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I N   S E N A T E

April 9, 2014

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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 effec-  
tiveness thereof; to amend chapter 1 of the laws of 1999, constituting  
the New York Health Care Reform act of 2000, in relation to the effec-  
tiveness 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 insur-  
ance law relating to making technical corrections

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

1     Section 1. Section 2807-c of the public health law, as amended by  
2     chapter 731 of the laws of 1993, paragraphs (a), (a-1), (b), (b-2), and  
3     (c) of subdivision 1, the opening paragraph of paragraph (a) of subdivi-  
4     sion 3-a, paragraph (c), clauses (B) and (D) of subparagraph (i) and  
5     subparagraph (ii) of paragraph (f) of subdivision 11, paragraph (a) of  
6     subdivision 14, paragraph (c) of subdivision 14-a, subparagraph (v) of  
7     paragraph (a) of subdivision 14-b, paragraph (a) of subdivision 14-c,  
8     paragraphs (a) and (b) of subdivision 14-d, paragraph (b) of subdivision  
9     16-a, the opening paragraph, and paragraphs (b) and (c) of subdivision  
10    18, the opening paragraph, paragraphs (b) and (b-1), and the opening  
11    paragraph of subparagraph (ii) of paragraph (f) of subdivision 19,  
12    subdivision 19-a, paragraph (e) of subdivision 21 as amended by and  
13    paragraph (a-3) of subdivision 1, paragraph (d) of subdivision 2, para-  
14    graph (s) of subdivision 11, paragraph (e) of subdivision 12, paragraph  
15    (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.

LBD13873-03-4

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 00 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)

1 and subparagraph (i) of paragraph (j) of subdivision 1 as amended by  
2 chapter 500 of the laws of 2007, subparagraph (ii) of paragraph (i) of  
3 subdivision 1 as amended by section 19, subparagraph (ii) of paragraph  
4 (j) of subdivision 1 as amended by section 19-a of part B, paragraph (h)  
5 of subdivision 18 as added by section 41 and paragraphs (a) and (b) of  
6 subdivision 30 as amended by section 22-b of part B and subdivision 33  
7 as added by section 12 of part C of chapter 58 of the laws of 2008,  
8 paragraph (e) of subdivision 4 as amended by section 30 and subdivision  
9 31 as amended by section 24 of part J of chapter 82 of the laws of 2002,  
10 paragraph (e-1) of subdivision 4 as added by section 12, paragraph (e-2)  
11 of subdivision 4 as added by section 13, subdivision 35 as added by  
12 section 2 of part C, subparagraph (iii) of paragraph (f) of subdivision  
13 4 as amended by section 16, subparagraph (iii) of paragraph (k) of  
14 subdivision 4 as amended by section 17, the opening paragraph of subpar-  
15 agraph (vi) of paragraph (b) of subdivision 5 as amended by section 18,  
16 the opening paragraph and subparagraph (i) of paragraph (c) of subdivi-  
17 sion 5 as amended by section 19 and clause (B-1) of subparagraph (i) of  
18 paragraph (f) of subdivision 11 as amended by section 20 of part B,  
19 paragraph (l) of subdivision 4 as amended by section 11, paragraph (s-8)  
20 of subdivision 11 as amended by section 13-a, clause (A) of subparagraph  
21 (i) of paragraph (a) of subdivision 30 as amended by section 4, clause  
22 (A) of subparagraph (i) of paragraph (b) of subdivision 30 as amended by  
23 section 5 and subparagraph (ii) of paragraph (a) of subdivision 33 as  
24 amended by section 1-b of part C of chapter 58 of the laws of 2009,  
25 clause (D) of subparagraph (iv) of paragraph (e-2) of subdivision 4 as  
26 added by section 30, the opening paragraph of paragraph (l) of subdivi-  
27 sion 4 as amended by section 25, subparagraphs (ii) and (x) of paragraph  
28 (b) of subdivision 35 as amended by section 33-a and paragraph (c) of  
29 subdivision 35 as amended by section 26 of part A, subparagraph (v) of  
30 paragraph (b) of subdivision 35 as amended by section 7 of part B,  
31 subdivision 14-f as amended by section 2 and the opening paragraph of  
32 subparagraph (i) of paragraph (i) of subdivision 35 as amended by  
33 section 4 of part C of chapter 56 of the laws of 2013, paragraphs (f)  
34 and (k) of subdivision 4 and clause (A) of subparagraph (iii) of para-  
35 graph (b) of subdivision 5 as separately amended by chapters 194 and 474  
36 of the laws of 1996, subparagraph (iii) of paragraph (b) as amended by  
37 section 2, clause (A) of subparagraph (iii) as amended by section 3 and  
38 clause (C) of subparagraph (iii) of paragraph (b) of subdivision 5 as  
39 added by section 4 of chapter 593 of the laws of 2006, subparagraph (iv)  
40 of paragraph (b) of subdivision 5 as added by chapter 194 of the laws of  
41 1996, subparagraphs (iv) and (v) of paragraph (b) of subdivision 5 as  
42 amended and paragraphs (s-1) and (s-2) of subdivision 11 as added by  
43 chapter 433 of the laws of 1997, subdivision 10 as amended by section 22  
44 and paragraphs (s-3) and (s-4) of subdivision 11 as added by section  
45 32-e of part F of chapter 412 of the laws of 1999, subparagraph (i) of  
46 paragraph (c) of subdivision 10 and paragraph (s-5) of subdivision 11 as  
47 amended by chapter 419 of the laws of 2000, subparagraph (vi) of para-  
48 graph (f) of subdivision 11 as added by chapter 170 of the laws of 1994,  
49 paragraph (s-6) of subdivision 11 as amended by section 6 of part H of  
50 chapter 686 of the laws of 2003, paragraph (s-7) of subdivision 11 as  
51 added by section 68 of part C, paragraph (c) of subdivision 16 as  
52 amended by section 64 and paragraph (f) of subdivision 31 as amended by  
53 section 7 of part B of chapter 58 of the laws of 2005, subparagraph (iv)  
54 of paragraph (b) of subdivision 5 as added and paragraph (b) of subdivi-  
55 sion 14 as amended by chapter 474 of the laws of 1996, paragraph (e) of  
56 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:

1 (A) [the hospital-specific average reimbursable inpatient operating  
2 cost per discharge pursuant to subdivision six of this section, and  
3 (B) group category average inpatient reimbursable operating cost per  
4 discharge pursuant to subdivision seven of this section, and  
5 (C) the operating cost component of rates of payment pursuant to para-  
6 graphs (f) and (k) of subdivision four of this section, and  
7 (D) the operating cost component of rates of payment in accordance  
8 with paragraphs (e), (g) and (i) of subdivision four of this section for  
9 general hospitals or distinct units of general hospitals not reimbursed  
10 on the basis of case based payments per discharge; and  
11 (E) notwithstanding clauses (A) through (D) of this subparagraph, for  
12 periods on and after December first, two thousand nine,] the operating  
13 cost component of rates of payment subject to subdivision [thirty-five]  
14 SEVENTEEN of this section, and  
15 [(F) notwithstanding clauses (A) through [(D)] (C) of this subpara-  
16 graph, for periods on and after December first, two thousand nine,]  
17 (B) the operating cost component of rates of payment subject to para-  
18 graphs [(e-1), (e-2) and (l) of subdivision four] (B), (C) AND (F) OF  
19 SUBDIVISION TWO of this section for general hospitals or distinct units  
20 of general hospitals not reimbursed on the basis of case based payments  
21 per discharge; and  
22 (ii) such rates of payment may be established by the commissioner on  
23 any appropriate payment basis, including a case mix adjusted per  
24 discharge basis.  
25 [(b) For patients discharged prior to January first, nineteen hundred  
26 ninety-seven, payments to general hospitals for reimbursement of inpa-  
27 tient hospital services provided to patients eligible for payments  
28 pursuant to the comprehensive motor vehicle insurance reparations act;  
29 or enrolled in a self-insured fund which provides for reimbursement  
30 directly to general hospitals on an expense incurred basis, with the  
31 exception of those enrollees covered under a payment rate methodology  
32 agreement in accordance with the provisions of paragraph (a) of subdivi-  
33 sion two of this section; or insured under a commercial insurer licensed  
34 to do business in this state and authorized to write accident and health  
35 insurance and whose policy provides inpatient hospital coverage on an  
36 expense incurred basis; or receiving inpatient hospital services pursu-  
37 ant to an out-of-plan benefits system authorized pursuant to section  
38 four thousand four hundred six of this chapter, except where such out-  
39 of-plan, inpatient hospital services are offered by an organization  
40 organized pursuant to the not-for-profit corporation law or which meets  
41 the qualifications of section 501(c) of the internal revenue code, shall  
42 be case based payments per discharge, for each diagnosis-related group  
43 established in accordance with paragraph (a) of subdivision three of  
44 this section, and equal to the case payments to general hospitals  
45 provided in accordance with paragraph (a) of this subdivision for  
46 services provided to subscribers of corporations organized and operating  
47 in accordance with article forty-three of the insurance law, adjusted  
48 for uncovered services, and increased by thirteen percent or, for  
49 payments pursuant to the workers' compensation law, the volunteer fire-  
50 fighters' benefit law and the volunteer ambulance workers' benefit law,  
51 increased by five percent. Funds received by a general hospital based on  
52 the payment differential applied pursuant to this paragraph shall be  
53 hospital funds for patient care purposes. Without due cause general  
54 hospitals shall not refuse to accept direct payments from a payor who  
55 would otherwise be eligible to reimburse hospitals for inpatient

