbursed on a per diem basis in accordance with [paragraphs (a), (d), (e), (g) and (i) of subdivision four] SUBDIVISION TWO of this section.

(c) In order to reconcile capital related inpatient expenses included in rates of payment based on a budget to actual expenses and statistics for the rate period for a general hospital, rates of payment for a general hospital shall be adjusted to reflect the dollar value of the difference between capital related inpatient expenses included in the computation of rates of payment for a prior rate period based on a budget and actual capital related inpatient expenses for such prior rate period, each as determined in accordance with paragraph (a) of this subdivision, adjusted to reflect increases or decreases in volume of service in such prior rate period compared to statistics applied in determining the capital related inpatient expenses component of rates of payment based on a budget for such prior rate period. [Notwithstanding any inconsistent provision of subparagraph (i) of paragraph (e) of subdivision nine of this section, capital related inpatient expenses of a general hospital included in the computation of rates of payment based on a budget shall not be included in the computation of a volume adjustment made in accordance with such subparagraph. Adjustments to rates of payment for a general hospital made pursuant to this paragraph shall be made in accordance with paragraph (c) of subdivision eleven of this section. Such adjustments shall not be carried forward except for such volume adjustment as may be authorized in accordance with subparagraph (i) of paragraph (e) of subdivision nine of this section for such general hospital.

(e)] (D) Notwithstanding any inconsistent provision of this subdivision, commencing April first, nineteen hundred ninety-five, when a factor for reconciliation of budgeted capital related inpatient expenses to actual capital related inpatient expenses for a prior year is included in the capital related inpatient expenses component of rates of payment, such capital related inpatient expenses component of rates of payment shall be reduced by the commissioner by the difference between the reconciled capital related inpatient expenses included in rates of payment determined in accordance with paragraphs (a), (b) and (c) of this subdivision for such prior year and capital related inpatient expenses for such prior year calculated based on the hospital's average capital related inpatient expenses computed on a per diem basis.

[(f)] (E) Notwithstanding any inconsistent provision of this section, commencing April first, nineteen hundred ninety-five for purposes of determining the capital related inpatient expenses component of rates of payment for patients eligible for payments made by state governmental agencies for a rate year, the submitted budget for capital related inpatient expenses of a general hospital applicable to the rate year shall be decreased by the commissioner to reflect the percentage amount by which the budget for the base year two years prior to the rate year for capital related inpatient expenses of the hospital exceeded actual expenses.

[(g)] (F) Notwithstanding any inconsistent provision of this article, commencing April first, nineteen hundred ninety-five for rates of payment for patients eligible for payments made by state governmental agencies, the capital related inpatient expenses component determined in accordance with paragraph (a) of this subdivision [and the capital cost

per visit components determined in accordance with subparagraphs (i) and (ii) of paragraph (g) of subdivision two of section twenty-eight hundred seven of this article] shall be adjusted by the commissioner to exclude such expenses related to:

(i) forty-four percent of the costs of major movable equipment; and

(ii) staff housing.

[9. Adjustments. For annual rate periods beginning on or after January first, nineteen hundred eighty-eight:

(a) The commissioner shall on his own initiative, or on the basis of a request from a general hospital, adjust an established rate to reflect:

(i) the reduction of costs related to the elimination of a general hospital inpatient service in instances where the costs of such service were included in the rate established; and

(ii) the correction of errors or omissions of data or in computation.

(b) General hospitals may request and the commissioner shall consider an adjustment to an established rate to reflect increased expenses in excess of costs reported by the general hospital in the nineteen hundred eighty-five cost report, after application of the trend factor, or reconsideration of disallowed expenses based on:

(i) justification of all or a portion of expenses not included in the rate resulting from the cost analysis process contained in subparagraph (i) of paragraph (a) of this subdivision;

(ii) additional operational expenses related to approved construction or service changes;

(iii) the addition of costs related to a state requirement for additional services to be provided or additional costs to be incurred in meeting state and federal requirements;

(iv) additional operational expenses to permit a more efficient and economical method of delivering a service;

(v) increased costs determined to be needed to recruit or maintain an appropriate level of personnel providing professional services to patients; and

(vi) increased costs for compensation of employees.

(c) In determining the reasonableness or justification of an adjustment to an established rate related to subparagraph (vi) of paragraph (b) of this subdivision, the commissioner shall consider:

(i) the fiscal capability of the general hospital to finance such increases from its own resources;

(ii) the past history of the general hospital with respect to compensation increases and allowed compensation trend factors; and

(iii) the economy in the area in which the general hospital is located.

(d) General hospitals may request and the commissioner shall consider a change in assignment among the group categories established pursuant to paragraph (b) of subdivision seven of this section to which the hospital is assigned for purposes of computing group category average reimbursable inpatient operating cost per discharge.

(e) (i) Volume adjustments which would result in revisions in case payment rates shall not be made to reflect increases or decreases in discharges for other than beneficiaries of title XVIII of the federal social security act (medicare) in rate years beginning on or after January first, nineteen hundred eighty-eight, except in those specific instances where a decrease in volume as measured by discharges, including discharges of patients for whom reimbursement is provided on a per diem basis in accordance with paragraph (a) of subdivision eleven of this section, is equal to or greater than one percent of discharges in

nineteen hundred eighty-seven for those general hospitals having two hundred or less certified acute care beds and classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety, or equal to or greater than ten percent of discharges in nineteen hundred eighty-seven for all other general hospitals, and the failure to make such adjustment seriously impacts on the financial stability of a needed hospital, and except in those specific instances where an increase in volume as measured by discharges is equal to or greater than ten percent of discharges in nineteen hundred eighty-seven. Provided, however, that an adjustment for volume increases shall not apply to those general hospitals having two hundred or less certified acute care beds and classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) or under state regulations, based on the total number of inpatient acute care beds for which such general hospital is certified pursuant to the operating certificate issued for such general hospital in accordance with section twenty-eight hundred five of this article in effect on June thirtieth, nineteen hundred ninety. For general hospitals and distinct units of general hospitals not reimbursed on a case based payment per discharge basis, volume adjustments may be made during the above indicated rate years in accordance with regulations adopted by the council and approved by the commissioner.

(ii) The commissioner shall adjust the rates for those general hospitals and units of general hospitals excluded from case payment in accordance with paragraph (e) or (g) of subdivision four of this section for case mix changes for other than beneficiaries of title XVIII of the federal social security act (medicare).

(f) General hospitals that did not qualify for a volume adjustment for the nineteen hundred eighty-six and nineteen hundred eighty-seven rate periods for rates of payment determined in accordance with section twenty-eight hundred seven-a of this article may request and the commissioner shall consider an adjustment to an established case based rate of payment for nineteen hundred eighty-eight based on increases in volume as measured by discharges, based on a comparison between nineteen hundred eighty-five and nineteen hundred eighty-seven discharges, excluding in such comparison discharges of patients who are beneficiaries of title XVIII of the federal social security act (medicare) and discharges related to transfer cases (transferring hospital) and short stay cases as defined in this section, provided such general hospital meets performance criteria established in accordance with rules and regulations adopted by the council and approved by the commissioner. Such criteria shall include but need not be limited to: maintenance of like patient occupancy rates for the rate periods nineteen hundred eighty-five, nineteen hundred eighty-six and nineteen hundred eighty-seven; a reduction in patient length of stay for other than beneficiaries of title XVIII of the federal social security act (medicare) based on a comparison with nineteen hundred eighty-five data; and an expanded use of ambulatory surgery by the general hospital based on a comparison with nineteen hundred eighty-five data. Such adjustment shall consider, but need not be limited to, the variable costs related to volume changes

in accordance with rules and regulations adopted by the council and approved by the commissioner.

(g) All appeals shall be submitted to the commissioner, who may submit a copy of the appeal to interested parties for the purpose of providing an opportunity for comment within a specified time period.

(h) The commissioner shall act upon all properly documented appeals for adjustments concerning base year costs by November first of the calendar year for which the rate is effective provided that all information necessary to determine whether an adjustment is justified is submitted by the facility prior to May first of such year. In the event such an appeal is filed by May first, but information necessary to determine whether an adjustment is justified is submitted after such date, the commissioner shall act on the appeal within six months after receiving the necessary information.

10.] 4. Trend factors. (a) The commissioner, in accordance with the methodology developed for rate periods through March thirty-first, two thousand, for rates of payment for state governmental agencies and through December thirty-first, nineteen hundred ninety-six for rates of payment for all other payors pursuant to paragraph (b) of this subdivision, shall establish trend factors to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs. The methodology for developing the trend factor shall include the appropriate external price indicators and shall also include the data from major collective bargaining agreements as reported quarterly by the federal department of labor, bureau of labor statistics, for non-supervisory employees.

(b) The methodology shall be developed for rate periods through March thirty-first, two thousand, for rates of payment for state governmental agencies and through December thirty-first, nineteen hundred ninety-six for rates of payment for all other payors by four independent consultants with expertise in health economics or reimbursement methodologies for health-related services appointed by the commissioner. For nineteen hundred ninety-six, through March thirty-first, two thousand, the commissioner shall apply the nineteen hundred ninety-five trend factor methodology. The commissioner shall monitor the actual price movements of the external price indicators used in the methodology for one interim adjustment to the trend factors to reflect such price movements and one final adjustment to the trend factors to reflect such price movements. At the same time adjustments are made to the trend factors in accordance with this paragraph, adjustments shall be made to all inpatient rates of payment affected by the adjusted trend factors.

(c) (1) For rate periods on and after April first, two thousand, the commissioner shall establish trend factors for rates of payment for state governmental agencies to project for the effects of inflation except that such trend factors shall not be applied to services for which rates of payment are established by the commissioners of the department of mental hygiene. The factors shall be applied to the appropriate portion of reimbursable costs.

(2) In developing trend factors for such rates of payment, the commissioner shall use the most recent Congressional Budget Office estimate of the rate year's U.S. Consumer Price Index for all urban consumers published in the Congressional Budget Office Economic and Budget Outlook after June first of the rate year prior to the year for which rates are being developed.

(3) After the final U.S. Consumer Price Index (CPI) for all urban consumers is published by the United States Department of Labor, Bureau

of Labor Statistics, for a particular rate year, the commissioner shall reconcile such final CPI to the projection used in subparagraph two of this paragraph and any difference will be included in the prospective trend factor for the current year.

(4) At the time adjustments are made to the trend factors in accordance with this paragraph, adjustments shall be made to all inpatient rates of payment affected by the trend factor adjustment.

[11.] 5. Special provisions. [(a) Notwithstanding any inconsistent provision of this chapter or any other law to the contrary, payment for inpatient hospital services provided on or after January first, nineteen hundred eighty-eight to a patient admitted to a general hospital prior to January first, nineteen hundred eighty-eight otherwise eligible for payment on a case based payment per discharge basis for a diagnosis-related group shall be at the rate of payment for such general hospital for such patient in effect for December thirty-first, nineteen hundred eighty-seven provided, however, that the operating cost components of such rates of payment for inpatient hospital services provided on or after January first, nineteen hundred eighty-eight shall be projected to the rate period by the trend factor determined in accordance with subdivision ten of this section and reconciled on a cumulative basis on or about March thirty-first, nineteen hundred eighty-eight and December thirty-first, nineteen hundred eighty-eight for payment of adjusted rates of payment based on such trend factor adjustment. The component of such rates of payment based on the allowances provided in accordance with paragraphs (e) and (f) of subdivision eight of section twenty-eight hundred seven-a of this article shall be returned to the applicable regional pool created in accordance with subdivision fifteen of such section and distributed in accordance with subdivision sixteen of such section based on needs for the financing of losses resulting from bad debts and the costs of charity care as determined for purposes of nineteen hundred eighty-seven distributions.

(b) The council shall adopt rules and regulations subject to the approval of the commissioner regarding payor payment responsibilities when a patient has coverage with more than one payor for general hospital inpatient services and during a hospital stay exhausts benefits available from the primary payor, or receives services not reimbursed by the primary payor, so that the hospital shall be reimbursed by a secondary payor for services not reimbursed by the primary payor that are included as a benefit of the secondary payor. A primary payor for purposes of this paragraph shall include benefits available pursuant to title XVIII of the federal social security act (medicare).

(c)(i) Adjustments to rates made pursuant to this section for rate periods commencing on or after January first, nineteen hundred ninety-seven may be made prospectively or retrospectively on the next following January or July unless otherwise specifically authorized.

(ii) The commissioner may further adjust rates retrospectively for payments by state governmental agencies upon a finding that the failure to do so seriously impacts on a general hospital's financial stability.

(iii) Regardless of whether rates are adjusted prospectively or retrospectively the authorized dollar value of the adjustment shall be the same, calculated by including the retroactive impact of such adjustment if such adjustment is made prospectively. A prospective adjustment to reflect the retroactive impact of an adjustment shall be included in the determination of rates of payment for a prospective rate period based on the methodology applied in accordance with this section for calculation of rates of payment for such prospective rate period. The

allowance reflected in payments to a general hospital or a pool related to a prospective adjustment which reflects the retroactive impact of an adjustment shall be computed based on the allowance percentage in effect during the prospective period such adjustment is in effect. No recalculation of the basis for distribution of funds from bad debt and charity care regional pools determined in accordance with subdivision seventeen of this section shall be made for a prospective adjustment which reflects the retroactive impact of an adjustment.

(d)] (A) Working capital. General hospitals may include as a financing or working capital charge an addition of two percent of any valid claim not paid within thirty days of submission or determination of payor liability, whichever is later, and one percent per month thereafter. Financing or working capital charges shall not be applied to hospital billings to third party payors participating in an advance payment system. Any payor not participating in an advance payment system or offering admission billing shall allow interim billing for a patient whose stay exceeds thirty days.

[(e)] (B) (i) Except for payments made pursuant to the workers' compensation law, the volunteer firefighters' benefit law, or the volunteer ambulance workers' benefit law, a two percent discount from general hospital payments shall be available to all payors whose payments are calculated in accordance with paragraphs [(b)] (E) and [(c)] (G) of subdivision one of this section making payment in full to a general hospital for covered hospital services within ten calendar days of receipt from the hospital by the appropriate payor of a bill for such services.

(ii) A three percentage point reduction in the differential of five percent for general hospital payments shall be available to all payors whose payments are calculated in accordance with paragraph [(b)] (E) of subdivision one or paragraph [(e)] (B) of subdivision [four] TWO of this section which are making payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law, or the volunteer ambulance workers' benefit law when such payments are made in full to a general hospital for covered hospital services within ninety calendar days of receipt from the hospital by the appropriate payor of a bill for such services, and an additional two percentage point reduction shall be available for such payors if such payment is made within forty-five calendar days of receipt of such a bill.

[(f) (i) In order to allow for real increases in general hospital case mix while limiting the effect of potential case mix changes that are the result of changes in coding practices rather than real changes in case mix, the commissioner shall annually for rate periods through December thirty-first, nineteen hundred ninety-six, in accordance with rules and regulations adopted by the council and approved by the commissioner, adjust individual general hospitals' case payment rates determined in accordance with paragraphs (a) and (b) of subdivision one of this section to account for increases in the statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups for all patients other than beneficiaries of title XVIII of the federal social security act (medicare), that exceed the allowable statewide increase determined in accordance with this subparagraph. The commissioner further shall adjust individual general hospitals' case payment rates determined in accordance with this section for state governmental agencies for the periods January first, nineteen hundred ninety-seven through March thirty-first, two thousand and on and after April first, two thousand, in accordance with clause (G) of this subpar-

agraph and to account for increases in statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups based on data only for patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law, including such patients enrolled in health maintenance organizations, that exceed the allowable statewide increase determined in accordance with clause (B-1) of this subparagraph.

(A) The increase in the statewide average case mix in a rate year during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety-three from the nineteen hundred eighty-seven statewide average case mix shall not exceed two percent in nineteen hundred eighty-eight compared to nineteen hundred eighty-seven, three percent in nineteen hundred eighty-nine compared to nineteen hundred eighty-seven, four percent in nineteen hundred ninety compared to nineteen hundred eighty-seven, five percent in nineteen hundred ninety-one compared to nineteen hundred eighty-seven, and, notwithstanding any inconsistent rule or regulation, for rates of payment for state governmental agencies six percent in nineteen hundred ninety-two compared to nineteen hundred eighty-seven and seven percent in nineteen hundred ninety-three compared to nineteen hundred eighty-seven, and for rates of payment for payors other than state governmental agencies six and seven-tenths percent in nineteen hundred ninety-two compared to nineteen hundred eighty-seven and seven percent in nineteen hundred ninety-three compared to nineteen hundred eighty-seven.

(B) The increase in the statewide average case mix in a rate year during the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six from the nineteen hundred ninety-two statewide average case mix, plus adjustments, shall not exceed: for rates of payment for state governmental agencies two percent in the period January first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-four, and, notwithstanding any inconsistent rule or regulation, six and two-tenths percent in the period July first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four, three percent in the period January first, nineteen hundred ninety-five through March thirty-first, nineteen hundred ninety-five, two percent in the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five, and three percent in the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six; and for rates of payment for payors other than state governmental agencies two percent in nineteen hundred ninety-four, three percent in nineteen hundred ninety-five, and four percent in the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six. Adjustments to the nineteen hundred ninety-two statewide average case mix shall mean an adjustment for any increase in nineteen hundred ninety-two statewide average case mix compared to nineteen hundred eighty-seven statewide average case mix in excess of six percent of nineteen hundred eighty-seven statewide average case mix and a further adjustment to reflect that measurement of case mix increase from the nineteen hundred ninety-two statewide average case mix rather than the nineteen hundred eighty-seven statewide average case mix reflects the increase in statewide average case mix from nineteen hundred eighty-seven to nineteen hundred ninety-two in order to maintain the effective maximum rate of allowable statewide average case mix increases at a percentage per year of the nineteen hundred eighty-seven statewide average case mix. Nineteen hundred ninety-two case mix shall

be determined based on nineteen hundred ninety-two data received by the department by April thirtieth, nineteen hundred ninety-three.

(B-1) The increase in the statewide average case mix in the periods January first, nineteen hundred ninety-seven through March thirty-first, two thousand and on and after April first, two thousand through March thirty-first, two thousand six and on and after April first, two thousand six through March thirty-first, two thousand seven, and on and after April first, two thousand seven through March thirty-first, two thousand nine, and on and after April first, two thousand nine through March thirty-first, two thousand eleven, from the statewide average case mix for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six shall not exceed one percent for nineteen hundred ninety-seven, two percent for nineteen hundred ninety-eight, three percent for the period January first, nineteen hundred ninety-nine through September thirtieth, nineteen hundred ninety-nine, four percent for the period October first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, and four percent for two thousand plus an additional one percent per year thereafter, based on comparison of data only for patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law, including such patients enrolled in health maintenance organizations.

(C) Rate year case mix shall be determined based on rate year data received by the department by April thirtieth next following the end of the rate year. Case mix may be determined based on general hospital data received or amended after such due dates provided, however, that a general hospital that does not submit the appropriate data in a timely manner shall be subject to the provisions of section twelve-d of this chapter.

(D) If in any rate period on an annualized basis the cumulative case mix increase exceeds the allowable statewide increase, rates of payment to general hospitals shall be adjusted in accordance with rules and regulations adopted by the council and approved by the commissioner which shall contain the specific methodology to allocate the reduction among general hospitals, in order to reduce the effect of the statewide increase on rates of payment to reflect the allowable increase. Notwithstanding any inconsistent provision of this paragraph, rate adjustments for purposes of this paragraph shall be made on a six month rate period basis for the period July first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four. The retroactive impact of adjustments to rates of payment for payors other than state governmental agencies based on the amendments to this paragraph effective July first, nineteen hundred ninety-four shall be reflected in a prospective adjustment to rates of payment for such payors for the period July first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four.

(E) Such methodology shall take into account past trends of individual general hospitals' case mix changes, and, within the aggregate allowable statewide increase in case mix, permit general hospitals to appeal to the commissioner their proposed allocation of a reduction in rates of payment related to increases in statewide average case mix based on such factors as changes in hospital service delivery and referral patterns.

(F) Case mix changes due to acquired immune deficiency syndrome, tuberculosis, epidemics or other catastrophes resulting in extraordinary hospital utilization shall not be subject to this limitation.

(G) Adjustments determined in accordance with clause (B) of this subparagraph for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six on a final basis, and in accordance with subparagraph (ii) of this paragraph on an interim basis, shall be applied to rates of payment for state governmental agencies during the period January first, nineteen hundred ninety-seven through March thirty-first, two thousand and periods on and after April first, two thousand.

(ii) (A) The commissioner shall, in accordance with rules and regulations adopted by the council and approved by the commissioner, for purposes of payments on an interim basis periodically compute an adjustment to individual general hospitals' case payment rates for prior periods for the payor categories specified in paragraphs (a) and (b) of subdivision one of this section to account for increases in the statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups for all patients other than beneficiaries of title XVIII of the federal social security act (medicare), that exceed the allowable statewide increase. The increase in the statewide average case mix in a rate year during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred ninety-three from the nineteen hundred eighty-seven statewide average case mix and in a rate year during the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six from the adjusted nineteen hundred ninety-two statewide average case mix shall not exceed the allowable statewide increase as determined in accordance with subparagraph (i) of this paragraph. Adjustments may be made on a quarterly basis consistent with this annual limitation. If in any quarter of the rate year the cumulative case mix increase for the rate year exceeds the allowable statewide increase, payment rates to general hospitals shall be adjusted in accordance with rules and regulations adopted by the council and approved by the commissioner which shall contain the specific methodology to allocate the reduction among general hospitals provided, however, that any funds to be recovered from hospitals based on such adjustments for prior periods shall be recovered by prospective adjustment of rates of payment in accordance with paragraph (c) of this subdivision, in order to reduce the effect of the statewide increase on rates of payment to reflect the allowable increase, taking into consideration the effect of any adjustment applicable in the rate period made in accordance with subparagraph (iii) of this paragraph. Case mix changes due to acquired immune deficiency syndrome, tuberculosis, epidemics or other catastrophes resulting in extraordinary hospital utilization shall not be subject to this limitation, pursuant to rules and regulations adopted by the council and approved by the commissioner.

(B) The commissioner further shall for purposes of payments on an interim basis periodically compute an adjustment to individual general hospitals' case payment rates for prior periods for payments made by state governmental agencies to account for increases in the statewide average case mix, based on increases in statewide average assignment to diagnosis-related groups for patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law eligible for payments made by state governmental agencies or by health maintenance organizations, that exceed the allowable statewide increase as determined in accordance with clause (B-1) of subparagraph (i) of this paragraph.

(iii) The commissioner shall, in accordance with rules and regulations adopted by the council and approved by the commissioner, periodically prospectively adjust for purposes of payments on an interim basis individual general hospitals' case payment rates for the payor categories specified in paragraphs (a) and (b) of subdivision one of this section to account for increases in statewide average assignment to diagnosis-related groups which exceed the allowable statewide increase as determined in accordance with subparagraph (ii) of this paragraph.

(iv) Rates of payment of a general hospital shall be adjusted in accordance with paragraph (c) of this subdivision to reflect the difference between an individual general hospital's case payment rates adjusted in accordance with subparagraph (i) of this paragraph for a rate period and such rates determined in accordance with paragraphs (a) and (b) of subdivision one of this section, taking into consideration any adjustment to case payment rates applicable for such rate period made in accordance with subparagraphs (ii) and (iii) and for the periods beginning on or after July first, nineteen hundred ninety, subparagraph (v) of this paragraph.

(v) Notwithstanding any inconsistent provision of law, for the periods beginning on or after July first, nineteen hundred ninety and subsequent annual rate periods beginning January first the commissioner shall reduce, in accordance with the methodology adopted for purposes of adjustments pursuant to subparagraph (ii) of this paragraph, for purposes of payments on an interim basis individual general hospitals' case payment rates applicable to state governmental agencies for a prospective period to reflect an estimate of the cumulative increase in statewide average assignment to diagnosis-related groups for prior periods including prior quarters of the rate period which exceeds the allowable statewide increase specified in subparagraph (i) of this paragraph for the prospective period. Such adjustment if effected for less than an annual prospective rate period shall reflect an annualized adjustment.

(vi) Notwithstanding any inconsistent provision of law, adjustments to rates of payment pursuant to this paragraph based on nineteen hundred ninety-three data that reflects an increase in statewide average case mix compared to nineteen hundred eighty-seven that exceeds the increase based on nineteen hundred ninety-two data in statewide average case mix compared to nineteen hundred eighty-seven shall not be implemented until April first, nineteen hundred ninety-five and shall be made prospectively for rates of payment issued effective April first, nineteen hundred ninety-five including the impact of such adjustment for the period January first, nineteen hundred ninety-five through March thirtieth, nineteen hundred ninety-five.

(g) Notwithstanding any other provisions of this section, all costs and statistics that are related to inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) shall not be included in the establishment of any payment rates computed in accordance with the provisions of this section.

(i) Unless provided otherwise in specific provisions included in this section, the exclusion of costs which are related to routine inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) and covered by title XVIII of the federal social security act (medicare) shall be based on the nineteen hundred eighty-five inpatient days actually paid on behalf of beneficiaries of title XVIII of the federal social security act (medicare) plus any days for such beneficiaries not paid on the basis of a decision by a review agent that the days were unnecessary. Ancillary costs related to inpatient

services provided to beneficiaries of title XVIII of the federal social security act (medicare) and covered by title XVIII of the federal social security act (medicare) shall be excluded on the basis of the nineteen hundred eighty-five cost center ratio of hospital ancillary inpatient service charges related to such beneficiaries to total hospital cost center inpatient ancillary services charges applied to cost center costs. Inpatient malpractice insurance costs which are attributable to title XVIII of the federal social security act (medicare) shall be excluded based on the methodology employed by title XVIII of the federal social security act (medicare) to identify such costs.

(ii) Costs and statistics related to inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) and covered by a secondary payor shall be excluded in accordance with rules and regulations adopted by the council and approved by the commissioner in the determination of case payment rates computed in accordance with the provisions of this section.

(h)(i) Any malpractice insurance costs which are the result of general hospitals having to purchase or provide excess malpractice insurance coverage for physicians in accordance with section nineteen of chapter two hundred ninety-four of the laws of nineteen hundred eighty-five or section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as amended shall not be included in calculating malpractice insurance costs for purposes of paragraph (e) of subdivision one of this section.

(ii) The component of general hospital reimbursable inpatient operating costs based on the general hospital's inpatient malpractice insurance costs plus the component of special additional inpatient operating costs determined in accordance with subparagraphs (i) and (iii) of paragraph (e) of subdivision one of this section specifically related to inpatient malpractice insurance costs used to determine payment rates for annual rate periods beginning on or after January first, nineteen hundred eighty-eight shall be allocated among the payors in accordance with regulations adopted by the council and approved by the commissioner.

(i) For patients discharged during the period April first, nineteen hundred ninety-two through March thirty-first, nineteen hundred ninety-three insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis, the payment rate shall be increased in addition to the payment rate conversion factor of thirteen percent by a supplementary payment rate conversion factor of eleven percent for a total conversion factor of twenty-four percent. This paragraph shall not apply to payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law, the comprehensive motor vehicle insurance reparations act, the terms of any personal injury liability insurance policy, marine and inland marine insurance policy or marine protections and indemnity insurance policy.

(j) No operating cost ceilings or disallowances other than those applicable for purposes of the determination of a general hospital's reimbursable inpatient operating cost base in accordance with paragraph (d) of subdivision one of this section shall be applied to general hospitals, except for any cost ceilings or disallowances applied for purposes of subdivision twenty-four of this section and cost disallowances for general hospitals with rates based on budgeted costs.

(k) Notwithstanding any inconsistent provision of this section, case based rates of payment per discharge may, in accordance with rules and regulations adopted by the council and approved by the commissioner, reflect incorporation of severity of illness considerations in the methodology to determine such rates of payment.

(l) Notwithstanding any inconsistent provision of this section, nothing in this section shall preclude a modification to case based rates of payment per discharge in accordance with rules and regulations adopted by the council and approved by the commissioner to reflect readmission of an individual or unnecessary multiple admissions of an individual to a general hospital or general hospitals.

(m) Notwithstanding any inconsistent provision of this section, a general hospital that exceeded maximum charge limitations as determined by the commissioner in the rate periods nineteen hundred eighty-four through nineteen hundred eighty-seven may be authorized in accordance with rules and regulations adopted by the council and approved by the commissioner to reduce payments determined pursuant to this section in order to effect a reduction equivalent to such amount by which such general hospital exceeded maximum charge limitations.

(n) (i) For a patient discharged from a general hospital on or after August first, nineteen hundred eighty-eight and covered by a payor included in the payor categories specified in paragraph (a) or (b) of subdivision one of this section that provides for a percentage coinsurance responsibility by or on behalf of such patient for covered hospital services: (A) the dollar value of such percentage coinsurance responsibility by or on behalf of such patient shall be determined by multiplying such coinsurance percentage by the hospital's charges for such patient, determined in accordance with paragraph (c) of subdivision one of this section or paragraph (e) of subdivision four of this section for a general hospital or distinct unit of a general hospital not reimbursed on case based payments, for the services covered by the payor, considering any applicable deductibles, and (B) the payment due to a general hospital for reimbursement of inpatient hospital services by such payor shall be determined by multiplying the payment rate determined in accordance with this section for such patient for covered hospital services by the coinsurance percentage for which such payor is responsible, considering any applicable deductibles.

(ii) A patient covered by a payor included in the payor categories specified in paragraph (a) or (b) of subdivision one of this section shall be deemed liable for the payment rate for inpatient hospital services for such patient for covered services determined in accordance with this section based on the rate of payment for such payor, provided, however, that for a patient discharged from a general hospital on or after August first, nineteen hundred eighty-eight a percentage coinsurance responsibility by or on behalf of such patient shall be deemed satisfied by payment of the dollar value of such percentage coinsurance responsibility determined in accordance with clause (A) of subparagraph (i) of this paragraph.

(o)] (C) No general hospital shall refuse to provide hospital services to a person presented or proposed to be presented for admission to such general hospital by a representative of a correctional facility or a local correctional facility as defined respectively in subdivisions four, fifteen and sixteen of section two of the correction law based solely on the grounds such person is an inmate of such correctional facility or local correctional facility. No general hospital may demand or request any charge for hospital services provided to such person in

addition to the charges or rates authorized in accordance with this article, except for charges for identifiable additional hospital costs associated with or reasonable additional charges associated with security arrangements for such person.

[(p)] (D) (i) Notwithstanding any inconsistent provision of law, a general hospital that provides an inpatient component of hospice care for persons eligible for payments to a hospice by a government agency made in accordance with subdivisions two and three of section four thousand twelve of this chapter shall be reimbursed for such inpatient services by or on behalf of the hospice at a rate of payment no greater than the applicable rate of payment determined in accordance with subdivisions two and three of section four thousand twelve of this chapter for such hospice and no general hospital may charge for such inpatient services rendered an amount in excess of such applicable rate of payment.

(ii) Notwithstanding any inconsistent provision of law, a general hospital that provides in accordance with contractual arrangements between a hospice and such general hospital an inpatient component of hospice care for persons who are not eligible for payments to the hospice by a government agency made in accordance with subdivisions two and three of section four thousand twelve of this chapter or as beneficiaries of title XVIII of the federal social security act (medicare) shall be reimbursed for such inpatient services by or on behalf of the hospice in accordance with such contractual arrangements.

[(q) A third-party payor specified in paragraph (a), (b) or (c) of subdivision one of this section, with the exception of governmental agencies, shall provide the general hospital with a remittance advice at the time payment or adjustment to such payment is made. Such remittance advice shall include the patient's name, date of service, admission or financial control number if available and diagnosis-related group classification number if applicable and if different than that billed by the hospital. Such remittance advice shall also include (i) the amount or percentage payable under the policy or certificate after deductibles, co-payments and any other reduction of the amount billed including deductions for prompt payment; and (ii) a specific explanation of any denial, reduction, or other reason including any other third-party payor coverage, for not providing full reimbursement of the amount claimed.

(r) Notwithstanding any inconsistent provision of this section, for purposes of establishing rates of payment by state governmental agencies for general hospital inpatient services provided for discharges on or after April first, nineteen hundred ninety-five, the reimbursable base year inpatient administrative and general costs of a general hospital, which shall include but not be limited to reported administrative and general, data processing, non-patient telephone, purchasing, admitting, and credit and collection costs, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year inpatient administrative and general costs. For the purposes of this paragraph, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses provided by this paragraph shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the commissioner for each general hospital.

(s) Notwithstanding any inconsistent provisions of this section, for the period July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed forty-five million dollars in the aggregate to be allocated among those voluntary non-profit and private proprietary general hospitals which qualified for rate adjustments pursuant to this paragraph as in effect for the period July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such general hospital's proportional share of the total funds allocated pursuant to this paragraph as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six.

(s-1) To the extent funds are available pursuant to the provisions of paragraph (s-2) of this subdivision and otherwise notwithstanding any inconsistent provision of law to the contrary, for the rate periods September first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, and April first, nineteen hundred ninety-eight through March thirty-first, nineteen hundred ninety-nine, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed forty-eight million dollars in the aggregate for each such rate period, allocated among those voluntary non-profit and private proprietary general hospitals which qualified for rate adjustments pursuant to paragraph (s) of this subdivision as in effect for the period July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such general hospital's proportional share of total funds allocated pursuant to paragraph (s) of this subdivision as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six. The rate adjustments calculated in accordance with this paragraph shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to paragraph (s) of this subdivision applicable to periods prior to September first, nineteen hundred ninety-seven.

(s-2) (i) Notwithstanding any inconsistent provision of law to the contrary, the following funds heretofore or hereinafter accumulated shall be transferred by the commissioner and credited to the credit of the state general fund medical assistance local assistance account in an aggregate amount equal to the non-federal share of the costs of the rate adjustments authorized pursuant to paragraph (s-1) of this subdivision:

(A) from pool reserves from statewide and regional pools established pursuant to sections twenty-eight hundred seven-a, twenty-eight hundred seven-c, and twenty-eight hundred eight-c of this article;

(B) from unobligated monies available pursuant to paragraph (b) of subdivision nineteen of section twenty-eight hundred seven-c of this article;

(C) from interest income derived from pools established pursuant to sections twenty-eight hundred seven-k, twenty-eight hundred seven-l and twenty-eight hundred seven-s of this article.

(ii) To the extent that funds available pursuant to the provisions of subparagraph (i) of this paragraph are insufficient to meet the non-federal share of the costs of the rate adjustments authorized pursuant to paragraph (s-1) of this subdivision, the following funds hereto or here-

inafter accumulated may be transferred by the commissioner to the state general fund medical assistance local assistance account for the purposes set forth in subparagraph (i) of this paragraph:

(A) from unobligated monies available pursuant to paragraphs (g) and (j) of subdivision 1 of section twenty-eight hundred seven-l of this article;

(B) from unobligated monies available pursuant to clause (D) of subparagraph (ii) of paragraph (b) of subdivision one of section twenty-eight hundred seven-l of this article.

(iii) Notwithstanding any inconsistent provision of law to the contrary, the commissioner shall transfer up to an additional two million dollars from the funding sources identified in subparagraph (i) of this paragraph to the state general fund. To the extent monies available from the funding sources identified in subparagraph (i) of this paragraph total less than two million dollars, the commissioner shall transfer monies from funding sources identified in subparagraph (ii) of this paragraph to the state general fund so that the total amount transferred pursuant to this provision equals two million dollars.

(s-3) To the extent funds are available pursuant to the provisions of paragraph (s-4) of this subdivision and otherwise notwithstanding any inconsistent provision of law to the contrary, for the rate period July first, nineteen hundred ninety-nine through March thirty-first, two thousand, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed thirty-six million dollars in the aggregate. Such amount shall be allocated among those voluntary non-profit and private proprietary general hospitals which continue to provide inpatient services as of July first, nineteen hundred ninety-nine under a previous or new name and which qualified for rate adjustments pursuant to paragraph (s) of this subdivision as in effect for the period July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such general hospital's proportional share of total funds allocated pursuant to paragraph (s) of this subdivision as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six, provided however, that amounts allocable to previously but no longer qualified hospitals shall be proportionally reallocated to the remaining qualified hospitals. The rate adjustments calculated in accordance with this paragraph shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to paragraph (s) of this subdivision applicable to periods prior to September first, nineteen hundred ninety-seven.

(s-4) Notwithstanding any inconsistent provision of law to the contrary, funds available pursuant to section 32-c of part F of the chapter of the laws of nineteen hundred ninety-nine which adds this paragraph shall be transferred by the commissioner and credited to the credit of the state general fund medical assistance local assistance account in an aggregate amount equal to the non-federal share of the costs of the rate adjustments authorized pursuant to paragraph (s-3) of this subdivision.

(s-5) To the extent funds are available pursuant to paragraph (s) of subdivision one of section twenty-eight hundred seven-v of this article and otherwise notwithstanding any inconsistent provision of law, for rate periods April first, two thousand through March thirty-first, two thousand three, the commissioner shall increase rates of payment for

patients eligible for payments made by state governmental agencies by an amount not to exceed forty-eight million dollars annually in the aggregate. Such amount shall be allocated among those voluntary non-profit and private proprietary general hospitals which continue to provide inpatient services as of July first, nineteen hundred ninety-nine under a previous or new name and which qualified for rate adjustments pursuant to paragraph (s) of this subdivision as in effect for the period July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such general hospital's proportional share of total funds allocated pursuant to paragraph (s) of this subdivision as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six, provided however, that amounts allocable to previously but no longer qualified hospitals shall be proportionally reallocated to the remaining qualified hospitals. The rate adjustments calculated in accordance with this paragraph shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to paragraph (s) of this subdivision applicable to periods prior to September first, nineteen hundred ninety-seven.

(s-6) To the extent funds are available otherwise notwithstanding any inconsistent provision of law to the contrary, for rate periods April first, two thousand three through March thirty-first, two thousand five, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed forty-eight million dollars annually in the aggregate. Such amount shall be allocated among those voluntary non-profit and private proprietary general hospitals which continue to provide inpatient services as of July first, nineteen hundred ninety-nine under a previous or new name and which qualified for rate adjustments pursuant to paragraph (s) of this subdivision as in effect for the period July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such general hospital's proportional share of total funds allocated pursuant to paragraph (s) of this subdivision as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six, provided however, that amounts allocable to previously but no longer qualified hospitals shall be proportionally reallocated to the remaining qualified hospitals. The rate adjustments calculated in accordance with this paragraph shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to paragraph (s) of this subdivision applicable to periods prior to September first, nineteen hundred ninety-seven. These payments may be added to rates of payment or made as aggregate payments to eligible hospitals.

(s-7) To the extent funds are available otherwise notwithstanding any inconsistent provision of law to the contrary, for rate periods April first, two thousand five through March thirty-first, two thousand seven, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed forty-eight million dollars annually in the aggregate. Such amount shall be allocated among those voluntary non-profit and private proprietary general hospitals which continue to provide inpatient

services as of April first, two thousand five under a previous or new name and which qualified for rate adjustments pursuant to paragraph (s) of this subdivision as in effect for the period July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six proportionally based on each such general hospital's proportional share of total funds allocated pursuant to paragraph (s) of this subdivision as in effect for the period of July first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-six, provided however, that amounts allocable to previously but no longer qualified hospitals shall be proportionally reallocated to the remaining qualified hospitals. The rate adjustments calculated in accordance with this paragraph shall be subject to retrospective reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation, to the extent allowable under federal law, provided however that the department shall not be required to reconcile payments made pursuant to paragraph (s) of this subdivision applicable to periods prior to September first, nineteen hundred ninety-seven.

(s-8) To the extent funds are available and otherwise notwithstanding any inconsistent provision of law to the contrary, for rate periods on and after April first, two thousand seven through November thirtieth, two thousand nine, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed sixty million dollars annually in the aggregate. Such amount shall be allocated among those voluntary non-profit general hospitals which continue to provide inpatient services as of April first, two thousand seven through March thirty-first, two thousand eight and which have medicaid inpatient discharges percentages equal to or greater than thirty-five percent. This percentage shall be computed based upon data reported to the department in each hospital's two thousand four institutional cost report, as submitted to the department on or before January first, two thousand seven. The rate adjustments calculated in accordance with this paragraph shall be allocated proportionally based on each eligible hospital's total reported medicaid inpatient discharges in two thousand four, to the total reported medicaid inpatient discharges for all such eligible hospitals in two thousand four, provided, however, that such rate adjustments shall be subject to reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation to the extent allowable under federal law. Such payments may be added to rates of payment or made as aggregate payments to eligible hospitals, provided, however, that subject to the availability of federal financial participation and solely for the period April first, two thousand seven through March thirty-first, two thousand eight, six million dollars in the aggregate of this sixty million dollars shall be allocated to voluntary non-profit hospitals which continue to provide inpatient services as of April first, two thousand seven through March thirty-first, two thousand eight and which have Medicaid inpatient discharge percentages of less than thirty-five percent and which had previously qualified for distributions pursuant to paragraph (s-7) of this subdivision. The rate adjustment calculated in accordance with this paragraph shall be allocated proportionally based on the amount of money the hospital had received in two thousand six.

12. Provisions for article forty-three insurance law corporations and article forty-four of this chapter organizations. Except as provided in paragraphs (a) and (b) of this subdivision, general hospital charges for inpatient and outpatient services to subscribers or beneficiaries of

contracts entered into pursuant to the provisions of article forty-three of the insurance law or to members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter for patient services rendered shall not exceed the rates of payment approved by the commissioner for payments by such article forty-three insurance law corporations or article forty-four organizations. No general hospital may demand or request any charge for such covered services in addition to the charges or rates authorized by this article.

(a) Any general hospital which terminated its contract with an article nine-c insurance law corporation or a comprehensive health services plan after October first, nineteen hundred seventy-six and prior to May first, nineteen hundred seventy-eight, may not charge subscribers or beneficiaries of contracts entered into pursuant to the provisions of article forty-three of the insurance law, or members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter, amounts in excess of the payments established by such hospital for patient services in accordance with the provisions of paragraph (c) of subdivision one of this section, or in the event the article forty-three insurance law corporation or comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter provides for reimbursement on an expense incurred basis and makes payment directly to such hospital for patient services for its subscribers or beneficiaries, such article forty-three insurance law corporation or comprehensive health services plan shall be an additional category of payor of inpatient hospital services whose rates of payment are determined in accordance with paragraph (b) of subdivision one of this section based on an imputed rate of payment determined in accordance with paragraph (a) of subdivision one of this section for an article forty-three insurance law corporation, adjusted for uncovered services, and increased by thirteen percent.

(b) Any general hospital which had notified in writing an article nine-c corporation or a comprehensive health services plan prior to June first, nineteen hundred seventy-eight of its intention to terminate its contract with such corporation or plan in accordance with the terms of such contract, except a general hospital subject to the provisions of paragraph (a) of this subdivision may not charge a subscriber or beneficiary of a contract entered into pursuant to the provisions of article forty-three of the insurance law, or a member of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter, after the effective date of termination of such contract, amounts in excess of the payments established by such hospital for patient services in accordance with the provisions of paragraph (c) of subdivision one of this section, or in the event the article forty-three insurance law corporation or comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter provides for reimbursement on an expense incurred basis and makes payment directly to such hospital for patient services for its subscribers or beneficiaries, such article forty-three insurance law corporation or comprehensive health services plan shall be an additional category of payor of inpatient hospital services whose rates of payment are determined in accordance with paragraph (b) of subdivision one of this section based on an imputed rate of payment determined in accordance with paragraph (a) of subdivision one of this section for an article forty-three insurance law corporation, adjusted for uncovered services, and increased by thirteen percent.

(c) No general hospital shall refuse to provide patient services to such subscribers or beneficiaries solely on the grounds of such subscription or membership.

(d) The provisions of this subdivision shall also apply to payments to general hospitals by a corporation organized and operating in accordance with article forty-three of the insurance law for inpatient and outpatient services on behalf of subscribers of a foreign corporation which performs similar functions in another state or which belongs to a national association comprised of similar corporations to which the article forty-three corporation also belongs; provided, however, the foreign corporation or the laws of the state in which the foreign corporation is organized extends to article forty-three corporations organized and operating in this state a reciprocal right to have the foreign corporation make payments to hospitals in that other state on behalf of subscribers of the article forty-three corporations at the same rate of payment as that foreign corporation pays for its own subscribers.

(e) The provisions of this subdivision shall not apply to patients discharged on or after January first, nineteen hundred ninety-seven.

13. Restitution authorization. In enforcing the provisions of subdivisions one and twelve of this section, the commissioner may, in addition to the penalties and injunctions set forth in section twelve of this chapter, order that any general hospital provide restitution for any overpayments made by any party. Any hospital may request a formal hearing pursuant to the provisions of section twelve-a of this chapter in the event the hospital objects to any order of the commissioner hereunder. The commissioner may direct that such a hearing be held without any request by a hospital.

14. Bad debt and charity care allowance. (a) With the exception of rates of payment for services provided to beneficiaries of title XVIII of the federal social security act (medicare), all rates and general hospital charges, including rates of payment for state governmental agencies provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allowance provided herein as a component of such payments are granted, established for rate periods commencing on or after January first, nineteen hundred eighty-eight and prior to January first, nineteen hundred ninety-seven in accordance with this section shall include the allowance specified in paragraph (c) of this subdivision. The allowance shall be computed on the basis of the operating and capital related components of such rates after trending of the operating portion. For the purposes of this subdivision and subdivision seventeen of this section, major public general hospitals are defined as all state operated general hospitals, all general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended and all other public general hospitals having annual inpatient operating costs in excess of twenty-five million dollars.

(b) The allowance shall be a percentage to reflect the needs for the financing of losses resulting from bad debts and the costs of charity care of general hospitals within article forty-three insurance law regions, or such other regions as adopted pursuant to subdivision sixteen of this section, and within a statewide determination of financial resources to be committed for this purpose.

Need shall be defined as inpatient losses from bad debts reduced to cost and the inpatient costs of charity care increased by any deficit of such hospital from providing ambulatory services, excluding any portion of such deficit resulting from governmental payments below average visit costs, and revenues and expenses related to the provision of referred ambulatory services. Funds received by major public general hospitals pursuant to article forty-one of the mental hygiene law shall be considered to have been provided for inpatient hospital deficits only. The council shall adopt rules and regulations, subject to the approval of the commissioner, to establish uniform reporting and accounting principles designed to enable hospitals to fairly and accurately determine and report losses from bad debts and the costs of charity care.

(c) The regional amounts to be included in rates approved for the rate year commencing January first, nineteen hundred eighty-eight shall be equal to the sum of the following two components divided by the total reimbursable inpatient costs for the general hospitals located in the region, excluding inpatient costs related to beneficiaries of title XVIII of the federal social security act (medicare), and after application of the trend factor. The first component shall be the result of the ratio between the total nominal payment amount in dollars as determined in subparagraph (i) of this paragraph that would be allocated to voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals in the region based on a targeted need formula applied in accordance with subparagraphs (i) and (ii) of this paragraph and the statewide sum of such nominal payment amounts to voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals applied to the total statewide resources committed for this purpose to regional pools in the rate year, excluding the total statewide amount allocated in the rate year for this purpose to major public general hospitals in accordance with subparagraph (iii) of this paragraph. The second component shall be the dollar amount allocated to major public general hospitals in the region in accordance with subparagraph (iii) of this paragraph. The regional amount to be included in the rates approved for the rate years commencing on or after January first, nineteen hundred eighty-nine shall be computed in the same manner except that the base year for the targeted need as specified in subparagraph (i) of this paragraph shall be the calendar year which is two years prior to the rate year. For each annual rate period commencing on or after January first, nineteen hundred eighty-eight, the statewide amount to be available in regional pools for this purpose shall equal five and forty-eight hundredths percent of the total hospital reimbursable inpatient costs, excluding inpatient costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), computed without consideration of inpatient uncollectible amounts, and after application of the trend factor.

(i) Targeted need shall be defined as the relationship of need to net patient service revenue expressed as a percentage. Net patient service revenue shall be defined as net patient revenue attributable to inpatient and outpatient services excluding referred ambulatory services. For the rate year beginning January first, nineteen hundred eighty-eight and ending December thirty-first, nineteen hundred eighty-eight the scale specified in subparagraph (ii) of this paragraph shall be utilized to calculate individual hospital's nominal payment amounts on the basis of the percentage relationship between their nineteen hundred eighty-six need and nineteen hundred eighty-six net patient service revenues. The

nominal payment amount shall be defined as the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to the scale specified in subparagraph (ii) of this paragraph. The sum of the nominal payment amounts for all hospitals in a region shall be the region's total nominal payment amount.