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

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

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

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

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

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

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

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

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

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

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

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



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

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

30 The additional increase of forty million dollars shall be allocated to  
31 costs of general hospitals that are included in group categories estab-  
32 lished pursuant to paragraph (b) of subdivision seven of this section  
33 based on the ratio of the nineteen hundred eighty-eight intermediate  
34 group operating costs of each such general hospital, and to costs of  
35 general hospitals that are excluded from the case based payment per  
36 diagnosis-related group system in accordance with paragraph (e) or (g)  
37 of subdivision four of this section based on the ratio of the nineteen  
38 hundred eighty-eight intermediate operating costs of each such general  
39 hospital, to the total sum of such intermediate group operating costs  
40 and intermediate operating costs applied to the forty million dollars.  
41 For purposes of this subparagraph, intermediate group operating costs of  
42 a general hospital shall be calculated in accordance with rules and  
43 regulations adopted by the council and approved by the commissioner  
44 based on the reimbursable inpatient operating cost base determined in  
45 accordance with paragraph (d) of this subdivision of such general hospi-  
46 tal; adjusted to exclude operating costs related to specialized hospital  
47 services for which an alternative reimbursement methodology is adopted  
48 pursuant to paragraph (e) or (g) or, if effective, (i) of subdivision  
49 four of this section; and trended to the nineteen hundred eighty-eight  
50 rate period by the trend factor determined in accordance with subdivi-  
51 sion ten of this section; and increased to reflect special additional  
52 inpatient operating costs determined and allocated in accordance with  
53 subparagraph (i) of this paragraph; and adjusted to exclude a factor for  
54 operating costs of patients who required an alternate level of care in  
55 accordance with paragraph (h) of subdivision four of this section; and  
56 adjusted to exclude the components of the trended reimbursable inpatient

1 operating cost base related to education, physician, ambulance services  
2 and organ acquisition costs determined in accordance with subparagraphs  
3 (i), (iii) and (iv) of paragraph (c) of subdivision seven of this  
4 section and malpractice insurance costs, and the components of special  
5 additional inpatient operating costs determined and allocated in accord-  
6 ance with subparagraph (i) of this paragraph associated with cost  
7 increases in such costs. For purposes of this subparagraph, intermediate  
8 operating costs of a general hospital excluded from the case based  
9 payment per diagnosis-related group system shall be calculated in  
10 accordance with rules and regulations adopted by the council and  
11 approved by the commissioner based on the reimbursable inpatient operat-  
12 ing cost base determined in accordance with paragraph (d) of this subdi-  
13 vision of such general hospital; trended to the nineteen hundred eight-  
14 y-eight rate period by the trend factor determined in accordance with  
15 subdivision ten of this section; and increased to reflect special addi-  
16 tional inpatient operating costs determined and allocated in accordance  
17 with subparagraph (i) of this paragraph; and adjusted to exclude a  
18 factor for operating costs of patients who required an alternate level  
19 of care developed consistent with the provisions of paragraph (h) of  
20 subdivision four of this section; and adjusted to exclude the components  
21 of the trended reimbursable inpatient operating cost base related to  
22 education, physician, ambulance services and organ acquisition costs  
23 determined consistent with the provisions of subparagraphs (i), (iii)  
24 and (iv) of paragraph (c) of subdivision seven of this section and malp-  
25 ractice insurance costs, and the components of special additional inpa-  
26 tient operating costs determined and allocated in accordance with  
27 subparagraph (i) of this paragraph associated with cost increases in  
28 such costs.

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

43 (A) Up to two hundred twenty-two million dollars shall be allocated  
44 for labor adjustments. If the total of the adjustments is less than two  
45 hundred twenty-two million dollars, then the adjustments shall be fully  
46 funded. If the total of the adjustments is more than two hundred twen-  
47 ty-two million dollars, then the adjustment specified in accordance with  
48 item (II) of this clause shall be funded at the lower of twenty percent  
49 of the total amount allocated for labor adjustments or its proportional  
50 share of the labor adjustments unless the labor adjustment specified in  
51 item (I) of this clause is less than eighty percent of the total amount  
52 allocated for labor adjustments in which case the adjustment specified  
53 in item (II) of this clause shall be equal to the difference between two  
54 hundred twenty-two million dollars and the total amount of the adjust-  
55 ment specified in item (I) of this clause.

1 (I) A portion of the amount allocated for labor adjustments shall be  
2 for labor cost increases related to registered nurses' salaries and  
3 fringes (twenty percent of salaries) and an add-on for the ripple effect  
4 on other health care professionals of at least thirty-five percent. Such  
5 adjustment shall cover both inpatient and outpatient cost incurred,  
6 based on costs reported in a survey conducted by the department for the  
7 period January first, nineteen hundred ninety through June thirtieth,  
8 nineteen hundred ninety on forms specified by the commissioner and  
9 received by the department no later than November first, nineteen  
10 hundred ninety, annualized, in excess of nineteen hundred eighty-five  
11 labor costs related to registered nurses' salaries and fringes trended  
12 to nineteen hundred ninety and the nineteen hundred eighty-eight state-  
13 wide nurse salary adjustment trended to nineteen hundred ninety by the  
14 appropriate components of the trend factors adjusted to reflect the  
15 effect of the annualization of nineteen hundred ninety data and the  
16 result trended to nineteen hundred ninety-one and shall be based exclu-  
17 sively on regional experience. Such regional adjustment shall not be  
18 less than zero. Each individual hospital within a region shall receive a  
19 portion of the regional adjustment equal to its share of the total inpa-  
20 tient and outpatient reimbursable operating costs for the region exclud-  
21 ing costs related to services provided to beneficiaries of title XVIII  
22 of the federal social security act (medicare) and excluding direct  
23 medical education costs.

24 (II) A portion of the amount allocated for labor adjustments shall be  
25 for personnel costs other than those related to registered nurses' sala-  
26 ries and fringes and the ripple effect on other health care profes-  
27 sionals. Such adjustment shall cover both inpatient and outpatient costs  
28 incurred, based on costs reported in a survey conducted by the depart-  
29 ment for the period January first, nineteen hundred ninety through June  
30 thirtieth, nineteen hundred ninety on forms specified by the commission-  
31 er and received by the department no later than November first, nineteen  
32 hundred ninety, annualized, in excess of nineteen hundred eighty-five  
33 personnel costs covered by this adjustment trended to nineteen hundred  
34 ninety and the annualized rate adjustments approved in nineteen hundred  
35 eighty-nine for personnel costs covered by this adjustment for increased  
36 hospital costs to meet additional state requirements that became effec-  
37 tive July first, nineteen hundred eighty-nine trended to nineteen  
38 hundred ninety by the appropriate components of the trend factors  
39 adjusted to reflect the effect of the annualization of nineteen hundred  
40 ninety data and the result trended to nineteen hundred ninety-one and  
41 shall be based exclusively on regional data.

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

49 (B) Health personnel development.

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

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

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

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

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

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

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

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

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

42 (I) Five hundred thousand dollars shall be allocated for a practition-  
43 er placement program to assist general hospitals in the placement of  
44 physicians and other health care practitioners to practice primary  
45 health care and/or dentistry in underserved areas, to serve the  
46 medically needy, and including services with affiliated community based  
47 providers. The commissioner shall make rate adjustments for such allo-  
48 cations. Notwithstanding any inconsistent provision of this subdivision,  
49 this clause shall not apply in rate periods commencing on or after Janu-  
50 ary first, nineteen hundred ninety-four.

51 (iv) Cost increases pursuant to this subparagraph shall be made for  
52 the nineteen hundred ninety-four rate period to reflect cost increases  
53 incurred in excess of the trend factor and not included in the costs  
54 used in determining payments in accordance with paragraph (d) of this  
55 subdivision and subparagraphs (i), (ii) and (iii) of this paragraph.  
56 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

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

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

19 (f) The commissioner and the state director of the budget shall  
20 consider providing a supplementary increase to general hospital reim-  
21 bursable inpatient operating costs for purposes of computing rates of  
22 payment for annual rate periods beginning on or after January first,  
23 nineteen hundred eighty-nine in accordance with this section for reason-  
24 able and necessary supplementary cost increases in general hospital  
25 operating costs for such rate period or periods based on increased mini-  
26 mum standards and procedures relating to general hospital operating  
27 certificates adopted by the council and approved by the commissioner or  
28 state initiatives related to recruitment or maintenance of an appropri-  
29 ate level of personnel providing professional services to patients. Any  
30 such supplementary increase shall be allocated to costs of general  
31 hospitals in accordance with rules and regulations adopted by the coun-  
32 cil and approved by the commissioner.

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

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

45 (i) rates of payment for patients eligible for payments made by state  
46 governmental agencies shall be reduced by the commissioner to reflect an  
47 exclusion from reimbursable inpatient operating costs commencing April  
48 first, nineteen hundred ninety-five of the special additional inpatient  
49 operating costs determined and allocated among general hospitals in  
50 accordance with clause (C) of subparagraph (iii) and clause (C) of  
51 subparagraph (iv) of paragraph (e) of this subdivision and the factor of  
52 one quarter of one percent of general hospitals' reimbursable inpatient  
53 operating cost base allocated to costs of general hospitals for technol-  
54 ogy advances in accordance with subparagraph (i) of paragraph (e) of  
55 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

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

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

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

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

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

54 (ii) for the period April first, two thousand eight through March  
55 thirty-first, two thousand nine, and each state fiscal year thereafter  
56 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

1 and has issued his written approval of the arrangement. The commissioner  
2 shall not approve such an arrangement if it would result in payments to  
3 a general hospital for inpatient services provided to subscribers of  
4 health maintenance organizations which in the aggregate are less than  
5 what otherwise would have been paid under the provisions of this  
6 section, unless the health maintenance organization demonstrates that  
7 such lower payments are justified because the arrangement will result in  
8 lower costs to the general hospital, and the payments approximate costs.  
9 Such arrangements may be approved by the commissioner to: integrate the  
10 medical delivery functions of the health maintenance organization with  
11 the medical delivery functions of the hospital, including but not limit-  
12 ed to joint staffing arrangements or pre-admission testing arrangements;  
13 or integrate the method of payment and financial incentives to the  
14 hospital with the method of payment and financial incentives to physi-  
15 cians or other providers in the health maintenance organization; or  
16 integrate the method of payment and financial incentives to the hospital  
17 with the health maintenance organization, including, but not limited to,  
18 bed leasing or capitation payments. Notwithstanding any inconsistent  
19 provision of this section, for periods beginning on or after January  
20 first, nineteen hundred ninety-four, negotiated agreements between  
21 health maintenance organizations and general hospitals which were  
22 approved by the commissioner and which were in effect on December thir-  
23 ty-first, nineteen hundred ninety-three, may continue.