(ii) The scale utilized for development of each hospital's nominal payment amount shall be as follows:

Targeted Need Percentage	Percentage of Reimbursement Attributable to that Portion of Targeted Need
0 -1%	35%
1+ -2%	50%
2+ -3%	65%
3+ -4%	85%
4+ -5%	90%
5%+	95%

(iii) The dollar amount allocated to major public general hospitals in a region in the rate years nineteen hundred eighty-eight, nineteen hundred eighty-nine and in that portion of the nineteen hundred ninety rate year beginning on January first and ending on June thirtieth shall be one hundred two percent and in that portion of the nineteen hundred ninety rate year beginning on July first and ending on December thirty-first, and in subsequent rate years shall be one hundred ten percent of the result of the application of the ratio of the major public general hospitals' inpatient reimbursable costs within the region to total statewide general hospital inpatient reimbursable costs, as computed on the basis of nineteen hundred eighty-five financial and statistical reports and excluding costs related to services to beneficiaries of title XVIII of the federal social security act (medicare), to the statewide resources committed for this purpose to regional pools, computed without consideration of inpatient uncollectible amounts.

(iv) Notwithstanding any inconsistent provision of this section, commencing April first, nineteen hundred ninety-five the allowance pursuant to this subdivision shall be a uniform regional allowance percentage of five and forty-eight hundredths percent for all regions.

(d) In the event the regional percentage bad debt and charity care allowances for general hospitals for a rate period commencing on or after January first, nineteen hundred ninety-four determined in accordance with paragraph (c) of this subdivision to be submitted to bad debt and charity care regional pools established pursuant to subdivision sixteen of this section and deposited in accordance with subdivision seventeen of this section do not qualify for waiver pursuant to federal law and regulation related to such regional allowance variations, in order for such allowances to be qualified as a broad-based health care related tax for purposes of the revenues received by the state from such allowances not reducing the amount expended by the state as medical assistance for purposes of federal financial participation, but the regional percentage allowances for the nineteen hundred ninety-three rate year do so qualify, then the regional percentage allowances for the regions for the nineteen hundred ninety-three rate year determined in accordance with paragraph (c) of this subdivision shall be further continued for such period for such regions.

14-a. Supplementary bad debt and charity care adjustment. (a) Notwithstanding any inconsistent provision of this section, rates of payment for inpatient hospital services for persons eligible for payments made by state governmental agencies for the period April first, nineteen hundred eighty-nine to December thirty-first, nineteen hundred eighty-nine and for each annual period commencing January first during the period January first, nineteen hundred ninety to December thirty-first, nineteen hundred ninety-three applicable to patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance provided pursuant to title eleven of article five of the social services law determined in accordance with this section for a major public general hospital, as defined in paragraph (a) of subdivision fourteen of this section, shall include a supplementary bad debt and charity care adjustment determined in accordance with paragraph (b) of this subdivision provided the state governmental agency or the county government in which such general hospital is located, or the city of New York for a general hospital operated by the New York city health and hospitals corporation, files in such time and manner as may be specified by the commissioner an election for such adjustment for such hospital for each period provided that such election is subject to the approval of the state director of the budget and provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the adjustment provided herein as a component of such payments are granted.

(b)(i) A supplementary bad debt and charity care adjustment for the period April first, nineteen hundred eighty-nine to December thirty-first, nineteen hundred eighty-nine and for each annual period commencing January first during the period January first, nineteen hundred ninety to December thirty-first, nineteen hundred ninety-three for an eligible major public general hospital shall be determined for each period in accordance with rules and regulations adopted by the council and approved by the commissioner based upon the amount calculated by subtracting the amount projected to be distributed to such major public general hospital pursuant to paragraph (a) of subdivision seventeen of this section for such period from an amount calculated as the product of the projected bad debt and charity care nominal payment amount coverage ratio for such period for voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals multiplied by the base year bad debt and charity care imputed nominal payment amount for such major public general hospital determined in accordance with the methodology provided in paragraph (c) of subdivision fourteen of this section for calculation of a nominal payment amount for voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals. The coverage ratio shall be computed as the ratio between the sum of the dollar value of the amount committed to the regional pools in accordance with paragraph (c) of subdivision fourteen of this section and paragraph (a) of subdivision nineteen of this section for the rate period that would be allocated to voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals in accordance with paragraph (b) of subdivision seventeen of this section and the base year nominal payment amount for such hospitals.

(ii) A supplementary bad debt and charity care adjustment provided in accordance with subparagraph (i) of this paragraph shall be adjusted to

reflect actual distributions pursuant to paragraph (a) and (b) of subdivision seventeen of this section.

(c) Notwithstanding any inconsistent provision of this subdivision, a supplementary bad debt and charity care adjustment shall be determined and provided for each of the nineteen hundred ninety-four, nineteen hundred ninety-five and nineteen hundred ninety-six rate periods, provided that the election pursuant to paragraph (a) of this subdivision is continued for such period, for a major public general hospital equal to the higher of such adjustment for the nineteen hundred ninety-one rate period or for the nineteen hundred ninety-three rate period. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

(d) Notwithstanding any inconsistent provision of law, the provisions of paragraphs (a), (b) and (c) of this subdivision shall not apply to payments for patients discharged on or after January first, nineteen hundred ninety-seven.

14-b. General health care services allowance. (a) With the exception of rates of payment for services provided to beneficiaries of title XVIII of the federal social security act (medicare), all rates and general hospital charges established for rate periods commencing on or after January first, nineteen hundred ninety-one in accordance with this section shall include a percentage allowance of the general hospital's reimbursable inpatient costs, excluding inpatient costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), computed without consideration of inpatient uncollectible amounts, and after application of the trend factor, as follows:

(i) for the nineteen hundred ninety-one, nineteen hundred ninety-two and nineteen hundred ninety-three rate periods, an allowance of twenty-three hundredths of one percent;

(ii) for the nineteen hundred ninety-four rate period, an allowance of six hundred fourteen thousandths of one percent;

(iii) for the January first, nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-five rate period, an allowance of six hundred thirty-seven thousandths of one percent

(iv) for the July first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five rate period, an allowance of one and forty-two hundredths percent; and

(v) for the January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six rate period, an allowance of one and nine hundredths percent.

(b) For rate periods beginning on or after January first, nineteen hundred ninety-one but prior to January first, nineteen hundred ninety-four, funds will be accumulated and made available in regional pools created by the commissioner for regional distributions in accordance with section twenty-eight hundred seven-bb of this chapter through the submission by or on behalf of general hospitals of the allowance included in rates and charges in accordance with paragraph (a) of this subdivision. Such regions shall be those established pursuant to paragraph (b) of subdivision sixteen of this section. The regional pools may be administered in accordance with the provisions of paragraph (c) of subdivision sixteen of this section applicable to bad debt and charity care regional pools. Payments by or on behalf of general hospitals to regional pools shall be due and arrearages shall be treated in accordance with the provisions of subdivision twenty of this section applicable to bad debt and charity care regional pools.

(c) If on September thirtieth, nineteen hundred ninety-four, any funds accumulated over the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three are unused or uncommitted for the allocations provided for in this subdivision, such unused or uncommitted funds shall be reallocated for use in accordance with the provisions of subdivision seventeen of this section.

(d) For the rate periods commencing on or after January first, nineteen hundred ninety-four, funds will be accumulated in a statewide pool created by the commissioner through the submission by or on behalf of general hospitals of the allowance included in rates and charges in accordance with paragraph (a) of this subdivision, for distributions in accordance with subdivision nineteen-a of this section.

(e) The commissioner is authorized to contract with a pool administrator designated in accordance with paragraph (c) of subdivision sixteen of this section or, if not available, such other administrators as the commissioner shall designate, to receive funds for the pools created pursuant to this subdivision and to distribute funds in accordance with this subdivision and subdivision nineteen-a of this section. If a pool administrator is designated, the commissioner shall conduct or cause to be conducted an annual audit of the receipt and distribution of pool funds. The reasonable costs and expenses of a pool administrator as approved by the commissioner, not to exceed for personnel services on an annual basis two hundred thousand dollars, shall be paid from the pooled funds.

(f) (i) Payments to the pools by or on behalf of general hospitals of funds due based on the allowances provided in accordance with this subdivision shall be due in accordance with the provisions of subdivision twenty of this section in the same manner as applicable to bad debt and charity care regional pools. Arrearages in payments due may be collected and interest and penalties due shall be determined and may be collected by the commissioner in accordance with the provisions of subdivision twenty of this section in the same manner as applicable to bad debt and charity care regional pools.

(ii) Notwithstanding any inconsistent provision of this section, as shall be necessary to obtain federal financial participation in medical assistance expenditures in accordance with title XIX of the federal social security act, the allowances included in rates of payment pursuant to this subdivision on behalf of patients eligible for medical assistance pursuant to title eleven of article five of the social services law shall be withheld from medical assistance payments to general hospitals and paid to pools on behalf of the general hospitals where a general hospital elects such withholding in such time and manner as specified by the commissioner, and in the event a general hospital does not elect such withholding, payments by such general hospital to a pool based on an allowance received for medical assistance patients shall be due within five days of receipt of such funds. Funds withheld by a payor and paid to a pool on behalf of a general hospital shall be considered received by such general hospital and paid to the pool by such general hospital for all purposes.

(g) The allowances provided pursuant to paragraph (a) of this subdivision shall be effective and implemented for purposes of determining rates of payment for state governmental agencies contingent on receipt of all federal approvals necessary by federal law or regulations for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon such allowances as a component of such payments.

If such federal approvals are not granted for such allowances or components thereof, rates of payment for state governmental agencies shall be determined in accordance with the provisions of this section without consideration of such allowances or such components plus an adjustment not subject to federal financial participation equal to one-half of the difference between such rates of payment determined without consideration of such allowances or components and a rate of payment determined based on such allowances or components. The pools established pursuant to this subdivision shall refund to the state governmental agency from pool reserves, current funds or future receipts any overpayment received based on a retroactive reduction pursuant to this paragraph in the allowances.

(h) The allowances provided pursuant to paragraph (a) of this subdivision or components thereof shall be of no force and effect and shall be deemed to have been null and void as of January first, nineteen hundred ninety-four in the event the secretary of the department of health and human services determines that such allowances or such components thereof are an impermissible health care related tax for purposes of the federal medicaid voluntary contribution and provider-specific tax amendments of nineteen hundred ninety-one for purposes of such funds reducing the amount deemed expended by the state as medical assistance for purposes of federal financial participation.

14-c. Bad debt and charity care allowance for financially distressed hospitals. (a) With the exception of rates of payment for services provided to beneficiaries of title XVIII of the federal social security act (medicare), all rates and general hospital charges established for rate periods commencing on or after January first, nineteen hundred ninety-one but prior to January first, nineteen hundred ninety-four in accordance with this section shall include an allowance of two hundred thirty-five thousandths of one percent; and for the rate periods during the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six an allowance of three hundred twenty-five thousandths of one percent of the general hospital's reimbursable inpatient costs, excluding inpatient costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), computed without consideration of inpatient uncollectible amounts, and after application of the trend factor.

(b) A statewide pool shall be created through the submissions by or on behalf of general hospitals of the allowance included in rates and charges in accordance with paragraph (a) of this subdivision. Funds accumulated in the statewide pool, including income from invested funds, shall be deposited by the commissioner and credited to a special revenue-other fund to be established by the comptroller. To the extent of funds appropriated therefor, funds shall be made available for distributions by or on behalf of the state, as payments under the state medical assistance program provided pursuant to title eleven of article five of the social services law, from the statewide pool in the same manner as distributions made in accordance with paragraph (c) of subdivision nineteen of this section. The statewide pools may be administered in accordance with the provisions of paragraph (c) of subdivision sixteen of this section applicable to bad debt and charity care regional pools. Payments by or on behalf of general hospitals to statewide pools shall be due and arrearages, interest and penalties shall be treated in accordance with the provisions of subdivision twenty of this section applicable to bad debt and charity care regional pools.

(c) Notwithstanding any inconsistent provision of law, the commissioner may allocate and distribute funds accumulated in the statewide pool created pursuant to this subdivision and funds accumulated in the statewide pool created by the assessments authorized in accordance with subdivision eighteen of this section and available for distribution in accordance with paragraphs (c) and (d) of subdivision nineteen of this section for contracts for independent management audits of financially distressed hospitals, provided, however, that the total amount for audits pursuant to this paragraph shall not exceed two million five hundred thousand dollars over the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-five. Copies of management audit reports of financially distressed hospitals shall be provided by the commissioner to the chairs of the senate and assembly health committees.

14-d. Supplementary low income patient adjustment. (a) Notwithstanding any inconsistent provision of this section, payment for inpatient hospital services for persons eligible for payments made by state governmental agencies for rate periods during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-six applicable to patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance provided pursuant to title eleven of article five of the social services law determined in accordance with this section shall include for eligible general hospitals a supplementary low income patient adjustment determined in accordance with paragraph (b) of this subdivision, provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the adjustment provided herein as a component of such payments are granted. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

(b) A supplementary low income patient adjustment for the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three shall be determined, subject to the provisions of subparagraph (iv) of this paragraph, and for the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six shall be determined for each eligible hospital according to the scale specified in subparagraph (iii) of this paragraph based upon the amount calculated by multiplying the applicable supplemental percentage coverage of need amount for the hospital by the hospital's need as defined in paragraph (b) of subdivision fourteen of this section; provided, however, that for the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six if the sum of the adjustments pursuant to clause (C) of subparagraph (iii) of this paragraph would exceed thirty-six million dollars for a rate year on an annualized basis the supplemental percentage coverage of need scale pursuant to clause (C) of subparagraph (iii) of this paragraph shall be reduced on a pro rata basis so that the sum of such adjustments provided for the rate year on an annualized basis shall not exceed thirty-six million dollars.

(i) The low income patient percentage of a general hospital shall be defined as the ratio of the sum of inpatient discharges of patients eligible for medical assistance pursuant to title eleven of article five of the social services law plus inpatient discharges of self-pay patients plus inpatient discharges of charity care patients divided by total inpatient discharges expressed as a percentage. For the period

January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three, the percentages shall be calculated based on base year nineteen hundred eighty-nine, received by the department no later than November first, nineteen hundred ninety, data from the statewide planning and research cooperative system consistent with data submitted in accordance with section twenty-eight hundred five-a of this article. For the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six, the percentages shall be calculated based on base year nineteen hundred ninety-one, received by the department no later than November first, nineteen hundred ninety-three, data from the statewide planning and research cooperative system consistent with data submitted in accordance with section twenty-eight hundred five-a of this article. In order to be eligible for an adjustment pursuant to this subdivision, a hospital must maintain its collection efforts to obtain payment in full from self-pay patients.

(ii) For the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three, hospital need shall be calculated based on base year nineteen hundred eighty-nine data. For the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six, hospital need shall be calculated based on base year nineteen hundred ninety-one data.

(iii)(A) The scale utilized for development of a hospital's supplementary low income patient adjustment shall be as follows for the period January first, nineteen hundred ninety-one through June thirtieth, nineteen hundred ninety-one:

Low Income Patient Percentage	Supplemental Percentage Coverage of Need
50+ 55%	5%
55+ 60%	10%
60+ 65%	15%
65+ 70%	22.5%
70+ 75%	30%
75+ 80%	37.5%
80+	45%

(B) The scale utilized for development of a hospital's supplementary low income adjustment shall be as follows for the period July first, nineteen hundred ninety-one for a public general hospital through December thirty-first, nineteen hundred ninety-six and for a voluntary non-profit or a private proprietary general hospital through September thirtieth, nineteen hundred ninety-two:

Low Income Patient Percentage	Supplemental Percentage Coverage of Need
35+ 55%	20%
55+ 60%	25%
60+ 65%	30%
65+ 70%	37.5%
70+	45%

(C) The scale utilized for development of a voluntary non-profit or private proprietary general hospital's supplementary low income patient adjustment shall be as follows for the period October first, nineteen hundred ninety-two through March thirty-first, nineteen hundred ninety-three and for the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-six:

Low Income Patient Percentage	Supplemental Percentage Coverage of Need

35+	50%	10%
50+	55%	20%
55+	60%	25%
60+	65%	30%
65+	70%	37.5%
70+		45%

(D) The scale utilized for development of a voluntary non-profit or private proprietary general hospital's supplementary low income patient adjustment for the period May fifteenth, nineteen hundred ninety-three through December thirty-first, nineteen hundred ninety-three shall be at one hundred twenty percent of the supplemental percentage coverage of need scale specified in clause (C) of this subparagraph.

(iv) A supplementary low income patient adjustment determined according to the scale specified in subparagraph (iii) of this paragraph shall be limited for rate periods during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three such that the amount of such adjustment for an eligible hospital, plus the amount committed to the regional pools in accordance with paragraph (c) of subdivision fourteen of this section and paragraph (a) of subdivision nineteen of this section for the rate period that would be allocated to such hospital, plus, if applicable, any distribution for the rate period pursuant to paragraph (d) of subdivision nineteen of this section for such hospital, and plus for a major public general hospital the amount of any supplementary bad debt and charity care adjustment provided pursuant to subdivision fourteen-a of this section for the rate period shall not exceed ninety percent of need.

(v) The provisions of this subdivision shall not apply to a general hospital eligible for distributions made pursuant to paragraph (c) of subdivision nineteen of this section.

(c) A supplementary low income patient adjustment provided in accordance with this subdivision for rate periods during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three shall be adjusted to reflect actual distributions pursuant to paragraphs (a) and (b) of subdivision seventeen of this section and paragraph (d) of subdivision nineteen of this section and adjustments provided pursuant to subdivision fourteen-a of this section.

(d) Notwithstanding any inconsistent provision of law, a voluntary non-profit or proprietary general hospital where the low income patient percentage, as determined in accordance with provisions of this subdivision, is between thirty-five and sixty-five percent shall be charged an assessment which for the period July first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-one shall equal five percent of the general hospital's bad debt and charity care need as determined in accordance with paragraph (b) of subdivision fourteen of this section and for the period January first, nineteen hundred ninety-two through September thirtieth, nineteen hundred ninety-two shall equal seven and one-half percent of the general hospital's bad debt and charity care need as determined in accordance with paragraph (b) of subdivision fourteen of this section. Such assessment shall be paid to the commissioner or his designee prior to October first, nineteen hundred ninety-two in accordance with a schedule established by the commissioner. The assessments may be administered in accordance with the provisions of paragraph (c) of subdivision sixteen of this section applicable to bad debt and charity care regional pools. Payments of the assessments shall be due and arrearages shall be treated in accordance

with the provisions of subdivision twenty of this section applicable to bad debt and charity care regional pools. Funds accumulated shall be deposited by the commissioner and credited to the department of social services medical assistance program general fund - local assistance account appropriation.

(e) Notwithstanding any inconsistent provision of law, the provisions of paragraphs (a) and (b) of this subdivision shall not apply to payments for patients discharged on or after January first, nineteen hundred ninety-seven.

14-f.] 6. Public general hospital indigent care adjustment. Notwithstanding any inconsistent provision of this section and subject to the availability of federal financial participation, payment for inpatient hospital services for persons eligible for payments made by state governmental agencies for the period [January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and periods on and after January first, two thousand] ON AND AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN applicable to patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance provided pursuant to title eleven of article five of the social services law determined in accordance with this section shall include for eligible public general hospitals [a public general hospital indigent care adjustment equal to the aggregate amount of the adjustments provided for such public general hospital for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six pursuant to subdivisions fourteen-a and fourteen-d of this section on an annualized basis, provided, however, that for periods on and after January first, two thousand thirteen] an annual amount of four hundred twelve million dollars [shall be] allocated to eligible major public hospitals based on each hospital's proportionate share of medicaid and uninsured losses to total medicaid and uninsured losses for all eligible major public hospitals, net of any disproportionate share hospital payments received pursuant to sections twenty-eight hundred seven-k and twenty-eight hundred seven-w of this article. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

[15. Special provisions for payments by governmental agencies. In the event that federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allowance specified in paragraph (c) of subdivision fourteen of this section as a component of such payments is not approved by the federal government, rates of payment by governmental agencies for the operating cost component of general hospital inpatient services shall be increased for each hospital by the same percentage allowance as each hospital's federal fiscal year nineteen hundred eighty-seven disproportionate share payment adjustment factor for revenues received from services provided to beneficiaries of title XVIII of the federal social security act (medicare) as determined in accordance with the provisions of section eighteen hundred eighty-six-d of title XVIII of the federal social security act (medicare). Increased amounts received by general hospitals in accordance with the provision of this subdivision shall be offset against distributions to such hospitals that were made or would be made pursuant to the provisions contained in subdivisions seventeen and nineteen of this section. In the event that distributions had been made to such hospitals pursuant to such subdivisions, the hospital shall, on a proportional basis, return to the pool from which the distributions were made an amount equal to

the increased amounts received under this subdivision to the extent that such increased amounts do not exceed distributions made. Funds in the statewide pool created in accordance with subdivision sixteen of this section, which would have been distributed in accordance with paragraph (c) of subdivision nineteen of this section if the provisions of this subdivision were not in effect, less any amounts not distributed as the result of the offset provisions of this subdivision shall be distributed to regional pools to the extent that such funds are available and necessary to maintain regional pool distributions, with consideration of the offset provisions in this subdivision, at the levels that would be available pursuant to the provisions of subdivision fourteen of this section if the provisions of this subdivision did not apply.

16. Bad debt and charity care regional pools and bad debt and charity care and capital statewide pool, general. (a) Funds will be made available in bad debt and charity care regional pools created by the commissioner for distributions in accordance with subdivision seventeen of this section through the submissions by or on behalf of general hospitals of the allowance included in rates and charges in accordance with paragraph (c) of subdivision fourteen of this section and through the transfer of funds available from the bad debt and charity care and capital statewide pool in accordance with paragraph (a) of subdivision nineteen of this section. Funds will be made available for distributions in accordance with subdivision nineteen of this section from a bad debt and charity care and capital statewide pool created by the commissioner through the submissions by general hospitals of the amount of the assessments authorized in accordance with subdivision eighteen of this section.

(b) The regions are established as the article forty-three insurance plan regions, with the exception that the southern sixteen counties shall be divided into three regions for the purposes of subdivisions fourteen and seventeen of this section with separate regions consisting of Richmond, Manhattan, Bronx, Queens and Kings counties; Nassau and Suffolk counties; and Delaware, Columbia, Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland and Westchester counties. Such regions shall be the same regions established and in effect January first, nineteen hundred eighty-five. The council with the approval of the commissioner may combine regions, with the exception of the above specified regions for the southern sixteen counties, upon application of the article forty-three insurance law plans involved and a demonstration that significant inequities would not occur.

(c) For periods prior to January first, two thousand five, the commissioner and the commissioner of social services are authorized to contract with the article forty-three insurance law plans, or if not available such other administrators as the commissioner and the commissioner of social services shall designate, to receive funds for the bad debt and charity care regional pools and/or the bad debt and charity care and capital statewide pool and distribute funds from such pools. In the event contracts with the article forty-three insurance law plans or other commissioners' designees are effectuated, the commissioner and the commissioner of social services shall jointly conduct or cause to be conducted annual audits of the receipt and distribution of the pooled funds. The reasonable costs and expenses of a pool administrator as approved by the commissioner and the commissioner of social services, not to exceed for personnel services on an annual basis four hundred thousand dollars for all pools, shall be paid from the pooled funds. Such pool administrator or pool administrators shall be acting on behalf

of the state medical assistance program provided pursuant to title eleven of article five of the social services law in the distribution to hospitals pursuant to subdivisions fourteen-c, seventeen and paragraphs (c) and (d) of subdivision nineteen of this section of pooled funds.

(d) In order for a general hospital to participate in the distribution of funds from the pools, the general hospital must implement collection policies and procedures approved by the commissioner and must be in compliance with bad debt and charity care reporting requirements established pursuant to this article.

(e)] 7. In order for a general hospital to be eligible for distribution of funds from the pools, such general hospital if it provides obstetrical care and services must agree to participate in a program approved by the department for the provision of prenatal care to persons eligible for medical assistance or medically indigent persons if requested by such a program. Nothing stated herein shall require a hospital to grant admitting privileges to a physician solely because such person is part of an approved program. The participation of hospitals in an approved program shall include, but not be limited to:

[(i)] (A) arrangements with designated prenatal care providers for prebooking pregnant women for approximate delivery time, and provision of staff and facilities for the delivery and necessary postpartum care for women and infants involved in such programs;

[(ii)] (B) a system for medical record transfer from a prenatal care provider to hospital staff participating in delivery and for the transfer of information regarding hospital delivery and care back to the prenatal care provider for postpartum follow-up; and

[(iii)] (C) an agreement with designated prenatal care providers to accept the care of high risk patients on a referral basis and/or to provide special tests and procedures which are not ordinarily available to prenatal care clinics if such hospital is capable of caring for high risk patients and/or providing special tests and procedures.

[(f) The council may adopt regulations subject to the approval of the commissioner to allow advanced distributions from these pools to a general hospital qualifying for distributions in accordance with paragraph (c) of subdivision nineteen of this section, based on a demonstration by the hospital that there is an inability to finance current obligations and obtain needed working capital.

(g) Notwithstanding any inconsistent provision of law to the contrary, from interest heretofore earned or hereinafter earned on funds in bad debt and charity care regional pools and the bad debt and charity care and capital statewide pool established pursuant to this section, such amounts as shall be necessary, within amounts appropriated, shall be reallocated to, and the state comptroller is hereby authorized and directed to receive for deposit to, the credit of the department of health's special revenue fund - other, hospital based grants program account, for purposes of services and expenses related to general hospital based grant programs for the period April first, nineteen hundred ninety-four through June thirtieth, nineteen hundred ninety-six and for the period July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-seven.

16-a. Pool administration, general. (a) If a general hospital fails to timely file a report with the department of funds due to a regional pool or a statewide pool established pursuant to this section, the commissioner may estimate the amount due from such hospital based on available financial and statistical data and may collect in accordance with subdivision twenty of this section any amount due based on such estimate as a

deficiency in payments to such regional pool or statewide pool with interest and penalties. The commissioner shall provide a general hospital with notice of any estimate of the amount due pursuant to this paragraph at least three days prior to collection of a deficiency by the commissioner. Such notice shall contain the financial basis for the commissioner's estimate.

(b) Notwithstanding any inconsistent provision of section one hundred twelve or one hundred seventy-four of the state finance law or any other law, at the discretion of the commissioner and the commissioner of social services without a competitive bid or request for proposal process, regional pool and statewide pool administration contracts in effect for rate year nineteen hundred ninety-three may be extended for administration of regional pools and statewide pools established for rate years nineteen hundred ninety-four and nineteen hundred ninety-five and nineteen hundred ninety-six to provide an uninterrupted continuation of services and may be amended as may be necessary.

17. Bad debt and charity care regional pool distributions. Funds accumulated in bad debt and charity care regional pools, including income from invested funds, from the allowance specified in paragraph (c) of subdivision fourteen of this section and funds accumulated in bad debt and charity care regional pools, including income from invested funds, from the transfer of funds available from the bad debt and charity care and capital statewide pool in accordance with paragraph (a) of subdivision nineteen of this section shall be deposited by the commissioner and credited to a special revenue-other fund to be established by the comptroller. To the extent of funds appropriated therefor, funds shall be made available for distribution by or on behalf of the state, as payments under the state medical assistance program provided pursuant to title eleven of article five of the social services law, from bad debt and charity care regional pools in accordance with the following methodology and sequence:

(a) For the nineteen hundred eighty-eight, nineteen hundred eighty-nine and for that portion of the nineteen hundred ninety rate year beginning on January first and ending on June thirtieth, each eligible major public general hospital shall receive a portion of its bad debt and charity care need equal to one hundred two percent of the result of the application of its percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), developed on the basis of nineteen hundred eighty-five financial and statistical reports, to the total of all regional pools. For that portion of the nineteen hundred ninety rate year beginning on July first and ending on December thirty-first and in the annual rate years beginning on or after January first, nineteen hundred ninety-one, each eligible major public general hospital shall receive a portion of its bad debt and charity care need equal to one hundred ten percent of the result of the application of its percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare), developed on the basis of nineteen hundred eighty-five financial and statistical reports, to the total of all regional pools.

(b) (i) Funds remaining in the regional pools after distribution in accordance with paragraph (a) of this subdivision shall be distributed to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, on the basis of each hospital's targeted need share. For the rate year beginning January

first, nineteen hundred eighty-eight, an individual hospital's targeted need share shall be defined as the relationship between each hospital's nineteen hundred eighty-six nominal payment amount as defined in subparagraph (i) of paragraph (c) of subdivision fourteen of this section to the nineteen hundred eighty-six nominal payment amounts for all hospitals in the region other than major public general hospitals. For annual rate years beginning on or after January first, nineteen hundred eighty-nine, the base need shall be the calendar year which is two years prior to the rate year. The amount of funds to be distributed in accordance with this paragraph and paragraph (a) of this subdivision shall be limited to the amount of funds accumulated in the pools.

(ii) Notwithstanding any inconsistent provision of this section, commencing April first, nineteen hundred ninety-five funds remaining in the regional pools after distribution in accordance with paragraph (a) of this subdivision shall be aggregated on a statewide basis and treated as a common pool for statewide distributions and distributed to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, on the basis of each hospital's targeted need share defined as the relationship between each hospital's base year nominal payment amount as defined in subparagraph (i) of paragraph (c) of subdivision fourteen of this section to the base year nominal payment amounts for all hospitals statewide other than major public general hospitals.

(d) The department may provide for interim payments to general hospitals of funds available for distribution from regional pools pursuant to this subdivision, subject to reasonable retainage for adjustments, subsequently reconciled to amounts due determined in accordance with this subdivision.

(e) Notwithstanding any inconsistent provision of this section, in the event funds available pursuant to paragraph (b-1) of subdivision nineteen of this section for programs to provide health care coverage for uninsured or underinsured children are inadequate to provide coverage to all eligible children for whom application for coverage is made in a rate period, such additional amounts not to exceed twenty-five million dollars for nineteen hundred ninety-four as shall be necessary to provide such coverage shall be reserved by the commissioner from the amount to be available in bad debt and charity care regional pools for such rate period for additional distributions to such programs. Ten million dollars of the amount reserved for nineteen hundred ninety-four shall not result in a decrease to disproportionate share payments to hospitals.

18.] 8. Bad debt and charity care and capital statewide pool funding. The commissioner shall create a bad debt and charity care and capital statewide pool which shall be funded [by a transfer of funds, which is hereby authorized, for the period January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five, the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six and the period July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six equal to seven million five hundred thousand dollars for the nineteen hundred ninety-five period, three million seven hundred fifty thousand dollars for the January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six period and three million seven hundred fifty thousand dollars for the July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six period to be submitted to a statewide pool, as designated by

the commissioner, from the medical malpractice insurance association pursuant to section five thousand five hundred sixteen-c of the insurance law and] through an assessment which shall be charged to general hospitals. [In the event that the transfers of funds authorized by section five thousand five hundred sixteen-c of the insurance law do not occur by January first, nineteen hundred ninety-five, January first, nineteen hundred ninety-six and August first, nineteen hundred ninety-six respectively, the commissioner for each period for which such transfer from the medical malpractice insurance association has not occurred shall transfer seven million five hundred thousand dollars for the nineteen hundred ninety-five period, three million seven hundred fifty thousand dollars for the January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six period and three million seven hundred fifty thousand dollars for the July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six period from regional or statewide pool reserves for pools established pursuant to this section and section twenty-eight hundred eight-c or twenty-eight hundred seven-a of this article to the bad debt and charity care and capitol statewide pool established pursuant to this subdivision.] Such assessment shall be submitted to a statewide pool as designated by the commissioner and distributed on a monthly basis in accordance with subdivision [twenty] TEN of this section.

(A) The assessment shall be[:

(a) one and seventy-five thousandths percent of each general hospital's gross revenue received for inpatient hospital services provided during the period January first, nineteen hundred eighty-eight through December thirty-first, nineteen hundred eighty-eight; one and five hundredths percent of each general hospital's gross revenue received for inpatient hospital services provided during the period January first, nineteen hundred eighty-nine through December thirty-first, nineteen hundred eighty-nine; and] one percent of each general hospital's gross revenue received for inpatient hospital services provided during annual periods beginning on or after January first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety-nine and on or after January first, two thousand[,].

[(b) provided, however, subject to the provisions of paragraph (e) of this subdivision there shall be no assessment against those voluntary non-profit and private proprietary general hospitals which qualify for distributions made in accordance with paragraph (c) of subdivision nineteen of this section, or for the annual assessment period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven which qualified for distributions made in accordance with paragraph (c) of subdivision nineteen of this section as of December thirty-first, nineteen hundred ninety-five, and

(c) provided further, however, subject to the provisions of paragraph (e) of this subdivision the assessment against those voluntary non-profit and private proprietary general hospitals which qualified for distributions made in accordance with paragraph (c) of subdivision nineteen of this section as of December thirty-first, nineteen hundred ninety-five shall for the annual assessment period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight be abated in the amount of three-quarters of one percent of gross revenue received and for the annual assessment period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine be abated in the amount of one-quarter of one percent of gross revenue received.

(d)] (B) Gross revenue received shall mean all moneys received for or on account of inpatient hospital service, provided, however, that subject to the provisions of paragraph [(e)] (C) of this subdivision gross revenue received shall not include distributions from bad debt and charity care regional pools, health care services pools, bad debt and charity care for financially distressed hospitals statewide pools and bad debt and charity care and capital statewide pools created in accordance with this section or distributions from funds allocated in accordance with section twenty-eight hundred seven-l, twenty-eight hundred seven-k, twenty-eight hundred seven-v or twenty-eight hundred seven-w of this article [and shall not include the components of rates of payment or charges related to the allowances provided in accordance with subdivisions fourteen, fourteen-b and fourteen-c of this section, the adjustment provided in accordance with subdivision fourteen-a of this section, the adjustment provided in accordance with subdivision fourteen-d of this section], the adjustment for health maintenance organization reimbursement rates provided in accordance with former subdivision two-a of this section, payments made pursuant to paragraph (i) of subdivision [thirty-five] SEVENTEEN of this section or[, if effective, the adjustment provided in accordance with subdivision fifteen of this section], the adjustment provided in accordance with section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as amended, revenue received from physician practice or faculty practice plan discrete billings for private practicing physician services, revenue from affiliation agreements or contracts with public hospitals for the delivery of health care services at such public hospitals, revenue received as disproportionate share hospital payments in accordance with title nineteen of the federal social security act, or revenue from government deficit financing, provided, however, that funds received as medical assistance payments which include state share amounts authorized pursuant to section twenty-eight hundred seven-v of this article that are not disproportionate share hospital payments shall be included within the meaning of gross revenue for purposes of this subdivision.

[(e)] (C) Each exclusion of hospitals or sources of gross revenue received from the assessments effective on or after October first, nineteen hundred ninety-two established pursuant to this subdivision shall be contingent upon either: (i) qualification of the assessments for waiver pursuant to federal law and regulation; or, (ii) consistent with federal law and regulation, not requiring a waiver by the secretary of the department of health and human services related to such exclusion; in order for the assessments under this section to be qualified as a broad-based health care related tax for purposes of the revenues received by the state pursuant to the assessments not reducing the amount expended by the state as medical assistance for purposes of federal financial participation. The commissioner shall collect the assessments relying on such exclusions, pending any contrary action by the secretary of the department of health and human services. In the event the secretary of the department of health and human services determines that the assessments do not so qualify based on any such exclusion, then the exclusion shall be deemed to have been null and void as of October first, nineteen hundred ninety-two and the commissioner shall collect any retroactive amount due as a result, without interest or penalty provided the hospital pays the retroactive amount due within ninety days of notice from the commissioner to the hospital that the exclusion is null and void. Interest and penalties shall be measured

from the due date of ninety days following notice from the commissioner to the hospital.

[(f)] (D) Payments of assessments and allowances required to be submitted by general hospitals pursuant to this subdivision and [subdivisions fourteen and fourteen-b of this section and] paragraph (a) of subdivision two of section twenty-eight hundred seven-d of this article shall be subject to audit by the commissioner for a period of six years following the close of the calendar year in which such payments are due, after which such payments shall be deemed final and not subject to further adjustment or reconciliation, including through offset adjustments or reconciliations made by general hospitals with regard to subsequent payments, provided, however, that nothing herein shall be construed as precluding the commissioner from pursuing collection of any such assessments and allowances which are identified as delinquent within such six year period, or which are identified as delinquent as a result of an audit commenced within such six year audit period, or from conducting an audit of any adjustment or reconciliation made by a general hospital within such six year period, or from conducting an audit of payments made prior to such six year period which are found to be commingled with payments which are otherwise subject to timely audit pursuant to this section. General hospitals which, in the course of such an audit, fail to produce data or documentation requested in furtherance of such an audit, within thirty days of such request may be assessed a civil penalty of up to ten thousand dollars for each such failure, provided, however, that such civil penalty shall not be imposed if the hospital demonstrates good cause for such failure. The imposition of such civil penalties shall be subject to the provisions of section twelve-a of this chapter.

[(g)] (E) If a general hospital fails to produce data or documentation requested in furtherance of an audit for a month to which an assessment applies, the commissioner may estimate, based on available financial and statistical data as determined by the commissioner, the amount due for such month. If the impact of exemptions permitted pursuant to paragraph [(d)] (B) of this subdivision cannot be determined from such available financial and statistical data the estimated amount due may be calculated on the basis of the general hospital's aggregate gross inpatient revenue amount, as determined from such available financial and statistical data for the year subject to audit. Estimated amounts due pursuant to this paragraph shall be paid by a general hospital within sixty days or within such other time period as agreed to by the commissioner and the facility. Thereafter the commissioner shall take all necessary steps to collect amounts owed pursuant to this paragraph, including by offsetting, or by directing the state comptroller to offset, such amounts due from any other payments made by state governmental agencies to the general hospital pursuant to this article. Interest and penalties shall be applied to such amounts due in accordance with the provisions of paragraph (c) of subdivision [twenty] TEN of this section.

[(h)] (F) The commissioner shall take all necessary steps to collect delinquent amounts owed pursuant to this subdivision, including by recoupment or offsetting, or by directing the state comptroller to offset, such amounts due from any other payments made by state governmental agencies to the general hospital pursuant to this article. Interest and penalties shall be applied to such amounts due in accordance with the provisions of paragraph (c) of subdivision [twenty] TEN of this section. Delinquent amounts which have been referred for recoupment or offset pursuant to this paragraph, or which have been referred to the

office of the attorney general for collection, shall be deemed final and not subject to further revision or reconciliation by the commissioner based on any additional reports or other information submitted by the hospital, provided, however, that such delinquencies shall not be referred for such recoupment or for such collection based on estimated amounts unless the hospital has received written notification of such delinquencies and has been given no less than thirty days in which to submit delinquent reports.

[(i)] (G) The commissioner may enter into agreements with general hospitals subject to this subdivision, in regard to which audit findings or prior settlements have been made pursuant to this subdivision, extending and applying such audit findings or prior settlements or a portion thereof, in settlement and satisfaction of potential audit liabilities for subsequent un-audited periods. The commissioner may reduce or waive payment of interest and penalties otherwise applicable to such subsequent un-audited periods when such amounts due as a result of such agreement, other than reduced or waived penalties and interest, are paid in full to the commissioner or the commissioner's designee within sixty days of execution of such agreement by all parties to the agreement. Any payments made pursuant to agreements entered into in accordance with this paragraph shall be deemed to be in full satisfaction of any liability arising under this subdivision, as referenced in such agreements and for the time periods covered by such agreements, provided, however, that the commissioner may audit future retroactive adjustments to payments made for such periods based on reports filed by hospitals subsequent to such agreements.

[19. Bad debt and charity care and capital statewide pool distribution. Funds accumulated in the statewide pool created by the assessment authorized in accordance with subdivision eighteen of this section for periods through December thirty-first, nineteen hundred ninety-six, including income from invested funds, shall be distributed or retained in accordance with the following sequence:

(a) Funds shall be distributed by the commissioner to bad debt and charity care regional pools established pursuant to subdivision sixteen of this section to provide additional funds for distribution from such bad debt and charity care regional pools in accordance with subdivision seventeen of this section equal to the amount computed as the difference between the amount that would be available in such regional pools based on a statewide determination of financial resources to be committed to regional pools in each year in accordance with paragraph (c) of subdivision fourteen of this section based upon a percentage factor equal to five and ninety-three hundredths percent and the amount to be available in such regional pools based on a statewide determination of financial resources to be committed to regional pools in each year in accordance with paragraph (c) of subdivision fourteen of this section based upon a percentage factor equal to five and forty-eight hundredths percent.

(b) An amount not to exceed seventeen million dollars on an annualized basis from the assessment through December thirty-first, nineteen hundred ninety-six may annually be placed in a statewide account in accordance with rules and regulations adopted by the council and approved by the commissioner for the purpose of securing financing of capital improvement projects for general hospitals qualifying for distributions made in accordance with paragraph (c) of this subdivision. Any reserved funds available on September first, nineteen hundred ninety-seven and not obligated, in accordance with section twelve of chapter nine hundred thirty-four of the laws of nineteen hundred eighty-five as

amended, for the purpose of securing financing of capital improvement projects for general hospitals and any reserved funds that thereafter become available may be transferred by the commissioner, in consultation with the director of the budget and the dormitory authority, to the health facility restructuring pool established pursuant to section twenty-eight hundred fifteen of this article or to the general hospital indigent care pool established pursuant to section twenty-eight hundred seven-k of this article.

(b-1) An amount equal to: twenty million dollars annually for the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-three; thirty million dollars for the period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four; thirty-seven million five hundred thousand dollars for the period January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five; eighteen million seven hundred fifty thousand dollars for the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six; and eighteen million seven hundred fifty thousand dollars for the period July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six shall annually be reserved and accumulated from year to year by the commissioner for distributions to programs to provide health care coverage for uninsured or underinsured children. Such accumulated funds shall not be used for any other purpose other than those authorized in section twenty-five hundred ten and twenty-five hundred eleven of this chapter. If on March thirty-first, nineteen hundred ninety-eight, any funds accumulated during the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-seven are unused or uncommitted for such distributions, such unused or uncommitted funds shall be immediately transferred by the commissioner to the health care initiatives pool established by the commissioner to provide additional funds for distribution to programs to provide health care coverage for uninsured or underinsured children pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter. For cash flow purposes, the commissioner may borrow from regional or statewide pool reserves for pools established pursuant to this section such funds as shall be necessary not to exceed the amount authorized to be reserved annually to meet premium requirements pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter for a rate year and shall refund such moneys when pool funds become available pursuant to this paragraph for such rate year.

(b-2) Funds available for distribution in accordance with paragraphs (c) and (d) of this subdivision shall be deposited by the commissioner and credited to a special revenue-other fund to be established by the comptroller. To the extent of funds appropriated therefor, funds shall be made available for distributions by or on behalf of the state, as payments under the state medical assistance program provided pursuant to title eleven of article five of the social services law from the bad debt and charity care and capital statewide pool pursuant to paragraphs (c) and (d) of this subdivision.

(c) Funds shall be made available on a statewide basis for distribution by the commissioner in accordance with rules and regulations adopted by the council and approved by the commissioner to assist voluntary non-profit and private proprietary general hospitals experiencing severe fiscal hardship because of insufficient resources to finance losses resulting from bad debts and the costs of charity care. Amounts

to be distributed for bad debt and charity care purposes shall be determined after consideration of amounts to be distributed from regional pools in accordance with subdivision seventeen of this section and shall result in up to one hundred percent as defined in paragraph (b) of subdivision fourteen of this section being financed for these general hospitals.

(d) Funds shall be made available on a statewide basis for distribution by the commissioner in accordance with rules and regulations adopted by the council and approved by the commissioner to assist voluntary non-profit and private proprietary general hospitals which qualified for distributions made in accordance with paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-a of this article during the nineteen hundred eighty-seven rate period or qualified for distributions made in accordance with paragraph (c) of this subdivision during a rate period or rate periods but which do not continue to qualify for distributions made in accordance with paragraph (c) of this subdivision during a rate period or rate periods. Amounts to be distributed to a general hospital pursuant to this paragraph for the initial rate period in which such general hospital does not continue to qualify for distributions made in accordance with paragraph (c) of this subdivision shall be two-thirds of the amount such general hospital would have received in accordance with paragraph (c) of this subdivision for such initial rate period if the hospital had continued to be eligible for such distribution and for the next succeeding annual rate period one-third of the amount such general hospital would have received in accordance with paragraph (c) of this subdivision for such succeeding rate period.

(e) There shall be set aside within a transition account in the statewide pool, from accumulated funds, from the total allocation to the bad debt and charity care and capital statewide pool of the assessment of one and seventy-five thousandths percent of gross revenue received in accordance with paragraph (a) of subdivision eighteen of this section for the rate period commencing January first, nineteen hundred eighty-eight and the assessment of one and five hundredths percent of gross revenue received in accordance with paragraph (a) of subdivision eighteen of this section for the rate period commencing January first, nineteen hundred eighty-nine an amount equal to seventy-five thousandths of one percent of gross revenue received and five hundredths of one percent of gross revenue received respectively to be distributed to voluntary non-profit, private proprietary and public general hospitals receiving less bad debt and charity care funds under the provisions of this section than if the provisions of section twenty-eight hundred seven-a of this article had applied using the same base year need as calculated in accordance with subdivision fourteen of this section. Rules for such distribution shall be those adopted by the council and approved by the commissioner.

(f) Any balance in the statewide pool shall be distributed in accordance with the following:

(i) Fifty percent of the balance shall be reserved and accumulated from year to year by the commissioner for distributions to regional pilot projects to provide health care coverage under insurance or equivalent mechanisms for uninsured or underinsured individuals and families and to provide health care coverage for catastrophic expenses provided legislation is enacted before July fifteenth, nineteen hundred eighty-eight authorizing such regional pilot projects and including an authorization for such regional pilot projects, notwithstanding any inconsist-

ent provision of law, to negotiate special payment rate methodologies with general hospitals for inpatient hospital services.

(ii) The remaining balance shall be reserved and accumulated from year to year by the commissioner for priority distributions in accordance with rules and regulations adopted by the council and approved by the commissioner: (A) to assist general hospitals in offsetting losses from bad debt and the costs of charity care in providing existing or expanded priority health services to the medically indigent or medically underserved in urban and rural areas including, but not limited to, services for pregnant women, services for children under the age of six, and services related to acquired immune deficiency syndrome; (B) for quality assurance demonstration projects; (C) for severity of illness measurement demonstration projects; (D) for cost analyses and evaluations of health care provider services; (E) for quality improvement program grants and contracts pursuant to subdivision fifteen of section two hundred six of this chapter and department of health administrative costs related thereto; and (F) for initiatives to improve public health and to expand the availability of health care services.

Notwithstanding any provision of law to the contrary, a sum not to exceed three million five hundred thousand dollars from funds available for distribution pursuant to this subparagraph may be allocated and distributed to regional pilot projects to provide health care coverage under insurance or equivalent mechanisms for uninsured or underinsured individuals and families pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight.

Notwithstanding any inconsistent provision of section one hundred twelve or one hundred seventy-four of the state finance law or any other law, funds available for distribution pursuant to this subparagraph may be allocated and distributed without a competitive bid or request for proposal process.

(iii) Any unused funds from the allocations provided for in paragraph (b) and paragraph (e) of this subdivision and subparagraph (i) of this paragraph and any funds contingently allocated to regional pilot projects pursuant to subparagraph (i) of this paragraph if authorizing legislation is not enacted as required by such subparagraph shall be reallocated for use in accordance with the provisions of subparagraph (ii) of this paragraph.

(iv) Notwithstanding any inconsistent provision of this section, the commissioner shall enter into agreements with one or more persons, not-for-profit corporations, or other organizations, other than a state employee, official or agency, for the purposes of an independent evaluation of the implementation and effectiveness of primary care initiatives, including preferred primary care provider designations, applicable to general hospitals, diagnostic and treatment centers and participating practitioners and may allocate and distribute funds otherwise available for distribution in accordance with subparagraph (ii) of this paragraph for the costs of such evaluation. The evaluation shall assess factors including but not limited to:

(A) the overall effect of such primary care initiatives on access to and utilization of health care services;

(B) the extent to which such initiatives have fostered cooperative working relationships between various providers of health care services;

(C) the impact of such initiatives on the cost of health care services.

An initial evaluation pursuant to this subparagraph shall be submitted to the governor and the legislature on or before April first, nineteen

hundred ninety-two and a further evaluation shall be submitted by April first, nineteen hundred ninety-three.