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

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

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

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

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

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

23 (b) The methodology for assignment of patient discharges within diag-  
24 nosis-related groups applicable for purposes of determining payments for  
25 discharges of beneficiaries of title XVIII of the federal social securi-  
26 ty act (medicare) in effect on the first day of July in the year preced-  
27 ing the rate period, revised to reflect such adjustments as may be made  
28 to the diagnosis-related group classification system pursuant to para-  
29 graph (a) of this subdivision, shall be applied to assign specific  
30 patient discharges within the diagnosis-related groups established  
31 pursuant to paragraph (a) of this subdivision. The council may adopt  
32 rules and regulations, subject to the approval of the commissioner, to  
33 revise the methodology for the assignment of specific patient discharges  
34 within the diagnosis-related groups to reflect revisions to the method-  
35 ology applicable for purposes of determining payments for discharges of  
36 beneficiaries of title XVIII of the federal social security act (medi-  
37 care) effective subsequent to the first day of July in the year preced-  
38 ing the rate period.

39 (c) (i) The commissioner shall determine an appropriate weighting  
40 factor for each diagnosis-related group which reflects the relative  
41 general hospital resources used by all patients, other than benefici-  
42 aries of title XVIII of the federal social security act (medicare), with  
43 respect to discharges classified within that diagnosis-related group  
44 compared to discharges classified within other diagnosis-related groups.  
45 For rate periods during the period January first, nineteen hundred  
46 eighty-eight through December thirty-first, nineteen hundred ninety, the  
47 appropriate weighting factor for each diagnosis-related group shall be  
48 determined using nineteen hundred eighty-five costs and statistics for a  
49 representative sample of general hospitals. For rate periods during the  
50 period January first, nineteen hundred ninety-one through December thir-  
51 ty-first, nineteen hundred ninety-three, the appropriate weighting  
52 factor for each diagnosis-related group shall be determined using nine-  
53 teen hundred eighty-nine costs and statistics for a representative  
54 sample of general hospitals. For rate periods during the period January  
55 first, nineteen hundred ninety-four through December thirty-first, nine-  
56 teen hundred ninety-nine and on and after January first, two thousand

1 through December thirty-first, two thousand seven, the appropriate  
2 weighting factor for each diagnosis-related group shall be determined  
3 using nineteen hundred ninety-two costs and statistics for a represen-  
4 tative sample of general hospitals. For rate periods on and after Janu-  
5 ary first, two thousand eight, the appropriate weighting factor for each  
6 diagnosis-related group shall be determined using two thousand four  
7 costs and statistics for a representative sample of general hospitals,  
8 and, further, the computation of the group average arithmetic inlier  
9 length-of-stays for each diagnostic related group, as otherwise deter-  
10 mined in accordance with applicable regulations, shall utilize two thou-  
11 sand four data as reported to the department, and, be based on a repre-  
12 sentative sample of general hospitals, and further, the short-stay and  
13 long-stay length-of-stay trimpoints, as otherwise determined in accord-  
14 ance with applicable regulations, shall be computed utilizing two thou-  
15 sand four data as reported to the department and based on a represen-  
16 tative sample of general hospitals. Provided however, that if the  
17 department does not release updated data and documentation described in  
18 subparagraph (iii) of this paragraph, the effective rate period shall be  
19 April 1, 2008. Discharges and costs related to the exceptions to case  
20 payment provided in accordance with paragraphs (e), (g) and (i) of  
21 subdivision four of this section shall be eliminated from the costs and  
22 statistics used in determining the appropriate weighting factors, while  
23 the cost factor related to the exception provided in paragraph (h) of  
24 subdivision four of this section shall be eliminated. The costs and  
25 statistics for the case payment modifications calculated pursuant to  
26 paragraphs (a), (b), (c) and (d) of subdivision four of this section  
27 shall be eliminated in accordance with paragraph (c) of subdivision six  
28 of this section. Costs related to education, physician, ambulance  
29 services and organ acquisition identified consistent with the provisions  
30 of paragraph (c) of subdivision seven of this section and costs related  
31 to malpractice insurance shall also be eliminated. The council may adopt  
32 rules and regulations, subject to the approval of the commissioner, to  
33 prospectively adjust weighting factors determined in accordance with  
34 this paragraph to reflect changes in medical technology. After the  
35 commissioner issues rate certifications pursuant to subdivision four of  
36 section twenty-eight hundred seven of this article the commissioner  
37 shall expeditiously make available for inspection by general hospitals  
38 and payors the data, consistent with appropriate department procedures  
39 for the release and protection of confidential data, and the methodology  
40 utilized to determine the appropriate weighting factors.

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

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

1 updated data and documentation that the department will utilize, in  
2 accordance with this paragraph, in developing appropriate service inten-  
3 sity weights for each diagnosis-related group for the two thousand eight  
4 rate period. The department will thereafter consult with hospital indus-  
5 try representatives in developing regulations to implement the utiliza-  
6 tion of such updated service intensity weight data applicable to rate  
7 periods on and after two thousand eight. If it is deemed appropriate by  
8 the commissioner, in consultation with hospital industry represen-  
9 tatives, such regulations may provide for the phase-in over a period of  
10 time of the application of such updated data in determining Medicaid  
11 rates on and after two thousand eight, provided, however, that the  
12 application of such updated data shall be fully reflected in such rates  
13 by no later than January first, two thousand ten.

14 (iv) By no later than December first, two thousand seven, the commis-  
15 sioner shall issue a report to the governor and the legislature describ-  
16 ing the updated data utilization applicable, in accordance with the  
17 provisions of this paragraph, to periods on and after two thousand eight  
18 and setting forth the factors considered in developing it.

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

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

34 3-a. Dispute resolution system. (a) The commissioner shall establish,  
35 in accordance with rules and regulations adopted by the council and  
36 approved by the commissioner, a payment dispute resolution system to  
37 resolve disputes between payors of inpatient hospital services and  
38 general hospitals for patients discharged on or after January first,  
39 nineteen hundred ninety-one and prior to January first, nineteen hundred  
40 ninety-seven. The commissioner shall designate the use of a uniform set  
41 of guidelines for determining the application of particular diagnosis-  
42 related group categories to particular patients which may include guide-  
43 lines published by associations, universities or other organizations.  
44 The dispute resolution process shall apply to all payors of hospital  
45 services described in paragraphs (a), (b) and (c) of subdivision one of  
46 this section, including patients or payors which pay hospitals' charges  
47 or coinsurance, provided, however, such process shall not include  
48 payments made for persons eligible for payments as beneficiaries of  
49 title XVIII of the federal social security act (medicare) as a patients'  
50 primary payor or payments made pursuant to title eleven of article five  
51 of the social services law, provided that this exception shall not  
52 include payments for medical assistance participants in health mainte-  
53 nance organizations or prepaid health services plans. A payor of hospi-  
54 tal services included in paragraph (a) of subdivision one of this  
55 section may serve as, or designate, the review agent for their subscrib-  
56 ers, beneficiaries or enrolled members for an initial review and a

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

4 In the event a third party payor or patient desires to challenge the  
5 appropriateness of a bill for hospital services rendered by a general  
6 hospital for a particular patient, or in the event a general hospital  
7 desires to challenge the appropriateness of a payment by a third party  
8 payor on behalf of a particular patient, then either the hospital or the  
9 payor may submit the question to the dispute resolution process estab-  
10 lished pursuant to this subdivision. The disputes submitted for resol-  
11 ution may include the appropriateness of the application of a particular  
12 diagnosis-related group category, as described in subdivision three of  
13 this section, to a particular patient; the appropriate classification  
14 and payment of an inpatient stay as a modification of a case payment  
15 pursuant to paragraph (a), (b), (c), or (d) of subdivision four of this  
16 section, including whether payment for services should be, based on  
17 medical necessity or other reasons, made as a case payment or payment as  
18 a modification of a case payment; whether payment should appropriately  
19 be made pursuant to an alternative reimbursement methodology authorized  
20 in accordance with paragraph (e) or (h) of subdivision four of this  
21 section and the payment for such services; whether payment for services  
22 rendered by a general hospital should be appropriately, based on medical  
23 necessity or other reasons, made as payment for inpatient care or  
24 payment for outpatient care and the payment for such services; or wheth-  
25 er the hospital stay should be classified as a readmission as defined in  
26 accordance with regulations adopted pursuant to paragraph (l) of subdi-  
27 vision eleven of this section and the payment for such stay.