19-a. Health care services allowance statewide pool distribution. Funds accumulated in the statewide pool created by the allowance authorized in accordance with subparagraphs (ii) and (iii) of paragraph (a) of subdivision fourteen-b of this section, including income from invested funds, shall be distributed or retained in accordance with the following:

(a) Funds shall be transferred to primary health care services regional pools created by the commissioner, and shall be available, including income from invested funds, for distributions in accordance with section twenty-eight hundred seven-bb of this article. Such funds shall be transferred to each regional pool so that the regional pool receives, for the rate periods January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four fifty-one and five-tenths percent, January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five forty-nine and six-tenths percent, and January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six forty-nine and six-tenths percent of the total funds to be accumulated in the statewide pool from the allowance submitted by or on behalf of hospitals in that region. Such regions shall be those established for purposes of section two thousand nine hundred four-b of this chapter.

(b) A fixed percentage of the total funds accumulated in the statewide pool, including income from invested funds, shall be available for primary care education and training. For the rate periods January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four, such percentage shall be twenty-two and one-tenth percent, and January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five, such percentage shall be twenty and four-tenths percent, and January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six such percentage shall be twenty and four-tenths percent. Funds shall be available for distributions as follows:

(i) up to four million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated for the following year for distribution by the commissioner for primary care undergraduate medical education in accordance with section nine hundred two of this chapter;

(ii) up to four million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated for the following year for distribution by the commissioner for the primary care physician loan repayment program in accordance with section nine hundred three of this chapter;

(iii) up to two million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated for the following year for distribution by the commissioner for the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter;

(iv) up to two million dollars annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be accumulated for the following year for distribution by the commissioner for the primary care practitioner education program in accordance with section nine hundred five of this chapter;

(v) the balance remaining annually plus income thereon from invested funds shall be set aside and reserved from accumulated funds and may be

accumulated from year to year for distributions by the commissioner for health care development in accordance with section nine hundred six of this chapter; and

(vi) provided, however, that the commissioner in the absence of qualified recipients within a category may reallocate any funds remaining or unallocated within such a category for distribution by the commissioner for the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter and the primary care practitioner education program in accordance with section nine hundred five of this chapter.

(c) A fixed percentage of the total funds accumulated in the statewide pool, including income from invested funds, shall be deposited by the commissioner into the miscellaneous special revenue fund - 339, health care planning account, which is established for services and expenses for health planning, for purposes of: (i) per capita support of health systems agencies, provided no health systems agency shall receive less than two hundred fifty thousand dollars annually from the per capita allocation, and provided further that a health systems agency receiving the minimum level of funding provided pursuant to a per capita formula shall also be entitled to receive matching support; (ii) matching support for other contributions received by health systems agencies from qualified sources as determined by the commissioner; (iii) five hundred thousand dollars for global budgeting demonstrations grants authorized pursuant to section twenty-eight hundred fourteen of this article; and (iv) five hundred thousand dollars for health networks grants authorized pursuant to section twenty-eight hundred fourteen of this article. For the rate period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four such percentage shall be eight and eight-tenths percent, and for the rate period January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-six such percentage shall be eight and two-tenths percent.

(c-1) Notwithstanding any other provision of law to the contrary, any unspent funds available for programs and services pursuant to subparagraphs (iii) and (iv) of paragraph (c) of this subdivision as of April first, nineteen hundred ninety-five and any additional funds available for programs and services pursuant to subparagraphs (iii) and (iv) of paragraph (c) of this subdivision for the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five shall be transferred by the commissioner and deposited and credited to the medical assistance program general fund - local assistance account.

(c-2) Notwithstanding any other provision of law to the contrary, funds accumulated for programs and services pursuant to subparagraphs (i) and (ii) of paragraph (c) of this subdivision for nineteen hundred ninety-five shall be transferred by the commissioner and deposited and credited to the general fund - local assistance account.

(d) A fixed percentage of the total funds accumulated in the statewide pool, including income from invested funds, shall be deposited by the commissioner and credited to the emergency medical services training account established for purposes of section ninety-seven-q of the state finance law for services and expenses related to emergency medical services training and administration. For the rate period January first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four, such percentage shall be seventeen and six-tenths percent, for the rate period January first, nineteen hundred ninety-five

through December thirty-first, nineteen hundred ninety-five, such percentage shall be twenty-one and eight-tenths percent, and for the rate period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six, such percentage shall be twenty-one and eight-tenths percent.

(f) Distributions from the pools created in accordance with this subdivision and subdivision fourteen-b of this section, and the components of rates of payment or charges related to the allowances provided in accordance with subdivision fourteen-b of this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of this section, subject to the provisions of paragraph (e) of subdivision eighteen of this section, and shall not be included in gross receipts received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

(g) Notwithstanding any inconsistent provisions of law, the commissioner may borrow from regional or statewide pool reserves for pools established pursuant to sections twenty-eight hundred eight-c, twenty-eight hundred seven-a or this section of this article such funds as shall be necessary, not to exceed the amounts projected to be available pursuant to paragraph (d) of subdivision fourteen-b of this section, annually for distributions in accordance with paragraphs (a), (b), (c), (d) and (h) of this subdivision for a rate year and shall refund such moneys when pool funds become available pursuant to paragraphs (a), (b), (c), (d) and (h) of this subdivision for such rate year.

(h) Notwithstanding any inconsistent provision of this subdivision, prior to allocation of funds in accordance with paragraphs (a), (b), (c) and (d) of this subdivision from the allowance for the period July first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five and from the allowance for the period January first, nineteen hundred ninety-six through June thirtieth, nineteen hundred ninety-six, thirty-nine million five hundred thousand dollars from the nineteen hundred ninety-five pool and forty-four million five hundred thousand dollars from the nineteen hundred ninety-six pool respectively shall be reserved by the commissioner from the amount accumulated in the statewide pool, proportionally based on the total amount of funds projected to be accumulated in the pool for the year, for additional distributions in accordance with paragraph (b-1) of subdivision nineteen of this section to programs to provide health care coverage for uninsured or underinsured children, and the balance of funds accumulated in the statewide pool shall be proportionally allocated in accordance with paragraphs (a), (b), (c) and (d) of this subdivision.

19-b.] 9. Funds accumulated in the statewide pool created by the assessment authorized in accordance with subdivision [eighteen] EIGHT of this section for a period during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and periods on and after January first, two thousand, including income from invested funds, shall be transferred by the commissioner and consolidated with funds accumulated from the allowance pursuant to subdivision two of section twenty-eight hundred seven-j of this article for such period and allocated in accordance with subdivision nine of section twenty-eight hundred seven-j of this article.

[20.] 10. Payments to pools. (a) [Payments by or on behalf of general hospitals to bad debt and charity care regional pools of funds due based on the allowance included in rates and charges in accordance with para-

graph (c) of subdivision fourteen of this section and to regional pools created pursuant to paragraph (b) of subdivision fourteen-b and to a statewide pool created pursuant to paragraph (b) of subdivision fourteen-c of this section shall be made on a time schedule established by the council, subject to the approval of the commissioner, by regulation; provided, however, that estimated payments of amounts due for patients discharged in a calendar month commencing on or after October first, nineteen hundred ninety-one must be made within sixty days of the end of each month unless payments of actual amounts due for such calendar months have been made within such sixty day time period. Upon receipt of notification from the commissioner, the comptroller, or a fiscal intermediary designated by the director of the budget, or the commissioner of social services, or a corporation organized and operating in accordance with article forty-three of the insurance law or an organization operating in accordance with article forty-four of this chapter shall withhold from the amount of any payment to be made by the state or such article forty-three corporation or article forty-four organization to a general hospital the amount of any arrearage resulting from such general hospital's failure to make a timely payment to the pools of funds due based on the allowances included in rates and charges in accordance with paragraph (c) of subdivision fourteen, paragraph (a) of subdivision fourteen-b and paragraph (a) of subdivision fourteen-c of this section. Upon withholding such amount, the comptroller, or a designated fiscal intermediary, or the commissioner of social services, or a corporation organized and operating in accordance with article forty-three of the insurance law or an organization operating in accordance with article forty-four of this chapter shall pay the commissioner, or his designee, such amount withheld for deposit into the applicable pool. Any general hospital in arrears resulting from failure to make a timely payment to a pool shall not be eligible for a distribution from a bad debt and charity care regional pool in accordance with subdivision seventeen of this section until such arrearage is satisfied.

(b)] (i) Payments by or on behalf of general hospitals to the [bad debt and charity care and capital statewide] APPLICABLE pool of funds due from the assessments pursuant to subdivision [eighteen] EIGHT of this section shall be made on a time schedule established by [the council, subject to the approval of] the commissioner[, by regulation]; provided, however, that estimated payments of amounts due [for patients discharged in a calendar month commencing on or after October first, nineteen hundred ninety-one] must be made within sixty days of the end of each month unless payments of actual amounts due for such calendar months have been made within such sixty day time period. Upon receipt of notification from the commissioner, the comptroller, or a fiscal intermediary designated by the director of the budget, [or a corporation organized and operating in accordance with article forty-three of the insurance law or an organization operating in accordance with article forty-four of this chapter] shall withhold from the amount of any payment to be made by the state [or such article forty-three corporation or article forty-four organization] to a general hospital the amount of any arrearage resulting from such general hospital's failure to make a timely payment to the [bad debt and charity care and capital statewide] APPLICABLE pool of funds due from the assessments. Upon withholding such amount, the comptroller, or a designated fiscal intermediary, [or a corporation organized and operating in accordance with article forty-three of the insurance law or an organization operating in accordance with article forty-four of this chapter] shall pay the commissioner, or

his designee, such amount withheld for deposit into the applicable pool. [Any general hospital in arrears resulting from failure to make a timely payment to the bad debt and charity care and capital statewide pool shall not be eligible for a distribution from the bad debt and charity care regional pools in accordance with subdivision seventeen of this section or the bad debt and charity care and capital statewide pool in accordance with subdivision nineteen of this section until such arrearage is satisfied.]

(ii) For periods on and after January first, two thousand five, reports submitted by general hospitals to implement the assessment set forth in subdivision [eighteen] EIGHT of this section shall be submitted electronically in a form as may be required by the commissioner; provided, however, general hospitals are not prohibited from submitting reports electronically on a voluntary basis prior to such date, and provided further, however, that all such electronic submissions submitted on and after July first, two thousand twelve shall be verified with an electronic signature as prescribed by the commissioner.

[(c)] (B) (i) Interest shall be due and payable to the commissioner by a general hospital or by a payor paying directly to a pool on the difference between the amount paid to a pool and the amount due to such pool by the hospital or payor from the day of the month the payment was due until the date of payment. The rate of interest shall be twelve percent per annum or at the rate of interest set by the commissioner of taxation and finance with respect to underpayments of tax pursuant to subsection (e) of section one thousand ninety-six of the tax law minus four percentage points. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar. Interest may be collected by the commissioner in the same manner as an arrearage pursuant to this subdivision.

(ii) If a payment by a general hospital or by a payor paying directly to a pool is less than seventy percent of the amount due to such pool by the hospital or payor, a penalty shall be due and payable to the commissioner by the hospital or payor of five percent of the difference between the amount paid to the pool and the amount due to such pool when the failure to pay is for a duration of not more than one month after the due date of the payment with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding twenty-five percent in the aggregate. A penalty may be collected by the commissioner in the same manner as an arrearage pursuant to this subdivision.

[21.] 11. Maximum distributions. (a) [No general hospital may receive in total from the distributions made in accordance with paragraph (b) of subdivision fourteen-c, paragraphs (a) and (b) of subdivision seventeen and paragraphs (c), (d) and (e) of subdivision nineteen of this section an amount which exceeds its need for financing losses related to bad debts and the costs of charity care as defined in paragraph (b) of subdivision fourteen of this section.

(b)](i) No public general hospital may receive in total from disproportionate share payment distributions [made in accordance with subdivision seventeen of this section and adjustments in accordance with subdivisions fourteen-a and fourteen-d of this section for the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four or for annual rate periods beginning on January first on or after January first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-six, or] made in accordance with section twenty-eight hundred seven-k of this article and

adjustments in accordance with subdivision [fourteen-f] SIX of this section for annual periods beginning on January first on and after January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand an amount which exceeds the costs incurred during such period of furnishing inpatient and ambulatory hospital services, net of medical assistance payments pursuant to title eleven of article five of the social services law, other than disproportionate share payments pursuant to [subdivision twenty-six of this section or] subdivision thirteen of section twenty-eight hundred seven-k of this article, and payments by uninsured patients, by the hospital to individuals who either are eligible for medical assistance pursuant to title eleven of article five of the social services law or have no health insurance or other source of third party coverage; provided, however, that the commissioner shall make such increase to such maximum or to the manner in which the limitation on disproportionate share payments is applied as shall increase the maximum limit for a period or part of a period as authorized by federal law or regulation or the secretary of the department of health and human services for purposes of federal financial participation pursuant to title XIX of the federal social security act. For purposes of this paragraph, payments to a general hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third party payment.

(ii) Reductions pursuant to this paragraph shall be made in the following sequence:

(A) [for periods through December thirty-first, nineteen hundred ninety-six, adjustments in accordance with subdivision fourteen-d of this section; adjustments in accordance with subdivision fourteen-a of this section; and distributions in accordance with subdivision seventeen of this section, and

(B) for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand,] adjustments in accordance with subdivision [fourteen-f] SIX of this section; and

(B) distributions in accordance with section twenty-eight hundred seven-k of this article.

(iii) [(A) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with subdivision seventeen of this section for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to subdivision seventeen of this section for periods through December thirty-first, nineteen hundred ninety-six equal to one-half of such reduction.

(B)] In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with section twenty-eight hundred seven-k of this article for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand equal to one-half of such reduction.

[(c)] (B)(i) No general hospital other than a public general hospital may receive in total from disproportionate share payment distributions

[made in accordance with paragraph (b) of subdivision fourteen-c, subdivision seventeen and paragraphs (c) and (d) of subdivision nineteen of this section and adjustments in accordance with subdivision fourteen-d of this section for the period April first, nineteen hundred ninety-five through December thirty-first, nineteen hundred ninety-five or for the annual rate period beginning on January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six, or] made in accordance with section twenty-eight hundred seven-k of this article for annual periods beginning on January first on and after January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand an amount which exceeds the costs incurred during such period of furnishing inpatient and ambulatory hospital services, net of medical assistance payments pursuant to title eleven of article five of the social services law, other than disproportionate share payments pursuant to [subdivision twenty-six of this section or] subdivision thirteen of section twenty-eight hundred seven-k of this article, and payments by uninsured patients, by the hospital to individuals who either are eligible for medical assistance pursuant to title eleven of article five of the social services law or have no health insurance or other source of third party coverage; provided, however, that the commissioner shall make such modifications to the manner in which the limitation on disproportionate share payments is applied to such hospitals as shall increase the maximum limit for a period or part of a period as authorized by federal law or regulation or the secretary of the department of health and human services for purposes of federal financial participation pursuant to title XIX of the federal social security act. For purposes of this paragraph, payments to a general hospital for services provided to indigent patients made by the state or a unit of local government within the state shall not be considered to be a source of third party payment.

(ii)[(A) Reductions pursuant to this paragraph for periods through December thirty-first, nineteen hundred ninety-six shall be made in the following sequence for general hospitals other than financially distressed hospitals: adjustments in accordance with subdivision fourteen-d of this section; and distributions in accordance with subdivision seventeen of this section.

(B) Reductions pursuant to this paragraph for periods through December thirty-first, nineteen hundred ninety-six shall be made in the following sequence for general hospitals designated as financially distressed hospitals: distributions in accordance with paragraph (b) of subdivision fourteen-c of this section; distributions in accordance with paragraphs (c) and (d) of subdivision nineteen of this section; and distributions in accordance with subdivision seventeen of this section.

(C)] Reductions pursuant to this paragraph for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand, shall be made from distributions in accordance with section twenty-eight hundred seven-k of this article.

(iii) [(A) In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with paragraph (b) of subdivision fourteen-c of this section, paragraph (c) or (d) of subdivision nineteen of this section, subdivision fourteen-d of this section or subdivision seventeen of this section for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal

financial participation from funds available pursuant to such subdivisions equal to one-half of such reduction for periods through December thirty-first, nineteen hundred ninety-six.

(B)] In the event a reduction pursuant to subparagraphs (i) and (ii) of this paragraph is effective for distributions in accordance with section twenty-eight hundred seven-k of this article for a general hospital, such general hospital shall receive a supplementary distribution not as a disproportionate share payment and not subject to federal financial participation from funds available pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand equal to one-half of such reduction.

[(d)] (C)(i) Commencing April first, nineteen hundred ninety-four, no general hospital may be eligible to receive disproportionate share payments determined [in accordance with subdivision twenty-six of this section through December thirty-first, nineteen hundred ninety-six or] in accordance with section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand unless the hospital has an inpatient utilization rate for patients eligible for payments pursuant to title eleven of article five of the social services law eligible for federal financial participation pursuant to title nineteen of the federal social security act of not less than one percent.

(ii) In the event a general hospital is disqualified pursuant to subparagraph (i) of this paragraph from receiving disproportionate share payments for a period, such general hospital shall receive distributions not as disproportionate share payments and not subject to federal financial participation from funds available [pursuant to subdivision seventeen of this section for periods through December thirty-first, nineteen hundred ninety-six, and] pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand equal to one-half of the distributions for which such general hospital would have been qualified pursuant to subdivision seventeen of this section for periods through December thirty-first, nineteen hundred ninety-six, and pursuant to section twenty-eight hundred seven-k of this article for periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand without consideration of subparagraph (i) of this paragraph.

[(e)] (D) For purposes of calculations pursuant to [paragraphs (b) and (c)] PARAGRAPH (A) of this subdivision of maximum disproportionate share payment distributions for a year or part thereof, costs incurred of furnishing hospital services net of medical assistance payments, other than disproportionate share payments, and payments by uninsured patients shall be determined initially based on base year data and statistics for the base year two years immediately preceding the year projected to the year by the trend factor determined in accordance with subdivision ten of this section and shall be subsequently revised to reflect actual period data and statistics. For purposes of calculations pursuant to paragraph [(d)] (B) of this subdivision of eligibility to receive disproportionate share payments for a year or part thereof, the hospital inpatient utilization rate shall be determined based on base year

statistics in accordance with a methodology established by the commissioner, and costs incurred of furnishing hospital services shall be determined in accordance with a methodology established by the commissioner consistent with requirements of the secretary of the department of health and human services for purposes of federal financial participation pursuant to title XIX of the federal social security act in disproportionate share payments.

[(e-1)] (E) For periods on and after January first, two thousand eleven, for purposes of calculations pursuant to [paragraphs (b) and (c)] PARAGRAPH (A) of this subdivision of maximum disproportionate share payment distributions for a rate year or part thereof, costs incurred of furnishing hospital services net of medical assistance payments, other than disproportionate share payments, and payments by uninsured patients [shall] for the two thousand eleven calendar year, shall be determined initially based on each hospital's submission of a fully completed two thousand eight disproportionate share hospital data collection tool, which is required to be submitted to the department by March thirty-first, two thousand eleven, and shall be subsequently revised to reflect each hospital's submission of a fully completed two thousand nine disproportionate share hospital data collection tool, which is required to be submitted to the department by October first, two thousand eleven.

For calendar years on and after two thousand twelve, such initial determinations shall reflect submission of data as required by the commissioner on a specified date. All such initial determinations shall subsequently be revised to reflect actual rate period data and statistics. Indigent care payments will be withheld in instances when a hospital has not submitted required information by the due dates prescribed in this paragraph, provided, however, that such payments shall be made upon submission of such required data. For purposes of calculations pursuant to paragraph [(d)] (B) of this subdivision of eligibility to receive disproportionate share payments for a rate year or part thereof, the hospital inpatient utilization rate shall be determined based on the base year statistics in accordance with the methodology established by the commissioner, and costs incurred of furnishing hospital services shall be determined in accordance with a methodology established by the commissioner consistent with requirements of the secretary of the department of health and human services for purposes of federal financial participation pursuant to [the] title XIX of the federal social security act in disproportionate share payments.

(f) The commissioner may recover any amounts paid in excess of maximum permissible distributions and adjustments determined pursuant to this subdivision by retroactive adjustment and recoupment from payments made for beneficiaries eligible for payments pursuant to title eleven of article five of the social services law.

[(g) Notwithstanding any inconsistent provision of this subdivision, the provision of subparagraph (iii) of paragraph (b), subparagraph (iii) of paragraph (c) or subparagraph (ii) of paragraph (d) of this subdivision shall be of no force and effect and shall be deemed to have been null and void as of January first, nineteen hundred ninety-four in the event the secretary of the department of health and human services determines that distributions based on such provisions would render a health care related tax on general hospitals an impermissible health care related tax for purposes of the federal medicaid voluntary contribution and provider specific tax amendments of nineteen hundred ninety-one for purposes of such health care related tax receipts reducing the

amount deemed expended by the state as medical assistance for purposes of federal financial participation.

22. Undistributed funds. Any funds, including income from invested funds, remaining in the bad debt and charity care and capital statewide pool after distributions in accordance with paragraphs (a), (b), (b-1), (c), (d), (e) and (f) of subdivision nineteen of this section shall be distributed proportionately to voluntary non-profit, private proprietary and public general hospitals, excluding major public general hospitals, on the basis of hospital specific assessments submitted to the pool.

23.] 12. Reimbursement rates. The assessments pursuant to subdivision [eighteen] EIGHT of this section shall not be an allowable cost in the determination of general hospital inpatient reimbursement rates in accordance with this section and section twenty-eight hundred seven of this article.

[24.] 13. Federal financial participation. The council may adopt rules and regulations, subject to the approval of the commissioner, to adjust rates of payment by governmental agencies for general hospital inpatient services determined in accordance with this section as necessary to meet federal requirements for securing federal financial participation pursuant to title XIX of the federal social security act in the event the state cannot provide assurances satisfactory to the secretary of health and human services related to a comparison of rates of payment in the aggregate to maximum aggregate payments determined in accordance with federal law and regulation which are substantially the same as such assurances as in effect on October twenty-sixth, nineteen hundred eighty-seven for securing such federal financial participation. Notwithstanding any other law, the state reserves the right to recoup any payments by governmental agencies for general hospital inpatient services authorized by this section for which federal financial participation has been denied in connection with that determination by the department of health and human services.

[25.] 14. Medical education expenses. [(a) Notwithstanding any inconsistent provision of this section, to encourage the training of more primary care physicians, for annual rate periods beginning on or after January first, nineteen hundred ninety-two, indirect medical education expenses, as defined in subparagraph (ii) of paragraph (c) of subdivision seven of this section, of a general hospital included in the determination of the operating cost component of general hospital rates of payment for a rate period in accordance with subdivisions six and seven of this section or in accordance with paragraph (e), (g) or (i) of subdivision four of this section for general hospitals or distinct units of general hospitals not reimbursed on the basis of case based payments per discharge shall be adjusted to reflect the following modifications:

(i) the calculation of interns and residents to bed ratios for purposes of determining indirect reimbursement shall include residents in non-hospital ambulatory settings. The sum in total for all general hospitals of the indirect medical education expenses shall equal the sum in total for each general hospital determined as if the provisions of this section were applied without consideration of residents in non-hospital ambulatory settings; and

(ii) for annual rate periods beginning on or after January first, nineteen hundred ninety-two, residencies shall be weighted to provide higher weights for primary care and emergency medicine physicians. Primary care residents specialties shall include family medicine, general pediatrics, primary care internal medicine and primary care obstetrics and gynecology. In determining whether a residency is in primary

care, the commissioner shall consult with the New York state council on graduate medical education and the state hospital review and planning council. Reimbursable indirect expenses of medical education of a general hospital for a rate period shall be weighted based on projected medical education statistics for such general hospital for such rate period, and subsequently reconciled through appropriate audit procedures to actual statistics by a prospective adjustment to rates of payment. The weighting factors shall be determined based on nineteen hundred ninety data and statistics and shall include residents identified in subparagraph (i) of this paragraph not previously included in such calculations such that the sum in total for all general hospitals of the results of the weighting factors multiplied by the indirect medical education expenses for each general hospital shall equal, approximately, the sum in total for all general hospitals of the indirect medical education expenses for each general hospital determined as if the provisions of this section were applied without consideration of the weighting factors or residents in non-hospital ambulatory settings determined pursuant to this subdivision. Residency positions in any specialty shall be weighted to equal no less than nine-tenths of what such position would have equaled if reimbursement were to have been calculated without regard to the weighting factors. If a general hospital is reimbursed by this provision in excess of the amount such hospital would have been reimbursed without regard to the weighting factors, such general hospital shall apply such additional funds to encourage the training of primary care physicians. The provisions of this subparagraph shall not apply to those four specialty eye and ear, special surgery and orthopedic and joint disease hospitals, specified by the commissioner, whose primary mission is to engage in research, training, and clinical care in the above-named areas.