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



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

6 (b) The commissioner shall approve a statewide utilization review  
7 organization or regional utilization review organizations to conduct and  
8 determine dispute resolution reviews, including reconsideration reviews,  
9 pursuant to this subdivision. To be approved as a utilization review  
10 organization in accordance with this subdivision such organization must  
11 meet the following criteria: the organization shall employ or otherwise  
12 secure the services of adequate personnel, including medical personnel,  
13 qualified to review such disputes, the organization shall demonstrate  
14 the ability to render decisions in a timely manner, the organization  
15 shall agree to provide ready access by the commissioner to all data,  
16 records and information it collects and maintains concerning its review  
17 activities under this subdivision, the organization shall agree to  
18 provide to the commissioner such data, information and reports as the  
19 commissioner determines necessary to evaluate the review process  
20 provided pursuant to this subdivision, the organization shall provide  
21 assurances that review personnel shall not have a conflict of interest  
22 in conducting a review based on payor, hospital or professional affil-  
23 iation, and the organization meets such other performance and efficiency  
24 criteria regarding the conduct of reviews pursuant to this subdivision  
25 established by the commissioner. The commissioner may withdraw approval  
26 of a utilization review organization where such organization fails to  
27 continue to meet approval criteria established pursuant to this para-  
28 graph. A utilization review organization approved pursuant to this para-  
29 graph shall be authorized to receive and review patient medical records  
30 and shall develop and implement appropriate procedures to maintain  
31 confidentiality of such patient medical records.

32 (c) Upon resolution of a payment dispute in accordance with this para-  
33 graph, the parties involved in the dispute shall be notified of the  
34 reason for the decision and the hospital bill in dispute shall be  
35 adjusted to reflect such resolution.

36 (d) The party initiating a payment dispute resolution review or any  
37 reconsideration review must submit to the utilization review organiza-  
38 tion a dispute resolution fee established to recover the costs related  
39 to the conduct of the initial dispute resolution reviews or a reconsid-  
40 eration review fee established to recover the costs related to the  
41 conduct of such reconsideration reviews, except that for payors in para-  
42 graph (a) of subdivision one of this section which serve as or designate  
43 the review agent for their subscribers, beneficiaries, or enrolled  
44 members a fee shall be charged only for the final step in the dispute  
45 resolution process. Upon resolution of a payment dispute in accordance  
46 with this subdivision in favor of the payor, the amount due to the  
47 hospital by a payor based upon the hospital bill shall be reduced by the  
48 amount of any fee paid pursuant to this paragraph by such payor. Upon  
49 resolution of a payment dispute in accordance with this subdivision in  
50 favor of the general hospital, the amount due to the hospital based upon  
51 the hospital bill shall be increased by the amount of any fee paid  
52 pursuant to this paragraph by such general hospital.

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

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

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

15 (g) For payment amounts eligible for payment dispute resolution pursu-  
16 ant to this subdivision, a general hospital shall not bill a patient or  
17 pursue collection efforts against a patient for the difference between a  
18 hospital bill and the payment made on such bill by a payor within the  
19 payor categories specified in paragraph (a), (b) or (c) of subdivision  
20 one of this section, except for uncovered services by a payor, deduct-  
21 ibles and coinsurance based on maximum hospital charges calculated based  
22 on the undisputed amount of the hospital bill, until final decision of  
23 the utilization review organization. Nothing in this subdivision shall  
24 be construed to prohibit a general hospital from issuing an informa-  
25 tional bill to a patient regarding such difference between the hospital  
26 bill and the payment made on such bill to advise the patient of the  
27 amount in dispute.

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

43 4.] 2. Modifications and exceptions to case payment rates. Case based  
44 rates of payment shall be modified and per diem or other unit of service  
45 payments shall be provided, or exceptions shall be made to case  
46 payments, in accordance with rules and regulations adopted by the coun-  
47 cil and approved by the commissioner, in the following circumstances:

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

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

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

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

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

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

1 unit's reimbursable inpatient operating cost base, determined in accord-  
2 ance with paragraph (d) of subdivision one of this section, projected to  
3 the applicable rate period by the trend factor determined in accordance  
4 with subdivision ten of this section, and increased in accordance with  
5 subparagraphs (i), (iii) and (iv) of paragraph (e) of subdivision one of  
6 this section to reflect special additional inpatient operating costs,  
7 and adjusted to exclude a factor for operating costs of patients who  
8 required an alternate level of care developed consistent with the  
9 provisions of paragraph (h) of this subdivision, and increased for  
10 excluded general hospitals to reflect the product of the group category  
11 percentage amount applicable for purposes of determining group category  
12 average inpatient reimbursable operating cost per discharge (price) in  
13 the rate period pursuant to paragraph (b) of subdivision five of this  
14 section for general hospitals reimbursed on a case based payment per  
15 diagnosis-related group applied to such excluded general hospital's  
16 additional cost increases determined in accordance with subparagraph  
17 (ii) of paragraph (e) of subdivision one of this section, and adjusted  
18 on a payor category basis to reflect allocation of malpractice insurance  
19 costs in accordance with the methodology developed pursuant to subpara-  
20 graph (ii) of paragraph (h) of subdivision eleven of this section, for  
21 those patients included in the payor categories pursuant to the  
22 provisions of paragraph (a) or (b) of subdivision one of this section;  
23 provided, however, for those patients included in the payor categories  
24 pursuant to the provisions of paragraph (b) of subdivision one of this  
25 section payment shall be at the per diem payment to the hospital or  
26 distinct unit of the hospital for services provided to subscribers of  
27 corporations organized and operating in accordance with article forty-  
28 three of the insurance law, adjusted for uncovered services, and  
29 increased by thirteen percent or by five percent, as the case may be;  
30 provided further, however, for those general hospitals that are not  
31 reimbursed on a case-based payment per diagnosis-related group for inpa-  
32 tient services provided to beneficiaries of title XVIII of the federal  
33 social security act (medicare) as a result of their designation by the  
34 secretary of health and human services as a comprehensive cancer hospi-  
35 tal or as a result of their status as an acute care exempt children's  
36 hospital, the base year for determining payments for services in such  
37 facilities shall be nineteen hundred eighty-seven, provided, however,  
38 such hospitals shall be allowed adjustments in rates of payment to  
39 reflect costs incurred subsequent to nineteen hundred eighty-seven but  
40 not reflected in such base. Funds received by a general hospital based  
41 on the payment differential in accordance with paragraph (b) of subdivi-  
42 sion one of this section applied pursuant to this paragraph shall be  
43 hospital funds for patient care purposes. For those patients not covered  
44 under the provisions of paragraph (a) or (b) of subdivision one of this  
45 section, or who are not covered under the provisions of paragraph (a) of  
46 subdivision two of this section, payment shall be on the basis of the  
47 hospital's charge schedule, limited to one hundred twenty percent of the  
48 total per diem payment that would have been made if the patient were  
49 included in the payor categories pursuant to the provisions of paragraph  
50 (b) of subdivision one of this section. Rates of payment for excluded  
51 general hospitals and excluded distinct units of general hospitals for a  
52 rate period shall be increased on a per diem basis by additions and  
53 allowances specified in subparagraphs (ii) and (iii) of paragraph (a) of  
54 subdivision one of this section. In adopting regulations for purposes of  
55 determining rates of payment for psychiatric services pursuant to this  
56 paragraph, the council and the commissioner shall consider the advice of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 reimbursable inpatient operating cost component of case based rates of  
2 payment per diagnosis-related group based one hundred percent on the  
3 general hospital's hospital-specific average reimbursable inpatient  
4 operating cost per discharge determined in accordance with subdivision  
5 six of this section; provided however,  
6 (i) commencing April first, nineteen hundred ninety-six through July  
7 thirty-first, nineteen hundred ninety-six, the reimbursable inpatient  
8 operating cost component of case based rates of payment per diagnosis-  
9 related group, excluding any operating cost components related to direct  
10 and indirect expenses of graduate medical education, for patients eligi-  
11 ble for payments made by state governmental agencies shall be reduced by  
12 five percent; and  
13 (ii) commencing August first, nineteen hundred ninety-six through  
14 March thirty-first, nineteen hundred ninety-seven, the reimbursable  
15 inpatient operating cost component of case based rates of payment per  
16 diagnosis-related group, excluding any operating cost components related  
17 to direct and indirect expenses of graduate medical education, for  
18 patients eligible for payments made by state governmental agencies shall  
19 be reduced by two and five-tenths percent; and  
20 (iii) commencing April first, nineteen hundred ninety-seven through  
21 March thirty-first, nineteen hundred ninety-nine and commencing July  
22 first, nineteen hundred ninety-nine through March thirty-first, two  
23 thousand and April first, two thousand through March thirty-first, two  
24 thousand five and for periods commencing April first, two thousand five  
25 through March thirty-first, two thousand six and for periods commencing  
26 on and after April first, two thousand six through March thirty-first,  
27 two thousand seven, and for periods commencing on and after April first,  
28 two thousand seven through March thirty-first, two thousand nine, and  
29 for periods commencing on and after April first, two thousand nine  
30 through March thirty-first, two thousand eleven, the reimbursable inpa-  
31 tient operating cost component of case based rates of payment per diag-  
32 nosis-related group, excluding any operating cost components related to  
33 direct and indirect expenses of graduate medical education, for patients  
34 eligible for payments made by state governmental agencies shall be  
35 reduced by three and thirty-three hundredths percent to encourage  
36 improved productivity and efficiency. Such election shall not alter the  
37 calculation of the group price component calculated pursuant to subpara-  
38 graph (i) of paragraph (a) of subdivision seven of this section;  
39 (g) in cases where general hospitals or distinct units of general  
40 hospitals, other than those specified in paragraphs (e) and (f) of this  
41 subdivision, may be excluded from case based payments or receive an  
42 adjustment to case based payment rates. An exclusion or adjustment shall  
43 be provided only where the council, subject to the approval of the  
44 commissioner, determines that the case based rates of payment determined  
45 in accordance with this section would not reflect medically appropriate  
46 patterns of health resource use for such general hospital services effi-  
47 ciently and economically provided. If an exclusion is provided, then the  
48 reimbursement provisions contained in paragraph (e) of this subdivision  
49 shall apply. The commissioner shall provide to the council an analysis  
50 of the effect of case based payments on rural general hospitals and the  
51 council, subject to the above criteria and the approval of the commis-  
52 sioner, may exclude for any of the annual rate periods beginning on or  
53 after January first, nineteen hundred eighty-eight any of these general  
54 hospitals from case based payments or provide an adjustment to the case  
55 based payments in addition to that authorized in accordance with para-  
56 graph (f) of this subdivision];



1 [(h)] (D) where alternate level of care (ALC) days are provided, a  
2 factor as determined in [subparagraph (i) of] this paragraph for the  
3 costs of these patients in a general hospital shall not be included in  
4 computations relating to the determination of general hospital case  
5 based rates of payment pursuant to this section. Alternate level of care  
6 days shall be days of care provided by a general hospital to a patient  
7 for whom it has been determined that inpatient hospital services are not  
8 medically necessary, but that post-hospital extended care services are  
9 medically necessary and are being provided by the general hospital.  
10 Separate rates of payment shall be established for such patients based  
11 on the level of care required and shall reflect[: (i)] operating costs  
12 based on the nineteen hundred eighty-seven regional average operating  
13 cost component of rates of payment for hospital based residential health  
14 care facilities determined in accordance with section twenty-eight  
15 hundred eight of this article and trended to the rate period[, and (ii)  
16 additions contained in subparagraph (iii) of paragraph (a) of subdivi-  
17 sion one of this section]. In the event that federal financial partic-  
18 ipation in payments made for beneficiaries eligible for medical assist-  
19 ance under title XIX of the federal social security act based upon the  
20 rates calculated in accordance with this paragraph is not approved by  
21 the federal government, the council subject to the approval of the  
22 commissioner shall adopt regulations for such payments;

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

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

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

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

3 (k) for facilities designated by the federal department of health and  
4 human services as an exempt acute care children's hospital, payment  
5 effective January first, nineteen hundred ninety-four will be based upon  
6 a hospital specific case payment amount inclusive of high cost and high  
7 length of stay outlier costs. The nineteen hundred eighty-seven base  
8 year cost, trended, volume adjusted and case mix adjusted where applica-  
9 ble to nineteen hundred ninety-two, trended will be utilized to deter-  
10 mine the rate of payment effective January first, nineteen hundred nine-  
11 ty-four.

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

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

24 (iii) commencing April first, nineteen hundred ninety-seven through  
25 March thirty-first, nineteen hundred ninety-nine and commencing July  
26 first, nineteen hundred ninety-nine through March thirty-first, two  
27 thousand and April first, two thousand through March thirty-first, two  
28 thousand five and commencing April first, two thousand five through  
29 March thirty-first, two thousand six, and for periods commencing on and  
30 after April first, two thousand six through March thirty-first, two  
31 thousand seven, and for periods commencing on and after April first, two  
32 thousand seven through March thirty-first, two thousand nine, and for  
33 periods commencing on and after April first, two thousand nine through  
34 March thirty-first, two thousand eleven, the operating cost component of  
35 rates of payment, excluding any operating cost components related to  
36 direct and indirect expenses of graduate medical education, for patients  
37 eligible for payments made by a state governmental agency shall be  
38 reduced by three and thirty-three hundredths percent to encourage  
39 improved productivity and efficiency. The facility will be eligible to  
40 receive the financial incentives for the physician specialty weighting  
41 incentive towards primary care pursuant to subparagraph (ii) of para-  
42 graph (a) of subdivision twenty-five of this section.

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

53 (i) for the period December first, two thousand eight through March  
54 thirty-first, two thousand nine, seventy-five percent of the operating  
55 cost component of such rates of payments shall reflect the operating  
56 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

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

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

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

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

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

20 (III) Northern metropolitan, consisting of the counties of Columbia,  
21 Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and West-  
22 chester;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35 (A) the amount determined in accordance with clause (B) of subpara-  
36 graph (iii) of this paragraph, excluding the value of direct medical  
37 education expenses, as defined in subparagraph (i) of paragraph (c) of  
38 subdivision seven of this section, reflected in the general hospital's  
39 hospital-specific average reimbursable inpatient operating cost per  
40 discharge and group category average inpatient reimbursable operating  
41 cost per discharge, and excluding the value of forty-five percent of the  
42 indirect medical education expenses, as defined in subparagraph (ii) of  
43 paragraph (c) of subdivision seven of this section, reflected in the  
44 general hospital's hospital specific average reimbursable inpatient  
45 operating cost per discharge, and excluding the value of fifty-five  
46 percent of the indirect medical education expenses reflected in a gener-  
47 al hospital's group category average inpatient reimbursable operating  
48 cost per discharge in accordance with subdivision twenty-five of this  
49 section as amended;

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

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

1 (D) minus five percent of the costs of hospital based physicians  
2 reflected in the direct medical education amount determined in accord-  
3 ance with clause (C) of this subparagraph;

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

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

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

19 (A) the amount determined in accordance with clause (B) of subpara-  
20 graph (iii) of this paragraph, excluding the value of direct medical  
21 education expenses, as defined in subparagraph (i) of paragraph (c) of  
22 subdivision seven of this section, reflected in the general hospital's  
23 hospital-specific average reimbursable inpatient operating cost per  
24 discharge and group category average inpatient reimbursable operating  
25 cost per discharge, and excluding the value of forty-five percent of the  
26 indirect medical education expenses, as defined in subparagraph (ii) of  
27 paragraph (c) of subdivision seven of this section, reflected in the  
28 general hospital's hospital specific average reimbursable inpatient  
29 operating cost per discharge, and excluding the value of fifty-five  
30 percent of the indirect medical education expenses reflected in a gener-  
31 al hospital's group category average inpatient reimbursable operating  
32 cost per discharge in accordance with subdivision twenty-five of this  
33 section as amended;

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

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

41 (D) minus five percent of the costs of hospital based physicians  
42 reflected in the direct medical education amount determined in accord-  
43 ance with clause (C) of this subparagraph;

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

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

53 (iv) for discharges on or after April first, nineteen hundred ninety-  
54 six through July thirty-first, nineteen hundred ninety-six for purposes  
55 of reimbursement of inpatient hospital services for patients eligible  
56 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



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

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

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

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

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

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

22 (vi) for discharges on or after April first, nineteen hundred ninety-  
23 seven through March thirty-first, nineteen hundred ninety-nine and for  
24 discharges on or after July first, nineteen hundred ninety-nine through  
25 March thirty-first, two thousand and for discharges on or after April  
26 first, two thousand through March thirty-first, two thousand five and  
27 for discharges on or after April first, two thousand five through March  
28 thirty-first, two thousand six, and for discharges on or after April  
29 first, two thousand six through March thirty-first, two thousand seven,  
30 and for discharges on or after April first, two thousand seven through  
31 March thirty-first, two thousand nine, and for discharges on or after  
32 April first, two thousand nine through March thirty-first, two thousand  
33 eleven, for purposes of reimbursement of inpatient hospital services for  
34 patients eligible for payments made by state governmental agencies, the  
35 average reimbursable inpatient operating cost per discharge of a general  
36 hospital shall, to encourage improved productivity and efficiency, be  
37 the sum of:

38 (A) the amount determined in accordance with clause (B) of subpara-  
39 graph (iii) of this paragraph, excluding the value of direct medical  
40 education expenses, as defined in subparagraph (i) of paragraph (c) of  
41 subdivision seven of this section, reflected in the general hospital's  
42 hospital-specific average reimbursable inpatient operating cost per  
43 discharge and group category average inpatient reimbursable operating  
44 cost per discharge, and excluding the value of forty-five percent of the  
45 indirect medical education expenses, as defined in subparagraph (ii) of  
46 paragraph (c) of subdivision seven of this section, reflected in the  
47 general hospital's hospital-specific average reimbursable inpatient  
48 operating cost per discharge, and excluding the value of fifty-five  
49 percent of the indirect medical education expenses reflected in a gener-  
50 al hospital's group category average inpatient reimbursable operating  
51 cost per discharge in accordance with subdivision twenty-five of this  
52 section as amended;

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

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

1 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;

4 (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;

7 (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

12 (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.

16 (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:

31 (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

48 (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

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

8 6. Operating costs. (a) A general hospital's hospital-specific average  
9 reimbursable inpatient operating cost per discharge shall be determined  
10 in accordance with rules and regulations adopted by the council and  
11 approved by the commissioner based on the hospital's reimbursable inpa-  
12 tient operating cost base determined in accordance with paragraph (d) of  
13 subdivision one of this section; adjusted in accordance with paragraph  
14 (b) of this subdivision to reflect exceptions to case payments; and  
15 projected to the applicable rate period by a trend factor determined in  
16 accordance with subdivision ten of this section; and increased in  
17 accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of  
18 subdivision one of this section to reflect special additional inpatient  
19 operating costs; and adjusted in accordance with subparagraphs (i), (ii)  
20 and (iv) of paragraph (c) of this subdivision to reflect modifications  
21 to case payments; and standardized to reflect nineteen hundred eighty-  
22 seven hospital case mix. A general hospital's hospital-specific average  
23 reimbursable inpatient operating cost per discharge shall be adjusted on  
24 a payor category basis to reflect allocation of malpractice insurance  
25 costs in accordance with the methodology developed pursuant to subpara-  
26 graph (ii) of paragraph (h) of subdivision eleven of this section.