(b)] Hospitals shall furnish to the department such reports and information as may be required by the commissioner to assess the cost, quality and health system needs for medical education provided.

[(c) For purposes of determining how such weighting factors have resulted in the increased training of physicians in primary care specialties, the council on graduate medical education shall prepare a report on or before March thirty-first, nineteen hundred ninety-five. Such report shall include, but shall not be limited to: an evaluation of the effectiveness such weighting factors have had on the number of residents matched in primary care specialties; the degree to which such weighting factors have impacted general hospitals to redirect their residency programs toward training primary care physicians; and the impact such weighting factors have had on graduate medical education within general hospitals. Such report shall also include recommendations to the governor and the legislature on the continuation, expiration or modification of such weighting factors.

(d) Notwithstanding any inconsistent provision of this section and subject to the availability of federal financial participation:

(i) For periods on and after April first, two thousand four, the commissioner shall adjust inpatient medical assistance rates of payment established pursuant to this section, including discrete rates of payment calculated pursuant to paragraph a-three of subdivision one of this section, for non-public general hospitals, and for periods on and after April first, two thousand seven, for public and non-public general hospitals, in accordance with subparagraph (ii) of this paragraph, for purposes of reimbursing graduate medical education costs based on the following methodology:

(ii) Rate adjustments for each general hospital shall be based on the difference between the graduate medical education component, direct and indirect, of the two thousand three medical assistance inpatient rates of payment, including exempt unit per diem rates, and an estimate of what the graduate medical education component, direct and indirect, of such medical assistance inpatient rates of payment, including exempt unit per diem rates would be, stated at two thousand three levels and calculated as follows:

(A) Each general hospital's total direct medical education costs as reported in the two thousand one institutional cost report submitted as of December thirty-first, two thousand three, and

(B) An estimate of the total indirect medical education costs for two thousand one calculated in accordance with the methodology applicable for purposes of determining an estimate of indirect medical education costs pursuant to subparagraph (ii) of paragraph (c) of subdivision seven of this section. The indirect medical education costs shall equal the product of two thousand one hospital specific inpatient operating costs, including exempt unit costs, and the indirect teaching cost percentage determined by the following formula:

where r equals the ratio of residents and fellows to beds for two thousand one adjusted to reflect the projected two thousand three resident counts.

(C) Each hospital's rate adjustment shall be limited to seventy-five percent of the graduate medical education component included in its two thousand three medical assistance inpatient rates of payment, including exempt unit rates. For periods on and after April first, two thousand seven, the seventy-five percent limit shall not apply to rate decreases calculated pursuant to this paragraph.

(D) For the period April first, two thousand four through March thirty-first, two thousand seven, no hospital shall receive a rate adjustment pursuant to this paragraph if such rate adjustment would be a negative amount. For periods on and after April first, two thousand seven, no public general hospital shall receive a rate increase calculated pursuant to this paragraph.

(iii) If the aggregate amount of rate adjustments calculated pursuant to this paragraph exceeds the upper payment limit calculated pursuant to federal regulations, such rate adjustments shall be reduced proportionally by the amount in excess of the federal upper payment limit. Such reduction, if applicable, shall be calculated on an annual basis.

(iv) Such rate adjustment shall be included as an add-on to medical assistance inpatient rates of payment, excluding exempt unit rates, but including inpatient rates of payment established in accordance with paragraph a-three of subdivision one of this section. Such rate add-on shall be based on medical assistance data reported in each hospital's annual cost report submitted for the period two years prior to the rate year and filed with the department by November first of the year prior to the rate year. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

(e) From amounts available pursuant to paragraph (oo) of subdivision one of section twenty-eight hundred seven-v of this article, allocations shall be made to non-public general hospitals receiving a rate adjustment pursuant to paragraph (d) of this subdivision when the rate adjustment pursuant to paragraph (d) of this subdivision results in the general hospital exceeding its applicable disproportionate share payment

limit in the year in which the adjustment is made and the amount of the associated reduction in the hospital's disproportionate share payments would result in the hospital receiving less than its total distribution amount in that year. A hospital's "total distribution amount" shall be the amount that the hospital would have received pursuant to paragraphs (c) and (d) of subdivision three of section twenty-eight hundred seven-m of this article prior to the effective date of this paragraph. A hospital's eligible loss for purposes of this paragraph shall be the amount of the loss in such total distribution amount. Each eligible hospital's allocation of available funds pursuant to this paragraph within a year shall be determined based on its proportionate share of the aggregate eligible losses for all such hospitals, limited by the amount of the rate adjustment pursuant to paragraph (d) of this subdivision.

26. Disproportionate share payments. Distributions to general hospitals from bad debt and charity care regional pools pursuant to subdivision seventeen of this section, distributions to general hospitals from the bad debt and charity care and capital statewide pool pursuant to paragraphs (c) and (d) of subdivision nineteen of this section, distributions to general hospitals from the bad debt and charity care for financially distressed hospitals statewide pool pursuant to subdivision fourteen-c of this section and the adjustment provided in accordance with subdivision fourteen-a of this section and the adjustment provided in accordance with subdivision fourteen-d of this section shall be considered disproportionate share payments for inpatient hospital services to general hospitals serving a disproportionate number of low income patients with special needs for purposes of providing assurances to the secretary of health and human services as necessary to meet federal requirements for securing federal financial participation pursuant to title XIX of the federal social security act.

27. Reports. (a) The commissioner of health shall submit a report to the legislature and the council on health care financing on or before February first, nineteen hundred eighty-eight detailing the objective, impact, design and computation for an inpatient pricing component. In terms of the design and computation for a pricing system such report shall include but not be limited to: a description and methodology for developing peer groups, identification of costs included in the calculation of a group average and any adjustments made to such costs, the methodology developed to reflect outliers, any teaching or disproportionate share adjustments made, the calculation of wage and power equalization factors, and identification of any adjustments made to the service intensity weights or diagnosis-related group categories. The commissioner shall explore methodologies for the inclusion of severity of illness considerations in determining group average costs and rates and shall include all details of his analysis in the report required under this subparagraph. If it is determined that a severity of illness adjustment cannot be developed for incorporation in the computations, the report filed shall include the specific reasons for this conclusion. With regard to a fiscal impact analysis such report shall include but not be limited to the impact on major types of general hospitals including rural, urban, teaching, non-teaching, plus a regional analysis; and should indicate any characteristics which can be observed regarding general hospitals which would be significantly impacted by the introduction of a pricing component. The commissioner shall expeditiously make available for inspection by interested parties pertinent data used in the development of the inpatient pricing component consistent with

appropriate department procedures for the release and protection of confidential data.

(b) The commissioner shall submit a report to the governor and the legislature on or before February first, nineteen hundred ninety-five regarding the objective, impact, design and implementation of the case based payment system for inpatient hospital services based on diagnosis-related groups created pursuant to this section including, in particular, an analysis of the group price component of case based rates of payment and the appropriateness and effectiveness of the provisions relating to financing of uncompensated care. The reports shall include but not be limited to a fiscal impact analysis of the impact of the case based payment system on major types of general hospitals including rural, urban, teaching and non-teaching, plus a regional analysis. Such reports shall evaluate the impact of the case based payment system on general hospital inpatient medical and clinical care and the quality of hospital services. The reports shall also include recommendations for continuation or modification of the case based payment system for inpatient hospital services provided on or after January first, nineteen hundred ninety-six.

(c) The commissioner shall report to the governor and the legislature on or before December first, nineteen hundred eighty-eight with a plan relating to the structure and financing of graduate medical education. Such plan shall include an evaluation of and recommendations for graduate medical education with respect to health services delivery and educational goals including but not limited to the following: appropriate supply and distribution of primary care providers by geographic area; adequate supply and distribution of medical specialists according to projected population needs; educational opportunities representative of current and future practice settings; the impact of such plan on health care delivery in currently underserved and rural areas; and reimbursement changes to effectuate the recommendations included in the plan. Such plan shall be developed with substantial participation by the department of education, the medical schools, residency training programs, health systems agencies, health care institutions, and physicians.

28. Notwithstanding any inconsistent provision of this section:

(a) the commissioner may adjust, on a per unit of service basis, general hospital inpatient services rates of payment established pursuant to this section as in effect on and before December thirty-first, nineteen hundred ninety-six prospectively as an additional factor to be paid, including the impact of payment differentials as were in effect pursuant to this section, in addition to, or as a reduction to, any hospital charges or negotiated rate (the adjustment may not be negotiated by the payor); including, but not limited to, capital related inpatient expenses reconciliation adjustments pursuant to subdivision eight of this section, rate adjustments for corrections, appeals and volume changes pursuant to subdivision nine of this section, rate adjustments to reflect trend factor adjustments pursuant to subdivision ten of this section, maximum case mix change adjustments pursuant to paragraph (f) of subdivision eleven of this section, and adjustments based on audits;

(b) the allowances percentages established pursuant to this article in effect for a rate period shall be applied to hospital charges or negotiated rates plus the prospectively adjusted payment of rates of payment of a general hospital in accordance with paragraph (a) of this subdivision;

(c) no recalculation of the basis for distribution of funds from regional or statewide pools established pursuant to this section shall be made based on the impact of a prospective adjustment to rates of payment authorized pursuant to this subdivision; and

(d) prospective rate adjustments authorized pursuant to this subdivision for a general hospital based on appeals approved after January first, nineteen hundred ninety-eight shall be included in rates of payment as a one hundred percent facility specific adjustment and shall not affect the calculation of the group category average inpatient reimbursable operating cost per discharge for such retrospective period for any other general hospital.

29.] 15. Coinsurance and deductibles. (a) If a general hospital and a third-party payor agree to a negotiated payment methodology for a period on or after January first, nineteen hundred ninety-seven that is based on a discount from hospital charges, such discount shall apply to the calculation of the charge basis for deductible and coinsurance amounts for such period owed for any patient covered by such third-party payor as the primary payor.

(b) If a general hospital and a third-party payor agree to a negotiated payment methodology for a period on or after January first, nineteen hundred ninety-seven that is not based on a discount from hospital charges, excluding capitation arrangements, the maximum amount to be charged for deductible and coinsurance amounts for such period for any patient covered by such third-party payor as the primary payor shall not exceed the amount calculated by applying the deductible and coinsurance amounts to the amount due on the basis of such negotiated payment arrangement.

[30. General hospital recruitment and retention of health care workers. Notwithstanding any inconsistent provision of this section and subject to the availability of federal financial participation:

(a) (i) The commissioner shall adjust inpatient medical assistance rates of payment established pursuant to this section for non-public general hospitals in accordance with subparagraph (ii) of this paragraph for purposes of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

(A) ninety-three million two hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; one hundred eighty-seven million eight hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; two hundred sixty-two million one hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; one hundred thirty-one million one hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, and two hundred forty-three million five hundred thousand dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, two hundred forty-three million five hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine; one hundred sixty-three million one hundred forty-five thousand dollars for the period April first, two thousand nine through November thirtieth, two thousand nine.

(ii) Such increases shall be allocated proportionally based on each non-public general hospital's reported total gross salary and fringe benefit costs as reported on exhibit 11 of the 1999 institutional cost report submitted as of November first, two thousand one to the total of

such reported costs for all non-public general hospitals, provided, however, that for periods on and after July first, two thousand seven, fifty percent of such increases shall be allocated proportionally, based on each non-public hospital's reported total gross salary and fringe benefit costs, as reported on exhibit 11 of the nineteen hundred ninety-nine institutional cost report as submitted to the department prior to November first, two thousand one, to the total of such reported costs for all non-public general hospitals, and fifty percent of such increases shall be allocated proportionally, based on each such hospital's total reported medicaid inpatient discharges, as reported in the two thousand four institutional cost report as submitted to the department prior to November first, two thousand six, to the total of such reported medicaid inpatient discharges for all non-public general hospitals, as weighted proportionally to reflect the relative medicaid case mix of each such hospital. These amounts shall be included as a reimbursable cost add-on to medical assistance inpatient rates of payment established pursuant to this section for non-public general hospitals based on medical assistance utilization data in each hospital's annual cost report submitted two years prior to the rate year. Such amounts shall be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year based on data reported in each hospital's cost report for the respective rate year. These amounts shall be included as a reimbursable cost add-on to medical assistance inpatient rates of payment established pursuant to this section for non-public general hospitals based on medical assistance utilization data in each facility's annual cost report submitted two years prior to the rate year. For rate adjustments effective May first, two thousand five and thereafter such amounts shall be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year based upon data reported in each hospital's institutional cost report for the respective rate year.

(b) (i) Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law and any other inconsistent provision of law, the commissioner shall make grants to public general hospitals without a competitive bid or request for proposal process for purposes of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

(A) eighteen million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; thirty-seven million four hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; fifty-two million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; twenty-six million one hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, forty-nine million dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, and forty-nine million dollars for the period April first, two thousand eight through March thirty-first, two thousand nine.

(ii) Such grants shall be allocated proportionally based on each public general hospital's reported total gross salary and fringe benefit costs as reported on exhibit 11 of the 1999 institutional cost report submitted as of November first, two thousand one to the total of such reported costs for all public general hospitals.

(c) From amounts available pursuant to paragraph (gg) of subdivision one of section twenty-eight hundred seven-v of this article, allocations shall be made to non-public general hospitals whose allocated labor adjustments pursuant to paragraphs (a) and (e) of this subdivision and adjustment pursuant to subdivision thirty-two of this section results in the general hospital exceeding its applicable disproportionate share payment limit. Each such hospital's allocation of available funds pursuant to this paragraph within a year shall be determined based on its proportionate share of the aggregate reduction of federal disproportionate share funding for all such hospitals for the year resulting from the allocated labor adjustments pursuant to paragraphs (a) and (e) of this subdivision and from the adjustment pursuant to subdivision thirty-two of this section.

(d) General hospitals which have their rates adjusted or receive grants pursuant to paragraphs (a) and (b) of this subdivision, respectively, shall use such funds for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Funds under this subdivision are not intended to supplant support provided by a local government. Each such general hospital shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. The commissioner is authorized to audit each general hospital to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. Such recoupment shall be in addition to applicable penalties under sections twelve and twelve-b of this chapter.

(e)(i) The commissioner shall adjust inpatient medical assistance rates of payment established pursuant to this section for general hospitals in accordance with subparagraph (ii) of this paragraph and shall establish discrete rates of payment for such hospitals in accordance with subparagraph (iii) of this paragraph, for purposes of additional support of recruitment and retention of health care workers in the following aggregate amounts for the following periods:

(A) one hundred twenty-one million dollars for the period May first, two thousand five through December thirty-first, two thousand five and one hundred twenty-one million dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(ii) Such increases shall be allocated proportionally based on each general hospital's reported gross salary and fringe benefit costs as reported on exhibit 11 of the 1999 institutional cost report submitted as of November first, two thousand one to the total of such reported costs for all general hospitals. These amounts shall be included as a reimbursable cost add-on to medical assistance inpatient rates of payment established pursuant to this section for general hospitals based on medical assistance utilization data in each facility's annual cost report submitted two years prior to the rate year. Such amounts shall be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year based upon data reported in each hospital's institutional cost report for the respective rate year.

(iii) The commissioner shall establish, subject to the approval of the director of the budget, discrete rates of payment for general hospitals for payments under the medical assistance program pursuant to titles eleven and eleven-D of article five of the social services law for persons eligible for medical assistance and family health plus who are enrolled in health maintenance organizations based on the calculation set forth in subparagraph (ii) of this paragraph for such general hospitals. If discrete rates of payment under this subparagraph are not established, the commissioner shall adjust the calculation established pursuant to subparagraph (ii) of this paragraph to account for medical assistance utilization described under this subparagraph for such non-public general hospital.

(iv) Payment of the non-federal share of the medical assistance payments made pursuant to this paragraph shall be the responsibility of the state and shall not include a local share. Payments made pursuant to this paragraph or pursuant to paragraph (a) of this subdivision may be added to rates of payment or made as aggregate payments to eligible general hospitals.

(f) In the event that a hospital entitled to an adjustment pursuant to paragraph (a) or (e) of this subdivision closes or otherwise experiences a change in status that eliminates its ability to continue to receive such adjustments, the commissioner shall allocate the amount determined under subparagraph (ii) of paragraph (a) and subparagraph (ii) of paragraph (e) of this subdivision for such hospital to hospitals in the immediate region of the closing hospital based upon the remaining hospitals' reported gross salary and fringe benefit costs as reported on exhibit eleven of the two thousand four institutional cost report submitted as of November first, two thousand five to the total of such reported costs for all general hospitals in the region, provided, however, that for periods on and after July first, two thousand seven, such allocations shall be based on such remaining hospitals' reported medicaid inpatient discharges, as reported in the two thousand four institutional cost report submitted to the department prior to November first, two thousand six, to the total of such reported medicaid inpatient discharges for all such remaining hospitals. The commissioner shall define the immediate region as the county or counties within which workers displaced from the closing hospital are likely to seek re-employment.

31. Supplemental general hospital recruitment and retention adjustment. (a) Notwithstanding any law, rule or regulation to the contrary, the commissioner shall, within amounts appropriated, and contingent on the availability of federal financial participation, make Medicaid rate adjustments for non-public general hospitals to address extraordinary costs associated with recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility at such general hospitals. Eligible hospitals shall be selected by the commissioner pursuant to a competitive process. Requests for proposals for eligible projects shall be issued by the commissioner.

(b) Such eligible projects may include:

(i) an increase in non-supervisory staff, either facility wide or targeted at a particular area of care or shift;

(ii) increased training and education of non-supervisory staff, including allowing non-supervisory staff to increase their level of licensure relevant to general hospital care;

(iii) efforts to decrease staff turn-over; and

(iv) other efforts related to the recruitment and retention of non-supervisory staff or any worker with direct patient care responsibility that will affect the quality of care at such facility.

(c) The commissioner shall consider, in selecting eligible projects, the likelihood that such project will provide needed resources to meet legal commitments for increased labor costs, the financial need of the facility, the existence of a shortage of qualified hospital workers in the geographic area in which the facility is located, the existence of high employee turn-over at the facility and such other matters as the commissioner deems appropriate.

(d) In implementing rate adjustments authorized under this subdivision, the commissioner shall establish, subject to the approval of the director of the budget, discrete rates of payment for non-public general hospitals for payments under the medical assistance program pursuant to titles eleven and eleven-D of article five of the social services law for persons eligible for medical assistance and family health plus who are enrolled in health maintenance organizations.

(e) Adjustments to Medicaid rates of payment made pursuant to this section shall not be subject to subsequent adjustment or reconciliation.

(f) Adjustments to Medicaid rates of payment made pursuant to this section shall not, in aggregate, exceed fifteen million dollars for the period beginning April first, two thousand two and ending December thirty-first, two thousand two and, on an annualized basis, for each annual period thereafter beginning January first, two thousand three and ending December thirty-first, two thousand six, and shall not, in aggregate, exceed seven million five hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven.

32. Rural hospital supplemental rate adjustment. Notwithstanding any inconsistent provision of this section:

(a) The commissioner shall adjust inpatient medical assistance rates of payment established pursuant to this section for rural hospitals as defined in paragraph (c) of subdivision one of section twenty-eight hundred seven-w of this article in accordance with paragraph (b) of this subdivision for purposes of supporting critically needed health care services in rural areas in the following aggregate amounts for the following periods:

seven million dollars for the period May first, two thousand five through December thirty-first, two thousand five, seven million dollars for the period January first, two thousand six through December thirty-first, two thousand six, seven million dollars for the period April first, two thousand seven through December thirty-first, two thousand seven, seven million dollars for calendar year two thousand eight, and six million four hundred seventeen thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(b) Such increases shall be allocated proportionately based on each such rural hospital's total reported medicaid inpatient discharges as reported in the two thousand two institutional cost report to the total of such discharges for all rural hospitals. These amounts shall be included as a reimbursable cost add-on to medical assistance inpatient rates of payment established pursuant to this section for rural hospitals based on medical assistance utilization data in each facility's annual cost report submitted two years prior to the rate year. Such amounts shall be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the

rate year based upon data reported in each hospital's institutional cost report for the respective rate year.

(c) Payment of the non-federal share of the medical assistance payments made pursuant to this subdivision shall be the responsibility of the state and shall not include a local share. Payments made pursuant to this subdivision may be added to rates of payment or made as aggregate payments to eligible general hospitals.

33.] 16. Notwithstanding any provision of law which is inconsistent with or contrary to the structure established by this subdivision and subdivision two-a of section twenty-eight hundred seven of this article in order to transition from nineteen hundred eighty-one base year costs to two thousand five base year costs by no later than December thirty-first, two thousand twelve, and subject to the availability of federal financial participation, medicaid per diem and per discharge rates of payment for general hospital inpatient services for discharges and days occurring on and after December first, two thousand eight, shall be computed in accordance with the following:

(a)(i) for the period December first, two thousand eight through March thirty-first, two thousand nine, such rates shall be subject to a uniform transition adjustment which shall be based on each general hospital's proportional share of projected medicaid reimbursable inpatient operating costs and result in an aggregate reduction in such rates equal to fifty-one million five hundred thousand dollars, as determined by the commissioner, provided, however, that such transition adjustment shall not apply to rates computed pursuant to [paragraph (1) of subdivision four] PARAGRAPH (F) OF SUBDIVISION TWO of this section; and

(ii) for the period April first, two thousand nine through March thirty-first, two thousand ten, such rates shall be revised pursuant to a chapter of the laws of two thousand nine and as reflecting the findings and recommendations of the commissioner as issued pursuant to the provisions of paragraph (b) of this subdivision, provided, however, that such revisions shall reflect an aggregate reduction in such rates of no less than one hundred fifty-four million five hundred thousand dollars, provided further, however, that, notwithstanding any contrary provision of law, as determined by the commissioner, to the extent that a chapter of the laws of two thousand nine is not enacted resulting in such an aggregate annual reduction of no less than one hundred fifty-four million five hundred thousand dollars in such rates, the commissioner shall implement a uniform reduction of such rates in accordance with the methodology described in subparagraph (i) of this paragraph to the extent necessary, as determined by the commissioner, to achieve such an aggregate reduction in such rates for the state fiscal year beginning April first, two thousand nine and each state fiscal year thereafter; and

(iii) for the periods April first, two thousand ten through March thirty-first, two thousand twelve, rates shall reflect prior year rate reductions and such additional reductions as are required to establish rates based on two thousand five reported allowable Medicaid costs pursuant to a chapter of the laws of two thousand ten.

(b) In consultation with the chairs of the senate and assembly health committees, the commissioner shall, by no later than July first, two thousand eight, establish a technical advisory committee for the purposes of examining data and evaluating rate-setting methodological issues, including the impact on hospitals of different methodologies in preparation for the phased transition to the utilization of reported allowable two thousand five operating costs for the purpose of setting

inpatient rates of payment for periods on and after April first, two thousand nine, which phased transition shall be authorized in accordance with a chapter of the laws of two thousand nine. The technical advisory committee shall consist of three representatives of hospital associations, two representatives of the health care industry and three representatives of community providers and consumers as determined by the commissioner. By no later than August first, two thousand eight, the commissioner shall make available to the technical advisory committee updated data and documentation relevant to the projected phased transition to utilization of reported allowable two thousand five operating costs for rate-setting purposes. The issues to be examined by the technical advisory committee shall include, but not be limited to, hospital re-basing, workforce recruitment and retention funding, graduate medical education funding, peer group pricing, wage equalization factors, case mix and such other related elements of the general hospital inpatient reimbursement system as deemed appropriate by the commissioner. The technical advisory committee shall also examine the scope and volume of hospital out-patient services. By no later than November first, two thousand eight the commissioner shall issue a report setting forth findings and recommendations, including divergent views of members of the technical advisory committee members concerning the matters examined by the technical advisory committee and the projected phased transition to utilization of two thousand five base year reported allowable operating costs for inpatient rates of payments on and after April first, two thousand nine.