27 (b) In accordance with rules and regulations adopted by the council  
28 and approved by the commissioner, the commissioner shall adjust reim-  
29 bursable inpatient operating costs and discharges to exclude operating  
30 costs and statistics related to specialized hospital services for which  
31 an alternative reimbursement methodology is adopted pursuant to para-  
32 graph (e) or (g) of subdivision four of this section, a factor for oper-  
33 ating costs of patients who required an alternate level of care in  
34 accordance with paragraph (h) of subdivision four of this section and  
35 the operating costs and statistics of AIDS patients pursuant to para-  
36 graph (i) of subdivision four of this section if effective.

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

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

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

16 (ii) an estimate of costs for the outlier portion of inpatient  
17 services which would qualify for additional payments as cost outliers in  
18 accordance with paragraph (b) of subdivision four of this section shall  
19 be eliminated from reimbursable inpatient operating costs based on a  
20 general hospital's high cost percentage outlier factor, applied to an  
21 acute care cost component of such general hospital's reimbursable inpa-  
22 tient operating cost base after application of the trend factor and the  
23 addition of special additional inpatient operating costs. The high cost  
24 percentage outlier factor shall be calculated based on a determination  
25 of the percentage of nineteen hundred eighty-seven discharges of  
26 patients other than beneficiaries of title XVIII of the federal social  
27 security act (medicare) for which the commissioner has complete hospital  
28 bill submissions or such discharges during a recent twelve month period  
29 prior thereto established by regulation for which hospital bills are  
30 available, as follows, (a) for general hospitals that have complete  
31 hospital bill submissions for at least ninety percent of their  
32 discharges, a high cost percentage outlier factor based on such data,  
33 and (b) for general hospitals that have complete hospital bill  
34 submissions for at least eighty percent but less than ninety percent of  
35 their discharges, a high cost percentage outlier factor based on such  
36 data plus an additional one-quarter of one percent, and (c) for general  
37 hospitals that have complete bill submissions for less than eighty  
38 percent of their discharges, a high cost percentage outlier factor  
39 determined based on nineteen hundred eighty-five data from a represen-  
40 tative sample of general hospitals plus an additional one-quarter of one  
41 percent. The calculation of the high cost percentage outlier factor  
42 shall be subsequently reconciled by an adjustment to reflect the  
43 percentage of such complete hospital bill submissions for such nineteen  
44 hundred eighty-seven discharges as submitted to the commissioner prior  
45 to August first, nineteen hundred eighty-eight.

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

1 records for which the commissioner has complete hospital bill  
2 submissions.

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

15 (iii) an estimate of inpatient costs which are related to a hospital  
16 stay in excess of the long stay threshold for long stay patients as  
17 defined in paragraph (c) of subdivision four of this section shall be  
18 eliminated from reimbursable inpatient operating costs in determining  
19 group category average inpatient reimbursable operating costs consider-  
20 ing a long stay patient cost conversion factor, which shall be estab-  
21 lished at sixty percent provided, however, such long stay patient cost  
22 conversion factor may be revised for an annual rate period or periods  
23 beginning on or after January first, nineteen hundred eighty-nine in  
24 accordance with rules and regulations adopted by the council and  
25 approved by the commissioner; a case mix neutral acute care cost compo-  
26 nent of a general hospital's reimbursable inpatient operating cost base  
27 per day after application of the trend factor and the addition of  
28 special additional inpatient operating costs; long stay patient days  
29 incurred by such general hospital in nineteen hundred eighty-seven or  
30 the number of such long stay patient days during a recent twelve month  
31 period prior thereto established by regulation for which data are avail-  
32 able subsequently reconciled by an adjustment to reflect nineteen  
33 hundred eighty-seven data; and the specific diagnosis-related groups  
34 with which the long stay patients are identified. The long stay outlier  
35 thresholds shall be determined by adding a sufficient number of standard  
36 deviations to the mean length of stay for each diagnosis-related group  
37 such that it is estimated for rates of payment during the period January  
38 first, nineteen hundred eighty-eight through December thirty-first,  
39 nineteen hundred ninety based upon nineteen hundred eighty-five data  
40 from a representative sample of general hospitals and for rates of  
41 payment during the period January first, nineteen hundred ninety-one  
42 through December thirty-first, nineteen hundred ninety-three based upon  
43 nineteen hundred eighty-nine data from a representative sample of gener-  
44 al hospitals and for rates of payment during the period January first,  
45 nineteen hundred ninety-four through December thirty-first, nineteen  
46 hundred ninety-nine and periods on and after January first, two thousand  
47 based upon nineteen hundred ninety-two data from a representative sample  
48 of general hospitals that the costs associated with the portion of  
49 hospital stays in excess of the long stay outlier thresholds do not  
50 exceed three percent of the total of the acute care cost components of  
51 reimbursable inpatient operating costs related to the determination of  
52 case based rates of payment. The costs associated with the outlier  
53 portion of long stay outliers for each general hospital participating in  
54 the determination of the weighting factors shall be removed from each  
55 diagnosis-related group before calculating the weighting factors;

1 (iv) an estimate of inpatient costs which are related to short stay  
2 patients as defined in paragraph (d) of subdivision four of this section  
3 shall be eliminated from reimbursable inpatient operating costs consid-  
4 ering a short stay patient cost conversion factor determined based on  
5 nineteen hundred eighty-five data from a representative sample of gener-  
6 al hospitals; a case mix neutral acute care cost component of a general  
7 hospital's reimbursable inpatient operating cost base per day after  
8 application of the trend factor and the addition of special additional  
9 inpatient operating costs; short stay patient days incurred by such  
10 general hospital in nineteen hundred eighty-seven or the number of such  
11 short stay patient days during a recent twelve month period prior there-  
12 to established by regulation for which data are available subsequently  
13 reconciled by an adjustment to reflect nineteen hundred eighty-seven  
14 data; and the specific diagnosis-related groups with which the short  
15 stay patients are identified. Such costs shall be eliminated in accord-  
16 ance with rules and regulations adopted by the council and approved by  
17 the commissioner which shall contain the specific methodology to  
18 adequately identify the costs related to short stay patients. Short stay  
19 cases shall be eliminated in computing discharges of a general hospital.  
20 The costs and discharges for short stay cases for each general hospital  
21 participating in the determination of the weighting factors shall be  
22 removed before calculating the weighting factors.

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

31 (i) The group price component shall be based on the costs and statis-  
32 tics of general hospitals in the group category established pursuant to  
33 paragraph (b) of this subdivision to which the hospital is assigned by  
34 the commissioner to compute a group based average inpatient reimbursable  
35 operating cost per discharge for the group category. General hospital  
36 costs and statistics shall be determined consistent with the methodology  
37 to determine hospital-specific average reimbursable inpatient operating  
38 cost per discharge pursuant to subdivision six of this section; adjusted  
39 to reflect additional cost increases in accordance with subparagraph  
40 (ii) of paragraph (e) of subdivision one of this section; and adjusted  
41 to exclude the components of hospital-specific inpatient reimbursable  
42 operating costs related to education, physician, ambulance services and  
43 organ acquisition costs determined in accordance with paragraph (c) of  
44 this subdivision and malpractice insurance costs, and the components of  
45 special additional inpatient operating costs determined and allocated in  
46 accordance with subparagraphs (i), (iii) and (iv) of paragraph (e) of  
47 subdivision one of this section associated with cost increases in such  
48 costs; and adjusted to exclude the components of special additional  
49 inpatient operating costs determined and allocated in accordance with  
50 clauses (B), (D), (H), and (I) of subparagraph (iii) and clauses (A),  
51 (E) and (F) of subparagraph (iv) of paragraph (e) of subdivision one of  
52 this section; and adjusted to reflect additional modifications to case  
53 payments in accordance with subparagraph (iii) of paragraph (c) of  
54 subdivision six of this section. The group based average inpatient reim-  
55 bursable operating costs computed for a general hospital shall be  
56 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

1 nineteen hundred eighty-seven for those general hospitals having two  
2 hundred or less certified acute care beds and classified as a rural  
3 hospital for purposes of determining payment for inpatient services  
4 provided to beneficiaries of title XVIII of the federal social security  
5 act (medicare) or under state regulations, based on the total number of  
6 inpatient acute care beds for which such general hospital is certified  
7 pursuant to the operating certificate issued for such general hospital  
8 in accordance with section twenty-eight hundred five of this article in  
9 effect on June thirtieth, nineteen hundred ninety, or equal to or great-  
10 er than ten percent of discharges in nineteen hundred eighty-seven for  
11 all other general hospitals, and the failure to make such adjustment  
12 seriously impacts on the financial stability of a needed hospital, and  
13 except in those specific instances where an increase in volume as meas-  
14 ured by discharges is equal to or greater than ten percent of discharges  
15 in nineteen hundred eighty-seven. Provided, however, that an adjustment  
16 for volume increases shall not apply to those general hospitals having  
17 two hundred or less certified acute care beds and classified as a rural  
18 hospital for purposes of determining payment for inpatient services  
19 provided to beneficiaries of title XVIII of the federal social security  
20 act (medicare) or under state regulations, based on the total number of  
21 inpatient acute care beds for which such general hospital is certified  
22 pursuant to the operating certificate issued for such general hospital  
23 in accordance with section twenty-eight hundred five of this article in  
24 effect on June thirtieth, nineteen hundred ninety. For general hospitals  
25 and distinct units of general hospitals not reimbursed on a case based  
26 payment per discharge basis, volume adjustments may be made during the  
27 above indicated rate years in accordance with regulations adopted by the  
28 council and approved by the commissioner.

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

34 (f) General hospitals that did not qualify for a volume adjustment for  
35 the nineteen hundred eighty-six and nineteen hundred eighty-seven rate  
36 periods for rates of payment determined in accordance with section twen-  
37 ty-eight hundred seven-a of this article may request and the commission-  
38 er shall consider an adjustment to an established case based rate of  
39 payment for nineteen hundred eighty-eight based on increases in volume  
40 as measured by discharges, based on a comparison between nineteen  
41 hundred eighty-five and nineteen hundred eighty-seven discharges,  
42 excluding in such comparison discharges of patients who are benefici-  
43 aries of title XVIII of the federal social security act (medicare) and  
44 discharges related to transfer cases (transferring hospital) and short  
45 stay cases as defined in this section, provided such general hospital  
46 meets performance criteria established in accordance with rules and  
47 regulations adopted by the council and approved by the commissioner.  
48 Such criteria shall include but need not be limited to: maintenance of  
49 like patient occupancy rates for the rate periods nineteen hundred  
50 eighty-five, nineteen hundred eighty-six and nineteen hundred eighty-  
51 seven; a reduction in patient length of stay for other than benefici-  
52 aries of title XVIII of the federal social security act (medicare) based  
53 on a comparison with nineteen hundred eighty-five data; and an expanded  
54 use of ambulatory surgery by the general hospital based on a comparison  
55 with nineteen hundred eighty-five data. Such adjustment shall consider,  
56 but need not be limited to, the variable costs related to volume changes

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

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

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

15 10.] 4. Trend factors. (a) The commissioner, in accordance with the  
16 methodology developed for rate periods through March thirty-first, two  
17 thousand, for rates of payment for state governmental agencies and  
18 through December thirty-first, nineteen hundred ninety-six for rates of  
19 payment for all other payors pursuant to paragraph (b) of this subdivi-  
20 sion, shall establish trend factors to project for the effects of  
21 inflation. The factors shall be applied to the appropriate portion of  
22 reimbursable costs. The methodology for developing the trend factor  
23 shall include the appropriate external price indicators and shall also  
24 include the data from major collective bargaining agreements as reported  
25 quarterly by the federal department of labor, bureau of labor statis-  
26 tics, for non-supervisory employees.

27 (b) The methodology shall be developed for rate periods through March  
28 thirty-first, two thousand, for rates of payment for state governmental  
29 agencies and through December thirty-first, nineteen hundred ninety-six  
30 for rates of payment for all other payors by four independent consult-  
31 ants with expertise in health economics or reimbursement methodologies  
32 for health-related services appointed by the commissioner. For nineteen  
33 hundred ninety-six, through March thirty-first, two thousand, the  
34 commissioner shall apply the nineteen hundred ninety-five trend factor  
35 methodology. The commissioner shall monitor the actual price movements  
36 of the external price indicators used in the methodology for one inter-  
37 im adjustment to the trend factors to reflect such price movements and  
38 one final adjustment to the trend factors to reflect such price move-  
39 ments. At the same time adjustments are made to the trend factors in  
40 accordance with this paragraph, adjustments shall be made to all inpa-  
41 tient rates of payment affected by the adjusted trend factors.

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

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

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

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

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

8 [11.] 5. Special provisions. [(a) Notwithstanding any inconsistent  
9 provision of this chapter or any other law to the contrary, payment for  
10 inpatient hospital services provided on or after January first, nineteen  
11 hundred eighty-eight to a patient admitted to a general hospital prior  
12 to January first, nineteen hundred eighty-eight otherwise eligible for  
13 payment on a case based payment per discharge basis for a diagnosis-re-  
14 lated group shall be at the rate of payment for such general hospital  
15 for such patient in effect for December thirty-first, nineteen hundred  
16 eighty-seven provided, however, that the operating cost components of  
17 such rates of payment for inpatient hospital services provided on or  
18 after January first, nineteen hundred eighty-eight shall be projected to  
19 the rate period by the trend factor determined in accordance with subdi-  
20 vision ten of this section and reconciled on a cumulative basis on or  
21 about March thirty-first, nineteen hundred eighty-eight and December  
22 thirty-first, nineteen hundred eighty-eight for payment of adjusted  
23 rates of payment based on such trend factor adjustment. The component of  
24 such rates of payment based on the allowances provided in accordance  
25 with paragraphs (e) and (f) of subdivision eight of section twenty-eight  
26 hundred seven-a of this article shall be returned to the applicable  
27 regional pool created in accordance with subdivision fifteen of such  
28 section and distributed in accordance with subdivision sixteen of such  
29 section based on needs for the financing of losses resulting from bad  
30 debts and the costs of charity care as determined for purposes of nine-  
31 teen hundred eighty-seven distributions.

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

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

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

49 (iii) Regardless of whether rates are adjusted prospectively or  
50 retrospectively the authorized dollar value of the adjustment shall be  
51 the same, calculated by including the retroactive impact of such adjust-  
52 ment if such adjustment is made prospectively. A prospective adjustment  
53 to reflect the retroactive impact of an adjustment shall be included in  
54 the determination of rates of payment for a prospective rate period  
55 based on the methodology applied in accordance with this section for  
56 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

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

3 (B-1) The increase in the statewide average case mix in the periods  
4 January first, nineteen hundred ninety-seven through March thirty-first,  
5 two thousand and on and after April first, two thousand through March  
6 thirty-first, two thousand six and on and after April first, two thou-  
7 sand six through March thirty-first, two thousand seven, and on and  
8 after April first, two thousand seven through March thirty-first, two  
9 thousand nine, and on and after April first, two thousand nine through  
10 March thirty-first, two thousand eleven, from the statewide average case  
11 mix for the period January first, nineteen hundred ninety-six through  
12 December thirty-first, nineteen hundred ninety-six shall not exceed one  
13 percent for nineteen hundred ninety-seven, two percent for nineteen  
14 hundred ninety-eight, three percent for the period January first, nine-  
15 teen hundred ninety-nine through September thirtieth, nineteen hundred  
16 ninety-nine, four percent for the period October first, nineteen hundred  
17 ninety-nine through December thirty-first, nineteen hundred ninety-nine,  
18 and four percent for two thousand plus an additional one percent per  
19 year thereafter, based on comparison of data only for patients that are  
20 eligible for medical assistance pursuant to title eleven of article five  
21 of the social services law, including such patients enrolled in health  
22 maintenance organizations.

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

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

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

53 (F) Case mix changes due to acquired immune deficiency syndrome,  
54 tuberculosis, epidemics or other catastrophes resulting in extraordinary  
55 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

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

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

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

25 (ii) The component of general hospital reimbursable inpatient operat-  
26 ing costs based on the general hospital's inpatient malpractice insur-  
27 ance costs plus the component of special additional inpatient operating  
28 costs determined in accordance with subparagraphs (i) and (iii) of para-  
29 graph (e) of subdivision one of this section specifically related to  
30 inpatient malpractice insurance costs used to determine payment rates  
31 for annual rate periods beginning on or after January first, nineteen  
32 hundred eighty-eight shall be allocated among the payors in accordance  
33 with regulations adopted by the council and approved by the commission-  
34 er.

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

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

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

6 (l) Notwithstanding any inconsistent provision of this section, noth-  
7 ing in this section shall preclude a modification to case based rates of  
8 payment per discharge in accordance with rules and regulations adopted  
9 by the council and approved by the commissioner to reflect readmission  
10 of an individual or unnecessary multiple admissions of an individual to  
11 a general hospital or general hospitals.

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

20 (n) (i) For a patient discharged from a general hospital on or after  
21 August first, nineteen hundred eighty-eight and covered by a payor  
22 included in the payor categories specified in paragraph (a) or (b) of  
23 subdivision one of this section that provides for a percentage coinsu-  
24 rance responsibility by or on behalf of such patient for covered hospi-  
25 tal services: (A) the dollar value of such percentage coinsurance  
26 responsibility by or on behalf of such patient shall be determined by  
27 multiplying such coinsurance percentage by the hospital's charges for  
28 such patient, determined in accordance with paragraph (c) of subdivision  
29 one of this section or paragraph (e) of subdivision four of this section  
30 for a general hospital or distinct unit of a general hospital not reim-  
31 bursed on case based payments, for the services covered by the payor,  
32 considering any applicable deductibles, and (B) the payment due to a  
33 general hospital for reimbursement of inpatient hospital services by  
34 such payor shall be determined by multiplying the payment rate deter-  
35 mined in accordance with this section for such patient for covered  
36 hospital services by the coinsurance percentage for which such payor is  
37 responsible, considering any applicable deductibles.

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

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

1 addition to the charges or rates authorized in accordance with this  
2 article, except for charges for identifiable additional hospital costs  
3 associated with or reasonable additional charges associated with securi-  
4 ty arrangements for such person.

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

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

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

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

1 (s) Notwithstanding any inconsistent provisions of this section, for  
2 the period July first, nineteen hundred ninety-six through March thir-  
3 ty-first, nineteen hundred ninety-seven, the commissioner shall increase  
4 rates of payment for patients eligible for payments made by state  
5 governmental agencies by an amount not to exceed forty-five million  
6 dollars in the aggregate to be allocated among those voluntary non-pro-  
7 fit and private proprietary general hospitals which qualified for rate  
8 adjustments pursuant to this paragraph as in effect for the period July  
9 first, nineteen hundred ninety-five through June thirtieth, nineteen  
10 hundred ninety-six proportionally based on each such general hospital's  
11 proportional share of the total funds allocated pursuant to this para-  
12 graph as in effect for the period of July first, nineteen hundred nine-  
13 ty-five through June thirtieth, nineteen hundred ninety-six.