(c) Paragraph (a) of this subdivision shall be effective the later of: (i) December first, two thousand eight; (ii) after the commissioner receives final approval of federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act for the rate methodology established pursuant to subdivision two-a of section twenty-eight hundred seven of this article; or (iii) after the commissioner determines that the department of health has the capability, for payments made pursuant to subdivision two-a of section twenty-eight hundred seven of this article, to electronically receive and process claims and transmit payments with remittance statements. Prior to the commissioner making such a determination, the department shall provide training sessions on the rate methodology and billing requirements for services pursuant to subdivision two-a of section twenty-eight hundred seven of this article and opportunity for hospitals to perform end-to-end testing on claims submission, processing and payment.

[35.] 17. Notwithstanding any inconsistent provision of this section, or any other contrary provision of law and subject to the availability of federal financial participation, rates of payment by governmental agencies for general hospital inpatient services with regard to discharges occurring on and after December first, two thousand nine shall be in accordance with the following:

(a) For periods on and after December first, two thousand nine the operating cost component of such rates of payments shall reflect the use of two thousand five operating costs as reported by each facility to the department prior to July first, two thousand nine and as otherwise computed in accordance with the provisions of this subdivision;

(b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the computation of general hospital inpatient rates and such regulations shall include, but not be limited to, the following:

(i) The computation of a case-mix neutral statewide base price, applicable to each rate period, but excluding adjustments for graduate medical education costs, high cost outlier costs, costs related to patient transfers, and other non-comparable costs as determined by the commissioner, such statewide base prices may be periodically adjusted to reflect changes in provider coding patterns and case-mix and such other factors as may be determined by the commissioner;

(ii) Only those two thousand five base year costs which relate to the cost of services provided to Medicaid inpatients, as determined by the applicable ratio of costs to charges methodology, shall be utilized for rate-setting purposes, provided, however, that the commissioner may utilize updated Medicaid inpatient related base year costs and statistics as necessary to adjust inpatient rates in accordance with clause (C) of subparagraph (x) of this paragraph;

(iii) Such rates shall reflect the application of hospital specific wage equalization factors reflecting differences in wage rates;

(iv) Such rates shall reflect the utilization of the all patient refined (APR) case mix methodology, utilizing diagnostic related groups with assigned weights that incorporate differing levels of severity of patient condition and the associated risk of mortality, and as may be periodically updated by the commissioner;

(v) such regulations shall incorporate quality related measures, including, but not limited to, potentially preventable re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), which shall be calculated in accordance with methodologies as determined by the commissioner, provided, however, that such methodologies shall be based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the commissioner and provided further that such rate adjustments or payment disallowances shall result in an aggregate reduction in Medicaid payments of no less than thirty-five million dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven and no less than fifty-one million dollars for annual periods beginning April first, two thousand eleven through March thirty-first, two thousand fourteen, provided further that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period July first, two thousand ten through March thirty-first, two thousand eleven and the period April first, two thousand eleven through March thirty-first, two thousand fourteen and as a result of decreased PPNOs during the period April first, two thousand eleven through March thirty-first, two thousand fourteen; and provided further that for the period July first, two thousand ten through March thirty-first, two thousand fourteen, such rate adjustments or payment disallowances shall not apply to behavioral health PPRs; or to readmissions that occur on or after fifteen days following an initial admission. By no later than July first, two thousand eleven the commissioner shall enter into consultations with representatives of the health care facilities subject to this section regarding potential prospective revisions to applicable methodologies and benchmarks set forth in regulations issued pursuant to this subparagraph;

(vi) Such regulations shall address adjustments based on the costs of high cost outlier patients;

(vii) Such rates shall continue to reflect trend factor adjustments as otherwise provided in paragraph (c) of subdivision [ten] FOUR of this section;

(viii) Such rates shall not include any adjustments pursuant to subdivision nine of this section;

(ix) Rates for non-public, not for profit general hospitals which have not, as of the effective date of this subdivision, published an ancillary charges schedule as provided in paragraph (j) of subdivision one of section twenty-eight hundred three of this article shall have their inlier payments increased by an amount equal to the average of cost outlier payments for comparable hospitals or by a methodology that uses a statewide or regional ratio of cost to charges applied to statewide or regional comparable charges for those cases determined by the commissioner;

(x) Such regulations shall provide for administrative rate appeals, but only with regard to: (A) the correction of computational errors or omissions of data, including with regard to the hospital specific computations pertaining to graduate medical education, wage equalization factor adjustments, (B) capital cost reimbursement, and, (C) changes to the base year statistics and costs used to determine the direct and indirect graduate medical education components of the rates as a result of new teaching programs at new teaching hospitals and/or as a result of residents displaced and transferred as a result of teaching hospital closures;

(xi) Rates for teaching general hospitals shall include reimbursement for direct and indirect graduate medical education as defined and calculated pursuant to such regulations. In addition, such regulations shall specify the reports and information required by the commissioner to assess the cost, quality and health system needs for medical education provided;

(xii) Such regulations may incorporate quality related measures pertaining to the inappropriate use of certain medical procedures, including, but not limited to, cesarean deliveries, coronary artery bypass grafts and percutaneous coronary interventions;

(xiii) Such regulations may impose a fee on general hospital sufficient to cover the costs of auditing the institutional cost reports submitted by general hospitals, which shall be deposited in the Health Care Reform Act (HCRA) resources account.

(c) The base period reported costs and statistics used for rate-setting for operating cost components, including the weights assigned to diagnostic related groups, shall be updated no less frequently than every four years and the new base period shall be no more than four years prior to the first applicable rate period that utilizes such new base period provided, however, that the first updated base period shall begin on January first, two thousand fourteen.

(d) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this subdivision shall remain subject to the provisions of subdivision [eight] THREE of this section.

(e) The provisions of this subdivision shall not apply to those general hospitals or distinct units of general hospitals whose inpatient reimbursement does not, as of November thirtieth, two thousand nine, reflect case based payment per diagnosis-related group or whose inpatient reimbursement is, for periods on and after July first, two thousand nine, governed by the provisions of [paragraphs (e-1) or (e-2) of subdivision four] PARAGRAPHS (B) OR (C) OF SUBDIVISION TWO of this section.

(f) Notwithstanding section one hundred twelve or one hundred sixty-three of the state finance law or any other law, rule or regulation to the contrary, the commissioner may contract with a vendor for consider-

ation to develop the specifications for the diagnosis-related groups methodology as provided for in regulations promulgated pursuant to paragraph (b) of this subdivision if the commissioner certifies to the comptroller that such contract is in the best interest of the health of the people of the state. Notwithstanding that such specifications shall be available pursuant to article six of the public officers law, such contract may provide that the specifications for such adjusted or additional diagnosis-related groups provided by the vendor shall be subject to copyright protection pursuant to federal copyright law.

(g) Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law, the commissioner may, for rate periods on and after December first, two thousand nine and subject to the availability of federal financial participation, make additional adjustments to the inpatient rates of payment of eligible general hospitals, to facilitate improvements in hospital operations and finances, in accordance with the following:

(i) General hospitals eligible for distributions pursuant to this paragraph shall be those non public hospitals with Medicaid discharges equal to or greater than seventeen and one-half percent for two thousand seven.

(ii) Funds distributed pursuant to this paragraph shall be allocated to eligible hospitals pursuant to a formula such that, to the extent of funds available, no hospital's reduction in Medicaid inpatient revenue as a result of the application of the provisions of paragraphs (a) and (b) of this subdivision exceeds a percentage reduction as determined by the commissioner.

(iii) Funding pursuant to this paragraph shall be available for the following periods and in the following amounts:

(A) for the period December first, two thousand nine through March thirty-first, two thousand ten, up to thirty-three million five hundred thousand dollars;

(B) for the period April first, two thousand ten through March thirty-first, two thousand eleven, up to seventy-five million dollars, provided, however, that, notwithstanding subparagraph (ii) of this paragraph, no facility shall receive an amount pursuant to this clause that is less than such facility received pursuant to clause (A) of this subparagraph;

(C) for the period April first, two thousand eleven through March thirty-first, two thousand twelve, up to fifty million dollars;

(D) for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, up to twenty-five million dollars.

(iv) Payments made pursuant to this paragraph shall be added to rates of payments and not be subject to retroactive adjustment or reconciliation.

(v) Each hospital receiving funds pursuant to this paragraph shall, as a condition for eligibility for such funds, adopt a resolution of the board of directors of each such hospital setting forth its current financial condition and a plan for reforming and improving such financial condition, including ongoing board oversight, and shall, after two years, issue a report as adopted by each such board of directors setting forth what progress has been achieved regarding such improvement, provided, however, if such report is not issued and adopted by each such board of directors, or if such report fails to set forth adequate progress, as determined by the commissioner, the commissioner may deem such facility ineligible for further distributions pursuant to this paragraph and may redistribute such further distributions to other

eligible facilities in accordance with the provisions of this paragraph. The commissioner shall be provided with copies of all such resolutions and reports.

(h) Inpatient rate adjustments made pursuant to paragraphs (a) through (f) of this subdivision after application of adjustments authorized pursuant to subdivision [thirty-three] SIXTEEN of this section shall result in a net statewide decrease in aggregate Medicaid payments of no less than seventy-five million dollars for the period December first, two thousand nine through March thirty-first, two thousand ten, and no less than two hundred twenty-five million dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven and each state fiscal year thereafter, provided, however, that such reductions shall be in addition to the reductions required pursuant to subparagraph (ii) of paragraph (a) of subdivision [thirty-three] SIXTEEN of this section.

(i) (i) Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, for the period July first, two thousand ten through March thirty-first, two thousand eleven, and each state fiscal year period thereafter, the commissioner shall make additional inpatient hospital payments up to the aggregate upper payment limit for inpatient hospital services after all other medical assistance payments, but not to exceed two hundred thirty-five million five hundred thousand dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven, three hundred fourteen million dollars for each state fiscal year beginning April first, two thousand eleven, through March thirty-first, two thousand thirteen, and no less than three hundred thirty-nine million dollars for each state fiscal year thereafter, to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. Such payments shall be made as medical assistance payments for fee-for-service inpatient hospital services pursuant to title eleven of article five of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act and in accordance with the following:

(A) Thirty percent of such payments shall be allocated to safety net hospitals based on each eligible hospital's proportionate share of all eligible safety net hospitals' Medicaid discharges for inpatient hospital services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services, based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year;

(B) Seventy percent of such payments shall be allocated to eligible general hospitals based on each such hospital's proportionate share of all eligible hospitals' Medicaid discharges for inpatient hospital

services, including both Medicaid fee-for-service and managed care discharges for acute and exempt services, based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year;

(C) No eligible general hospital's annual payment amount pursuant to this paragraph shall exceed the lower of the sum of the annual amounts due that hospital pursuant to section twenty-eight hundred seven-k and section twenty-eight hundred seven-w of this article; or the hospital's facility specific projected disproportionate share hospital payment ceiling established pursuant to federal law, provided, however, that payment amounts to eligible hospitals pursuant to clauses (A) and (B) of this subparagraph in excess of the lower of such sum or payment ceiling shall be reallocated to eligible hospitals that do not have excess payment amounts. Such reallocations shall be proportional to each such hospital's aggregate payment amount pursuant to clauses (A) and (B) of this subparagraph to the total of all payment amounts for such eligible hospitals;

(D) Subject to the availability of federal financial participation, the payment methodology set forth in this subparagraph may be further revised by the commissioner on an annual basis pursuant to regulations issued pursuant to this subdivision for periods on and after April first, two thousand eleven; and

(E) Subject to the availability of federal financial participation and in conformance with all applicable federal statutes and regulations, such payments shall be made as upper payment limit payments and, further, such payments shall be made as aggregate monthly payments to eligible general hospitals.

(ii) In the event that the commissioner determines that federal financial participation will not be available for aggregate payments made in accordance with clause (E) of subparagraph (i) of this paragraph, payments pursuant to this paragraph shall be included as rate add-ons to medical assistance inpatient rates of payment established pursuant to this subdivision based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year, provided, however, that if such payments are made as rate add-ons, the commissioner shall establish a procedure to reconcile payment amounts to reflect changes in medical assistance utilization from the period two years prior to the rate year and the actual rate year based on data as reported on each hospital's annual institutional cost report for the respective rate year, as submitted to the department as of October first of the year following the rate year.

(iii) Notwithstanding any other law, rule or regulation to the contrary, projections of each general hospital's disproportionate share limitations as computed by the commissioner pursuant to applicable regulations shall be adjusted to reflect any additional revenue received or anticipated to be received by each such general hospital pursuant to this paragraph.

S 2. Subdivision 6 of section 2500-d of the public health law, as amended by chapter 639 of the laws of 1996, is amended to read as follows:

6. A general hospital which is designated as a regional poison control center shall submit a budget indicating the costs of operating such center. Costs determined by the commissioner to be necessary and reasonable in order to comply with the requirements of this section shall be

reimbursable and shall be allocated to costs of general hospital emergency services. Such reimbursable costs for a rate period shall be considered in the calculation of rates of payment for emergency services of a general hospital for such rate period in accordance with subdivision two of section twenty-eight hundred seven of this chapter without application of the maximum payment for the operating cost component of rates of payment for emergency services. Notwithstanding any inconsistent provision of law, reimbursable costs of a general hospital of operating a regional poison control center determined pursuant to this subdivision for annual rate periods beginning on or after January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-six allocable to emergency services provided to persons within such payor categories as specified in paragraphs (a)[, (b) and (c)] AND (E) of subdivision one of section twenty-eight hundred seven-c of this chapter for inpatient hospital services, excluding governmental agencies, shall be included in the determination of inpatient rates of payment for such payors, excluding governmental agencies, and rates of payment determined in accordance with section twenty-eight hundred seven-c of this chapter shall be adjusted on a hospital-specific basis in accordance with rules and regulations adopted by the state hospital review and planning council, subject to the approval of the commissioner, to reflect such costs and maximum inpatient charges of such general hospital computed in accordance with such section shall be adjusted accordingly; and cost based rates of payment for emergency services for such payors, other than governmental agencies, shall be calculated excluding costs of operating a regional poison control center.

S 3. Subparagraph (iii) of paragraph (a) of subdivision 2 of section 2803 of the public health law, as amended by chapter 639 of the laws of 1996, is amended to read as follows:

(iii) the identification of appropriate and reasonable standards for the development of acceptable collection procedures used by general hospitals in an effort to collect unpaid bills prior to the determination that the unpaid bill is a bad debt eligible for reimbursement consideration pursuant to paragraphs (e) and (f) of subdivision eight of section twenty-eight hundred seven-a or [paragraph (b) of subdivision fourteen of section twenty-eight hundred seven-c and] SECTION twenty-eight hundred seven-k of this article,

S 4. Subparagraph (ii) of paragraph (c) of subdivision 2 of section 2803-i of the public health law, as added by chapter 2 of the laws of 1988, is amended to read as follows:

(ii) Notwithstanding any inconsistent provision of law, general hospital contract costs incurred in accordance with subparagraph (i) of this paragraph may be included as an additional charge for general hospital inpatient services in determining patient charges for payors included in the payor categories specified in paragraph (c) of subdivision one of section twenty-eight hundred seven-c of this article, or as a charge in addition to rates of payment for general hospital inpatient services in determining payment due for payors included in the payor categories specified in paragraph [(b)] (E) of subdivision one of section twenty-eight hundred seven-c of this article, or paragraph (a) of such subdivision one if a payor has not designated a review agent for such payor's subscribers or beneficiaries or enrolled members[, or paragraph (a) or (b) of subdivision two of section twenty-eight hundred seven-c of this article]. Such additional charges shall not be subject to maximum charge or rate of payment ceilings determined in accordance with section twenty-eight hundred seven-c of this article for such payors.

S 5. Paragraph (a) of subdivision 2 of section 2805-a of the public health law, as amended by chapter 639 of the laws of 1996, is amended to read as follows:

(a) A report of hospital expenses incurred in providing services during the period covered by the reports required under this section for which payment was not received and is not anticipated for such periods for which pool distributions pursuant to [section twenty-eight hundred seven-c or] section twenty-eight hundred seven-k of this article are made related to such expenses. The report shall be completed in accordance with regulations developed by the council and approved by the commissioner which shall include definitions for bad debts and charity care. The report shall identify as bad debts or charity care the cost of services provided to emergency inpatients, non-emergency inpatients, emergency ambulatory patients, clinic patients and referred or private ambulatory patients for which the hospital did not receive and does not anticipate payment.

S 6. Subdivision 3 of section 2807 of the public health law, as amended by chapter 2 of the laws of 1988, is amended to read as follows:

3. Commissioner rate certification, governmental payments. Prior to the approval of such rates, as provided in subdivision two of this section, the commissioner shall determine, and in the case of approvals by the state director of the budget, certify to such official that the proposed rate schedules for payments to hospitals for hospital and health-related services are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital is located, the rate of increase or decrease of the economy in the area in which the hospital is located, costs of hospitals of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economies and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of in-hospital service, including, but not limited to, obstetrical, pediatric, laboratory, training, radiology, pharmacy, laundry, purchasing, preadmission, nursing home, ambulatory or home care services. The commissioner shall exclude costs for research and those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service, and allowances for costs which are not specifically identified except for allowances authorized under section twenty-eight hundred seven-a [or twenty-eight hundred seven-c] of this article. In determining and certifying to the state director of the budget rates of payment, including rates of payment for residential health care facilities, the commissioner shall take into consideration the different levels of care authorized to be provided in such hospital or health-related service and determine and certify distinct rates of payment for each such level of care. If the modification of an operating certificate of a hospital pursuant to subdivision six of section twenty-eight hundred six of this article requires the establishment of a rate for a level of service not previously provided in such hospital during the rate period existing at the time of such modification, a new rate period for that portion of the hospital reclassified as a result of such modification may be established upon sixty days' prior notice.

7. Section 2807-b of the public health law, as added by section 11 of part D of chapter 57 of the laws of 2006, is amended to read as follows:

S 2807-b. Outstanding payments and reports due under subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c, sections twenty-eight hundred seven-d, twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article. 1. If there is a basis for estimating the amount of outstanding payments due in accordance with subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, and sections twenty-eight hundred seven-d, twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article, the commissioner shall bill applicable providers and payors for such payments, including any interest and penalties set forth in this article, no later than ninety days after each calendar quarter following enactment of this section.

2. If there is no basis for estimating the amount of outstanding payments due in accordance with subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, and sections twenty-eight hundred seven-d, twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article, the commissioner shall notify applicable providers and payors of outstanding reports and payments no later than ninety days after each calendar quarter following the effective date of this section. Such notice shall include information regarding any interest, penalties or other sanctions which may be implemented in accordance with this article.

S 8. Paragraph (b) of subdivision 1 of section 2807-d of the public health law, as amended by chapter 41 of the laws of 1992, subparagraph (i) as amended by chapter 639 of the laws of 1996, is amended to read as follows:

(b) Subject to the provisions of subdivision twelve of this section, the following categories of hospitals shall not be charged assessments pursuant to this section: (i) [voluntary nonprofit and private proprietary general hospitals which qualify for distributions made in accordance with paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article, or for assessments during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven voluntary nonprofit and private proprietary general hospitals which qualified for distributions made in accordance with paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article as of December thirty-first, nineteen hundred ninety-five; (ii)] voluntary nonprofit hospitals totally financed by charitable contributions or by the income thereon dedicated to free care of low income patients; and [(iii)] (II) any facility dedicated solely to the care of police, firefighters, volunteer firefighters, and emergency service personnel.

S 9. Paragraph (a) of subdivision 3 of section 2807-d of the public health law, as amended by section 3-e of part B of chapter 109 of the laws of 2010, is amended to read as follows:

(a) for general hospitals, all monies received for or on account of inpatient hospital service, outpatient service, emergency service, referred ambulatory service and ambulatory surgical service, or other hospital or health-related services, excluding, subject to the provisions of subdivision twelve of this section: distributions from bad debt and charity care regional pools, primary health care services regional pools, bad debt and charity care for financially distressed hospitals statewide pools and bad debt and charity care and capital statewide pools created in accordance with section twenty-eight hundred

seven-c of this article and the components of rates of payment or charges related to the allowances provided in accordance with subdivisions fourteen, fourteen-b and fourteen-c, the adjustment provided in accordance with subdivision fourteen-a, the adjustment provided in accordance with subdivision fourteen-d, the adjustment for health maintenance organization reimbursement rates provided in accordance with section twenty-eight hundred seven-f of this article, the adjustment for commercial insurer reimbursement rates provided in accordance with paragraph (i) of subdivision eleven of section twenty-eight hundred seven-c of this article or, if effective, the adjustment provided in accordance with subdivision fifteen of section twenty-eight hundred seven-c of this article or the adjustment provided in accordance with section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as amended and physician practice or faculty practice plan revenue received by a general hospital based on discrete billings for private practicing physician services, revenue received by a general hospital from a public hospital pursuant to an affiliation agreement contract for the delivery of health care services to such public hospital, revenue received pursuant to paragraph (i) of subdivision [thirty-five] SEVENTEEN of section twenty-eight hundred seven-c of this article, revenue received pursuant to section twenty-eight hundred seven-w of this article, all revenue received as disproportionate share hospital payments, in accordance with title nineteen of the federal Social Security Act, revenue received pursuant to sections eleven, twelve, thirteen and fourteen of part A of chapter one of the laws of two thousand two, revenue received pursuant to sections thirteen and fourteen of part B of chapter one of the laws of two thousand two, revenue from patient personal fund allowances, revenue from income earned on patient funds, investment income from externally restricted funds, revenue from investment sinking funds, revenue from investment operating escrow accounts, investment income from funded depreciation, investment income from mortgage repayment escrow accounts, revenue derived from the operation of schools leading to licensure, and revenue from the collection of sales and excise taxes;

S 10. Paragraph (c) of subdivision 1 and paragraph (a) of subdivision 2 of section 2807-e of the public health law, as added by chapter 731 of the laws of 1993, paragraph (a) of subdivision 2 as further amended by section 104 of part A of chapter 62 of the laws of 2011, are amended to read as follows:

(c) "Third-party payor" shall mean those payors within the payor categories specified in paragraphs (a) and [(b)] (E) of subdivision one of section twenty-eight hundred seven-c of this article, except for payments made for persons who are eligible as beneficiaries of title XVIII of the federal social security act (medicare).

(a) Notwithstanding any inconsistent provisions of law, the commissioner shall, on or after July first, nineteen hundred ninety-five, develop a uniform patient bill for the purpose of providers providing a health care consumer with a patient bill for hospital and health-related services, in consultation with the superintendent of financial services, statewide organizations representative of providers of hospital and health-related services, third-party payors as described in paragraphs (a) and [(b)] (E) of subdivision one of section two thousand eight hundred seven-c of this article, and representatives of health care consumers. Such patient bill shall be in such form and shall contain such information as may be required in accordance with rules and regulations developed by the commissioner, provided that distinct uniform

patient bills may be developed for each type or level of health-related service.

S 11. Paragraph (d) of subdivision 4 of section 2807-f of the public health law is REPEALED.

S 12. Paragraph (d) of subdivision 2 of section 2807-j of the public health law, as amended by section 50 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(d) The total percentage allowance for payments by governmental agencies, as determined in accordance with paragraphs (a) and [(a-1)] (B) of subdivision one of section twenty-eight hundred seven-c of this article as in effect on December thirty-first, nineteen hundred ninety-six, or health maintenance organizations for services provided to subscribers eligible for medical assistance pursuant to title eleven of article five of the social services law, or approved organizations for services provided to subscribers eligible for the family health plus program pursuant to title eleven-D of article five of the social services law, shall be five and ninety-eight-hundredths percent, provided, however, that for services provided on and after July first, two thousand three the total percentage allowance shall be six and forty-seven hundredths percent, and further provided that for services provided on and after January first, two thousand six, the total percentage allowance shall be six and fifty-four hundredths percent, and further provided that for services provided on and after April first, two thousand nine, the total percentage allowance shall be seven and four hundredths percent.

S 13. Paragraph (a) and subparagraph (i) of paragraph (c) of subdivision 4 of section 2807-j of the public health law, paragraph (a) as amended by section 62 of part B of chapter 58 of the laws of 2005, subparagraph (i) of paragraph (c) as added by chapter 1 of the laws of 1999, are amended to read as follows:

(a) For periods prior to January first, two thousand five, the commissioner is authorized to contract with the article forty-three insurance law plans, or such other contractors as the commissioner shall designate, to receive and distribute funds from the allowances established pursuant to this section, and funds from the assessments established pursuant to subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of the funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis two million two hundred thousand dollars for collection and distribution of allowances and assessments established pursuant to this section and subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, shall be paid from the allowance and assessment funds.

(i) Funds accumulated and pooled pursuant to this section, paragraph (a) of subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, and sections twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article; and

S 14. The opening paragraph of subdivision 9 of section 2807-j of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

Funds accumulated, including income from invested funds, from the allowances specified in this section, and the assessments pursuant to subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, and the assessments pursuant to paragraph (c) of subdivi-

sion nine of section twenty-eight hundred seven-d of this article, plus such funds as may be allocated in accordance with section twenty-eight hundred seven-s of this article, including interest and penalties, shall be deposited by the commissioner or the commissioner's designee as follows:

S 15. Subdivision 12 of section 2807-j of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

12. Revenue from the allowances pursuant to this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

S 16. Clause (A) of subparagraph (ii) of paragraph (d) of subdivision 5-a of section 2807-k of the public health law, as added by section 28-b of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(A) payments in accordance with subdivision [fourteen-f] SIX of section twenty-eight hundred seven-c of this article;

S 17. Subparagraph (iv) of paragraph (b) of subdivision 5-d of section 2807-k of the public health law, as added by section 1 of part C of chapter 56 of the laws of 2013, is amended to read as follows:

(iv) Such regulations shall reserve one percent of the funds available for distribution in the two thousand fourteen and two thousand fifteen calendar years pursuant to this subdivision, subdivision [fourteen-f] SIX of section twenty-eight hundred seven-c of this article, and sections two hundred eleven and two hundred twelve of chapter four hundred seventy-four of the laws of nineteen hundred ninety-six, in a "financial assistance compliance pool" and shall establish methodologies for the distribution of such pool funds to facilities based on their level of compliance, as determined by the commissioner, with the provisions of subdivision nine-a of this section.

S 18. Subdivision 10 of section 2807-k of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

10. In order for a general hospital to be eligible for distribution of funds from the pool, such general hospital if it provides obstetrical care and services must be in compliance with the provisions of [paragraph (e) of subdivision sixteen] SUBDIVISION SEVEN of section twenty-eight hundred seven-c of this article.

S 19. Subdivision 13 of section 2807-k of the public health law, as amended by chapter 80 of the laws of 2004, is amended to read as follows:

13. Distributions to general hospitals pursuant to this section and the adjustments provided in accordance with subdivision [fourteen-f] SIX of section twenty-eight hundred seven-c of this article shall be considered disproportionate share payments for inpatient hospital services to general hospitals serving a disproportionate number of low income patients with special needs for purposes of providing assurances to the secretary of health and human services as necessary to meet federal requirements for securing federal financial participation pursuant to title XIX of the federal social security act.

S 20. Subdivision 15 of section 2807-k of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

15. Revenue from distributions pursuant to this section and adjustments pursuant to subdivision [fourteen-f] SIX of section twenty-eight hundred seven-c of this article shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

S 21. Subdivision 16 of section 2807-k of the public health law, as amended by chapter 419 of the laws of 2000, is amended to read as follows:

16. Supplemental indigent care distributions. From available resources established pursuant to paragraph (a-1) of subdivision four of this section, each hospital shall receive a proportionate share, provided that no hospital shall receive less than the reduction amount calculated pursuant to paragraph (d) of subdivision three of section twenty-eight hundred seven-m of this article, subject to hospital specific disproportionate share payment limits calculated in accordance with subdivision [twenty-one] ELEVEN of section twenty-eight hundred seven-c of this article.

S 22. Subdivision 17 of section 2807-k of the public health law, as added by section 3-b of part B of chapter 109 of the laws of 2010, is amended to read as follows:

17. Indigent care reductions. For each hospital receiving payments pursuant to paragraph (i) of subdivision [thirty-five] SEVENTEEN of section twenty-eight hundred seven-c of this article, the commissioner shall reduce the sum of any amounts paid pursuant to this section and pursuant to section twenty-eight hundred seven-w of this article, as computed based on projected facility specific disproportionate share hospital ceilings, by an amount equal to the lower of such sum or each such hospital's payments pursuant to paragraph (i) of subdivision [thirty-five] SEVENTEEN of section twenty-eight hundred seven-c of this article, provided, however, that any additional aggregate reductions enacted in a chapter of the laws of two thousand ten to the aggregate amounts payable pursuant to this section and pursuant to section twenty-eight hundred seven-w of this article shall be applied subsequent to the adjustments otherwise provided for in this subdivision.

S 23. Subdivision 3 of section 2807-l of the public health law, as amended by section 7 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

3. Revenue from distributions pursuant to this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

S 24. Subparagraph (i) of paragraph (s) of subdivision 1 of section 2807-m of the public health law, as amended by section 16 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(i) determining the difference between (A) a calculation of what each teaching general hospital would have been paid if payments made pursuant to paragraph [(a-3)] (D) of subdivision one of section twenty-eight hundred seven-c of this article between January first, nineteen hundred ninety-six and December thirty-first, two thousand three were based solely on the case mix of persons eligible for medical assistance under the medical assistance program pursuant to title eleven of article five of the social services law who are enrolled in health maintenance organizations and persons paid for under the family health plus program enrolled in approved organizations pursuant to title eleven-D of article five of the social services law during those years, and (B) the actual payments to each such hospital pursuant to paragraph [(a-3)] (D) of subdivision one of section twenty-eight hundred seven-c of this article between January first, nineteen hundred ninety-six and December thirty-first, two thousand three.

S 25. Subdivision 8 of section 2807-m of the public health law, as added by chapter 639 of the laws of 1996 and as renumbered by chapter 1 of the laws of 1999, is amended to read as follows:

8. Revenue from distributions pursuant to this section shall be included in gross revenue received for purposes of the assessments pursuant to subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article and for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article.

S 26. Subdivision 9 of section 2807-s of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

9. Revenue from the allowances pursuant to this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

S 27. Subdivision 5 of section 2807-w of the public health law, as added by section 3-c of part B of chapter 109 of the laws of 2010, is amended to read as follows:

5. For each hospital receiving payments pursuant to paragraph (i) of subdivision [thirty-five] SEVENTEEN of section twenty-eight hundred seven-c of this article, the commissioner shall reduce the sum of any amounts paid pursuant to this section and pursuant to section twenty-eight hundred seven-k of this article, as computed based on projected facility specific disproportionate share hospital ceilings, by an amount equal to the lower of such sum or each such hospital's payments pursuant to paragraph (i) of subdivision [thirty-five] SEVENTEEN of section twenty-eight hundred seven-c of this article, provided, however, that any additional aggregate reductions enacted in a chapter of the laws of two thousand ten to the aggregate amounts payable pursuant to this section and pursuant to section twenty-eight hundred seven-k of this article shall be applied subsequent to the adjustments otherwise provided for in this subdivision.

S 28. Paragraph (a) of subdivision 1 of section 2807-y of the public health law, as added by section 67 of part B of chapter 58 of the laws of 2005, is amended to read as follows:

(a) subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of this article;

S 29. Subparagraph (i) of paragraph (a) of subdivision 2-b of section 2808 of the public health law, as amended by section 2 of part I of chapter 2 of the laws of 2009, is amended to read as follows:

(i) Subject to the provisions of subparagraphs (ii) through (vi) of this paragraph, for the two thousand seven rate period the operating cost component of rates of payment shall reflect the operating cost component of rates effective for October first, two thousand six, as adjusted for inflation in accordance with paragraph (c) of subdivision [ten] FOUR of section twenty-eight hundred seven-c of this article; and for the January first, two thousand eight through March thirty-first, two thousand nine rate period the operating cost component of rates of payment shall reflect the operating cost component of rates effective for December thirty-first, two thousand six, as adjusted for inflation in accordance with paragraph (c) of subdivision [ten] FOUR of section twenty-eight hundred seven-c of this article.

S 30. Clause (A) of subparagraph (i) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 61 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(A) Subject to the provisions of subparagraphs (ii) through (xiv) of this paragraph, for periods on and after April first, two thousand nine the operating cost component of rates of payment shall reflect allowable operating costs as reported in each facility's cost report for the two thousand two calendar year, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision [ten] FOUR of section twenty-eight hundred seven-c of this article, provided, however, that for those facilities which are determined by the commissioner to be qualifying facilities in accordance with the provisions of clause (B) of this subparagraph, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, and provided further that the operating cost component of rates of payment for those facilities which are determined by the commissioner to be qualifying facilities in accordance with the provisions of clause (B) of this subparagraph shall not be less than the operating component such facilities received in the two thousand eight rate period, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision [ten] FOUR of section twenty-eight hundred seven-c of this article and further provided, however, that rates for facilities whose operating cost component reflects base year costs subsequent to January first, two thousand two shall have rates computed in accordance with this paragraph, utilizing allowable operating costs as reported in such subsequent base year period, and trended forward to the rate year in accordance with applicable inflation factors.

S 31. Paragraph (b) of subdivision 9 of section 2808 of the public health law, as added by chapter 190 of the laws of 1990, is amended to read as follows:

(b) The methodology shall be developed by four independent consultants with expertise in health economics appointed by the commissioner pursuant to paragraph (b) of subdivision [ten] FOUR of section twenty-eight hundred seven-c of this chapter. On or about September first of each year following the effective date of this subdivision, the consultants shall provide to the commissioner and the council the methodology to be used to determine the trend factors for subsequent rate periods only,

beginning with the nine month period commencing April first, nineteen hundred ninety-one and for subsequent twelve month periods commencing January first, nineteen hundred ninety-two and thereafter. The commissioner shall monitor the actual price movements during these periods of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants and shall implement the recommendations of the consultants for one prospective interim annual adjustment to the trend factors to reflect such price movements and to be effective on January first, one year after the initial trend factor was established and one prospective final annual adjustment to the trend factors to reflect such price movements and to be effective on January first, two years after the initial trend factor was established.

S 32. Paragraph (d) of subdivision 2 of section 4406 of the public health law, as amended by chapter 504 of the laws of 1995, is amended to read as follows:

(d) If the commissioner determines that an organization has permitted the benefits provided pursuant to an out-of-plan system to exceed ten percent, except as permitted by paragraph (b) or (c) of this subdivision, the commissioner may, where appropriate, assess an organization a civil penalty not to exceed the amount determined by multiplying the percentage permitted in excess of ten percent by the amount, in dollars, of the difference between what the organization paid all inpatient hospitals for such year and the amount such organization would have paid such hospitals had it been a payor within the categories specified in paragraph [(b)] (E) of subdivision one of section twenty-eight hundred seven-c of this chapter and not authorized to negotiate hospital rates. The commissioner, in consultation with the superintendent, may revoke, suspend or limit an approval issued pursuant to this subdivision for non-compliance by the organization with any of the provisions of this article or the rules and regulations promulgated thereunder.

S 33. Paragraph (b) of subdivision 8 of section 4900 of the public health law is REPEALED and paragraphs (c), (d) and (e) are relettered paragraphs (b), (c) and (d).

S 34. Subdivisions 9 and 10 of section 365 of the social services law, subdivision 9 as added by chapter 74 of the laws of 1989, subdivision 10 as added by chapter 938 of the laws of 1990, are amended to read as follows:

9. Any inconsistent provision of this chapter or other law notwithstanding, the social services district in which an eligible major public general hospital is physically located shall be responsible for the supplementary bad debt and charity care adjustment component of the rate of payment for such major public general hospital [(as determined in accordance with subdivision fourteen-a of section twenty-eight hundred seven-c of the public health law)] for all inpatient hospital services provided by such major public general hospital in accordance with section three hundred sixty-five-a of this article, regardless of whether another social services district or the department may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such inpatient services.

10. Any inconsistent provision of this chapter or other law notwithstanding, the social services district in which an eligible public general hospital is physically located shall be responsible for the supplementary low income patient adjustment component of the rate of payment for such public general hospital [(as determined in accordance with subdivision fourteen-d of section twenty-eight hundred seven-c of the public health law)] for all inpatient hospital services provided by

such public general hospital in accordance with section three hundred sixty-five-a of this article, regardless of whether another social services district or the department may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such inpatient services.

S 35. Subdivision 12 of section 365 of the social services law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

12. Any inconsistent provision of this chapter or other law notwithstanding, the social services district in which an eligible public general hospital is physically located shall be responsible for the public general hospital indigent care adjustment component of the payments to such public general hospital (as determined in accordance with subdivision [fourteen-f] SIX of section twenty-eight hundred seven-c of the public health law) for all inpatient hospital services provided by such public general hospital in accordance with section three hundred sixty-five-a of this article, regardless of whether another social services district or the department may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such inpatient services.

S 36. Subparagraph 4 of paragraph (c) of subdivision 5 of section 366 of the social services law, as amended by chapter 41 of the laws of 1992, is amended to read as follows:

(4) Any transfer made by a person or the person's spouse under subparagraph three of this paragraph shall cause the person to be ineligible for nursing facility services, for services at a level of care equivalent to that of nursing facility services for the lesser of (i) a period of thirty months from the date of transfer, or (ii) a period equal to the total uncompensated value of the resources so transferred, divided by the average cost of nursing facility services to a private patient for a given period of time at the time of application as determined by the commissioner. For purposes of this subparagraph the average cost of nursing facility services to a private patient for a given period of time at the time of application shall be presumed to be one hundred twenty percent of the average medical assistance rate of payment as of the first day of January of each year for nursing facilities within the region as established [pursuant to paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of the public health law] BY THE COMMISSIONER, wherein the applicant resides.

S 37. Subparagraph 4 of paragraph (d) of subdivision 5 of section 366 of the social services law, as added by chapter 170 of the laws of 1994, is amended to read as follows:

(4) Any transfer made by an individual or the individual's spouse under subparagraph three of this paragraph shall cause the person to be ineligible for services for a period equal to the total, cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average monthly costs of nursing facility services provided to a private patient for a given period of time at the time of application, as determined pursuant to the regulations of the department. The period of ineligibility shall begin with the first day of the first month during or after which assets have been transferred for less than fair market value, and which does not occur in any other periods of ineligibility under this paragraph. For purposes of this subparagraph, the average monthly costs of nursing facility services to a private patient for a given period of time at the time of application shall be presumed to be one hundred twenty percent of the average medical assistance rate of payment as of the first day of January of

each year for nursing facilities within the region wherein the applicant resides, as established [pursuant to paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of the public health law] BY THE COMMISSIONER.

S 38. Subparagraph 5 of paragraph (e) of subdivision 5 of section 366 of the social services law, as added by section 26-a of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(5) Any transfer made by an individual or the individual's spouse under subparagraph three of this paragraph shall cause the person to be ineligible for services for a period equal to the total, cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average monthly costs of nursing facility services provided to a private patient for a given period of time at the time of application, as determined pursuant to the regulations of the department. For purposes of this subparagraph, the average monthly costs of nursing facility services to a private patient for a given period of time at the time of application shall be presumed to be one hundred twenty percent of the average medical assistance rate of payment as of the first day of January of each year for nursing facilities within the region where the applicant resides, as established [pursuant to paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of the public health law] BY THE COMMISSIONER. The period of ineligibility shall begin the first day of a month during or after which assets have been transferred for less than fair market value, or the first day the otherwise eligible individual is receiving services for which medical assistance coverage would be available based on an approved application for such care but for the provisions of subparagraph three of this paragraph, whichever is later, and which does not occur in any other periods of ineligibility under this paragraph.

S 39. Paragraphs (k), (m) and (o) of subdivision 1 of section 368-a of the social services law are REPEALED.

S 40. Section 335 of the insurance law, as added by chapter 2 of the laws of 1988, is amended to read as follows:

S 335. Implementation of hospital reimbursement methodology. The superintendent shall have the power to prescribe rules and regulations governing insurer procedures and subscriber contract provisions necessary to implement a hospital reimbursement methodology established in accordance with the provisions of article twenty-eight of the public health law, and insurer procedures and subscriber contract provisions necessary to implement a hospital inpatient discharge review program established in accordance with the provisions of section twenty-eight hundred three-i of the public health law, and to establish standards, criteria and procedures for evaluation of insurer performance in offering contracts for hospital and medical benefits on an open enrollment basis necessary for a determination of the hospital payment rate conversion factor [in accordance with the provisions of paragraph (i) of subdivision eleven of section twenty-eight hundred seven-c of the public health law].

The superintendent shall periodically report his findings and conclusions to the commissioner of health and to the chairman and vice-chairman of the council on health care financing concerning insurer performance in offering contracts for hospital and medical benefits on an open enrollment basis.

S 41. Paragraph 2 of subsection (h) of section 4900 of the insurance law is REPEALED and paragraphs 3, 4 and 5 are renumbered paragraphs 2, 3 and 4.

S 42. Subdivisions (a) and (b) of section 92-dd of the state finance law, as amended by section 3 of part T of chapter 61 of the laws of 2011, are amended to read as follows:

(a) On and after April first, two thousand five, such fund shall consist of the revenues heretofore and hereafter collected or required to be deposited pursuant to paragraph (a) of subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c, and sections twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of the public health law, subdivision (b) of section four hundred eighty-two of the tax law and required to be credited to the tobacco control and insurance initiatives pool, subparagraph (O) of paragraph four of subsection (j) of section four thousand three hundred one of the insurance law, section twenty-seven of part A of chapter one of the laws of two thousand two and all other moneys credited or transferred thereto from any other fund or source pursuant to law.

(b) The pool administrator under contract with the commissioner of health pursuant to section twenty-eight hundred seven-y of the public health law shall continue to collect moneys required to be collected or deposited pursuant to paragraph (a) of subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c, and sections twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of the public health law, and shall deposit such moneys in the HCRA resources fund. The comptroller shall deposit moneys collected or required to be deposited pursuant to subdivision (b) of section four hundred eighty-two of the tax law and required to be credited to the tobacco control and insurance initiatives pool, subparagraph (O) of paragraph four of subsection (j) of section four thousand three hundred one of the insurance law, section twenty-seven of part A of chapter one of the laws of two thousand two and all other moneys credited or transferred thereto from any other fund or source pursuant to law in the HCRA resources fund.

S 43. Subdivision (c) of section 92-dd of the state finance law, as amended by section 75-f of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(c) The pool administrator shall, from appropriated funds transferred to the pool administrator from the comptroller, continue to make payments as required pursuant to sections twenty-eight hundred seven-k, twenty-eight hundred seven-m (not including payments made pursuant to subparagraph (ii) of paragraph (b) and paragraphs (c), (d), (e), (f) and (g) of subdivision five-a and subdivision seven of section twenty-eight hundred seven-m), and twenty-eight hundred seven-w of the public health law, paragraph (e) of subdivision [twenty-five] FOURTEEN of section twenty-eight hundred seven-c of the public health law, AS SUCH SUBDIVISION WAS IN EFFECT PRIOR TO TWO THOUSAND FOURTEEN, paragraphs (b) and (c) of subdivision thirty of section twenty-eight hundred seven-c of the public health law, paragraph (b) of subdivision eighteen of section twenty-eight hundred eight of the public health law, subdivision seven of section twenty-five hundred-d of the public health law and section eighty-eight of chapter one of the laws of nineteen hundred ninety-nine.

S 44. Subdivision 1 of section 97-x of the state finance law, as amended by section 731 of the laws of 1993, is amended to read as follows:

1. Each general hospital shall be assessed an annual fee by the commissioner of health calculated on the basis of its proportionate share of the sum of total costs reported by all general hospitals in the most recent calendar year for which certified data are available. Such

fee shall not exceed one-tenth of one percent of the total costs reported by such general hospital. Where rates of payment for general hospital services established pursuant to section twenty-eight hundred seven-a of the public health law or pursuant to section twenty-eight hundred seven-c of the public health law have not been adjusted to reflect the proportionate share of costs associated with such annual fee, rates shall be so adjusted. The commissioner of health shall promulgate regulations establishing a time schedule for payment of annual fees assessed on general hospitals. The commissioner of health shall charge a user fee for the production of any data to any person or organization, provided, however, that the commissioner of health may waive such fee for the provision of reports, to be defined in regulation, to a general hospital or its designee as approved by the commissioner of health or third-party payor or health systems agency to perform duties and functions provided for in subdivision seven, excluding paragraph (s) of such subdivision, of section twenty-nine hundred four-b of the public health law. Notwithstanding any inconsistent provisions of any general or special law, charges established pursuant to subdivision twelve of section twenty-eight hundred seven-a of the public health law or pursuant to paragraph [(c)] (H) of subdivision one of section twenty-eight hundred seven-c of the public health law shall be permitted to increase to reflect increased costs resulting from the proportionate cost of the annual fees assessed pursuant to this subdivision.

S 45. Subparagraph 1 of subdivision (d) of section 13 of the workers' compensation law, as amended by chapter 419 of the laws of 2000, is laws of 1993, is amended to read as follows:

(1) In the event that an insurer or health benefits plan makes payments for medical and/or hospital services for or on behalf of an injured employee they shall be entitled to be reimbursed for such payments by the carrier or employer within the limits of the medical and hospital fee schedules if the board determines that the claim is compensable. For the purposes of this section, an insurer or health benefits plan includes a medical expense indemnity corporation, a health or hospital service corporation, a commercial insurance company licensed to write accident and health insurance in the state of New York, a health maintenance organization operating in accordance with article forty-three of the insurance law or article forty-four of the public health law, or a self-insured or self-funded health care benefits plan operated by, or on behalf of, any business, municipality or other entity (including an employee welfare fund as defined in article forty-four of the insurance law or any other union trust fund or union health benefits plan). Notwithstanding any other provision of law, in no event shall the carrier or employer be required to reimburse the insurer or health benefits plan in an amount greater than the amount paid for medical and hospital services for or on behalf of the injured employer by such corporation or company; provided, however, if the carrier or employer does not reimburse the insurer or health benefits plan within thirty days after the board determines that the claim is compensable, the carrier or employer shall reimburse the insurer or health benefits plan at the amount the carrier or employer would be obligated to reimburse the hospital or other provider of medical services if the carrier or employer made payment directly to the provider of medical and/or hospital services pursuant to this chapter (or, in the case of inpatient hospital services, pursuant to paragraphs [(b) and (b-1)] (E) AND (F) of subdivision one of section twenty-eight hundred seven-c of the public health law). Upon reimbursement to the insurer or health benefits plan

pursuant to this subdivision, the carrier or employer shall be relieved of liability for the medical and/or hospital services for which payment has been made by the insurer or health benefits plan.

S 46. Subdivision 5 of section 168 of chapter 639 of the laws of 1996, constituting the New York Health Care Reform Act of 1996, as amended by section 1 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

5. sections [2807-c,] 2807-j, 2807-s and 2807-t of the public health law, [as amended or] as added by this act, shall expire on December 31, 2014, and shall be thereafter effective only in respect to any act done on or before such date or action or proceeding arising out of such act including continued collections of funds from assessments and allowances and surcharges established pursuant to sections [2807-c,] 2807-j, 2807-s and 2807-t of the public health law, and administration and distributions of funds from pools established pursuant to sections [2807-c,] 2807-j, 2807-k, 2807-l, 2807-m, 2807-s and 2807-t of the public health law related to patient services provided before December 31, 2014, and continued expenditure of funds authorized for programs and grants until the exhaustion of funds therefor;

S 47. Subdivision 1 of section 138 of chapter 1 of the laws of 1999, constituting the New York Health Care Reform Act of 2000, as amended by section 2 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

1. sections [2807-c,] 2807-j, 2807-s, and 2807-t of the public health law, as amended by this act, shall expire on December 31, 2014, and shall be thereafter effective only in respect to any act done before such date or action or proceeding arising out of such act including continued collections of funds from assessments and allowances and surcharges established pursuant to sections [2807-c,] 2807-j, 2807-s and 2807-t of the public health law, and administration and distributions of funds from pools established pursuant to sections [2807-c,] 2807-j, 2807-k, 2807-l, 2807-m, 2807-s, 2807-t, 2807-v and 2807-w of the public health law, as amended or added by this act, related to patient services provided before December 31, 2014, and continued expenditure of funds authorized for programs and grants until the exhaustion of funds therefor;

S 48. Subdivision 2 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 4 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and sections twelve, thirteen and fourteen of this act shall be deemed to be in full force and effect on and after April 1, 2011 [through March 31, 2015];

S 49. This act shall take effect immediately; provided that the amendments to section 2807-j of the public health law made by sections twelve, thirteen, fourteen and fifteen of this act and the amendments to section 2807-s of the public health law made by section twenty-six of this act shall not affect the expiration of such sections and shall be deemed to expire therewith.