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

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

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

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

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

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

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

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

7 (B) from unobligated monies available pursuant to clause (D) of  
8 subparagraph (ii) of paragraph (b) of subdivision one of section twen-  
9 ty-eight hundred seven-1 of this article.

10 (iii) Notwithstanding any inconsistent provision of law to the contra-  
11 ry, the commissioner shall transfer up to an additional two million  
12 dollars from the funding sources identified in subparagraph (i) of this  
13 paragraph to the state general fund. To the extent monies available from  
14 the funding sources identified in subparagraph (i) of this paragraph  
15 total less than two million dollars, the commissioner shall transfer  
16 monies from funding sources identified in subparagraph (ii) of this  
17 paragraph to the state general fund so that the total amount transferred  
18 pursuant to this provision equals two million dollars.

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

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

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

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

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

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



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

18 (s-8) To the extent funds are available and otherwise notwithstanding  
19 any inconsistent provision of law to the contrary, for rate periods on  
20 and after April first, two thousand seven through November thirtieth,  
21 two thousand nine, the commissioner shall increase rates of payment for  
22 patients eligible for payments made by state governmental agencies by an  
23 amount not to exceed sixty million dollars annually in the aggregate.  
24 Such amount shall be allocated among those voluntary non-profit general  
25 hospitals which continue to provide inpatient services as of April  
26 first, two thousand seven through March thirty-first, two thousand eight  
27 and which have medicaid inpatient discharges percentages equal to or  
28 greater than thirty-five percent. This percentage shall be computed  
29 based upon data reported to the department in each hospital's two thou-  
30 sand four institutional cost report, as submitted to the department on  
31 or before January first, two thousand seven. The rate adjustments calcu-  
32 lated in accordance with this paragraph shall be allocated propor-  
33 tionally based on each eligible hospital's total reported medicaid inpa-  
34 tient discharges in two thousand four, to the total reported medicaid  
35 inpatient discharges for all such eligible hospitals in two thousand  
36 four, provided, however, that such rate adjustments shall be subject to  
37 reconciliation to ensure that each hospital receives in the aggregate  
38 its proportionate share of the full allocation to the extent allowable  
39 under federal law. Such payments may be added to rates of payment or  
40 made as aggregate payments to eligible hospitals, provided, however,  
41 that subject to the availability of federal financial participation and  
42 solely for the period April first, two thousand seven through March  
43 thirty-first, two thousand eight, six million dollars in the aggregate  
44 of this sixty million dollars shall be allocated to voluntary non-profit  
45 hospitals which continue to provide inpatient services as of April  
46 first, two thousand seven through March thirty-first, two thousand eight  
47 and which have Medicaid inpatient discharge percentages of less than  
48 thirty-five percent and which had previously qualified for distributions  
49 pursuant to paragraph (s-7) of this subdivision. The rate adjustment  
50 calculated in accordance with this paragraph shall be allocated propor-  
51 tionally based on the amount of money the hospital had received in two  
52 thousand six.

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

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

10 (a) Any general hospital which terminated its contract with an article  
11 nine-c insurance law corporation or a comprehensive health services plan  
12 after October first, nineteen hundred seventy-six and prior to May  
13 first, nineteen hundred seventy-eight, may not charge subscribers or  
14 beneficiaries of contracts entered into pursuant to the provisions of  
15 article forty-three of the insurance law, or members of a comprehensive  
16 health services plan operating pursuant to the provisions of article  
17 forty-four of this chapter, amounts in excess of the payments estab-  
18 lished by such hospital for patient services in accordance with the  
19 provisions of paragraph (c) of subdivision one of this section, or in  
20 the event the article forty-three insurance law corporation or compre-  
21 hensive health services plan operating pursuant to the provisions of  
22 article forty-four of this chapter provides for reimbursement on an  
23 expense incurred basis and makes payment directly to such hospital for  
24 patient services for its subscribers or beneficiaries, such article  
25 forty-three insurance law corporation or comprehensive health services  
26 plan shall be an additional category of payor of inpatient hospital  
27 services whose rates of payment are determined in accordance with para-  
28 graph (b) of subdivision one of this section based on an imputed rate of  
29 payment determined in accordance with paragraph (a) of subdivision one  
30 of this section for an article forty-three insurance law corporation,  
31 adjusted for uncovered services, and increased by thirteen percent.

32 (b) Any general hospital which had notified in writing an article  
33 nine-c corporation or a comprehensive health services plan prior to June  
34 first, nineteen hundred seventy-eight of its intention to terminate its  
35 contract with such corporation or plan in accordance with the terms of  
36 such contract, except a general hospital subject to the provisions of  
37 paragraph (a) of this subdivision may not charge a subscriber or benefi-  
38 ciary of a contract entered into pursuant to the provisions of article  
39 forty-three of the insurance law, or a member of a comprehensive health  
40 services plan operating pursuant to the provisions of article forty-four  
41 of this chapter, after the effective date of termination of such  
42 contract, amounts in excess of the payments established by such hospital  
43 for patient services in accordance with the provisions of paragraph (c)  
44 of subdivision one of this section, or in the event the article forty-  
45 three insurance law corporation or comprehensive health services plan  
46 operating pursuant to the provisions of article forty-four of this chap-  
47 ter provides for reimbursement on an expense incurred basis and makes  
48 payment directly to such hospital for patient services for its subscrib-  
49 ers or beneficiaries, such article forty-three insurance law corporation  
50 or comprehensive health services plan shall be an additional category of  
51 payor of inpatient hospital services whose rates of payment are deter-  
52 mined in accordance with paragraph (b) of subdivision one of this  
53 section based on an imputed rate of payment determined in accordance  
54 with paragraph (a) of subdivision one of this section for an article  
55 forty-three insurance law corporation, adjusted for uncovered services,  
56 and increased by thirteen percent.

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

4 (d) The provisions of this subdivision shall also apply to payments to  
5 general hospitals by a corporation organized and operating in accordance  
6 with article forty-three of the insurance law for inpatient and outpa-  
7 tient services on behalf of subscribers of a foreign corporation which  
8 performs similar functions in another state or which belongs to a  
9 national association comprised of similar corporations to which the  
10 article forty-three corporation also belongs; provided, however, the  
11 foreign corporation or the laws of the state in which the foreign corpo-  
12 ration is organized extends to article forty-three corporations organ-  
13 ized and operating in this state a reciprocal right to have the foreign  
14 corporation make payments to hospitals in that other state on behalf of  
15 subscribers of the article forty-three corporations at the same rate of  
16 payment as that foreign corporation pays for its own subscribers.

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

19 13. Restitution authorization. In enforcing the provisions of subdivi-  
20 sions one and twelve of this section, the commissioner may, in addition  
21 to the penalties and injunctions set forth in section twelve of this  
22 chapter, order that any general hospital provide restitution for any  
23 overpayments made by any party. Any hospital may request a formal hear-  
24 ing pursuant to the provisions of section twelve-a of this chapter in  
25 the event the hospital objects to any order of the commissioner here-  
26 under. The commissioner may direct that such a hearing be held without  
27 any request by a hospital.

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

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

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

13     (c) The regional amounts to be included in rates approved for the rate  
14 year commencing January first, nineteen hundred eighty-eight shall be  
15 equal to the sum of the following two components divided by the total  
16 reimbursable inpatient costs for the general hospitals located in the  
17 region, excluding inpatient costs related to beneficiaries of title  
18 XVIII of the federal social security act (medicare), and after applica-  
19 tion of the trend factor. The first component shall be the result of the  
20 ratio between the total nominal payment amount in dollars as determined  
21 in subparagraph (i) of this paragraph that would be allocated to volun-  
22 tary non-profit, private proprietary and public general hospitals other  
23 than major public general hospitals in the region based on a targeted  
24 need formula applied in accordance with subparagraphs (i) and (ii) of  
25 this paragraph and the statewide sum of such nominal payment amounts to  
26 voluntary non-profit, private proprietary and public general hospitals  
27 other than major public general hospitals applied to the total statewide  
28 resources committed for this purpose to regional pools in the rate year,  
29 excluding the total statewide amount allocated in the rate year for this  
30 purpose to major public general hospitals in accordance with subpara-  
31 graph (iii) of this paragraph. The second component shall be the dollar  
32 amount allocated to major public general hospitals in the region in  
33 accordance with subparagraph (iii) of this paragraph. The regional  
34 amount to be included in the rates approved for the rate years commenc-  
35 ing on or after January first, nineteen hundred eighty-nine shall be  
36 computed in the same manner except that the base year for the targeted  
37 need as specified in subparagraph (i) of this paragraph shall be the  
38 calendar year which is two years prior to the rate year. For each annual  
39 rate period commencing on or after January first, nineteen hundred  
40 eighty-eight, the statewide amount to be available in regional pools for  
41 this purpose shall equal five and forty-eight hundredths percent of the  
42 total hospital reimbursable inpatient costs, excluding inpatient costs  
43 related to services provided to beneficiaries of title XVIII of the  
44 federal social security act (medicare), computed without consideration  
45 of inpatient uncollectible amounts, and after application of the trend  
46 factor.

47     (i) Targeted need shall be defined as the relationship of need to net  
48 patient service revenue expressed as a percentage. Net patient service  
49 revenue shall be defined as net patient revenue attributable to inpa-  
50 tient and outpatient services excluding referred ambulatory services.  
51 For the rate year beginning January first, nineteen hundred eighty-eight  
52 and ending December thirty-first, nineteen hundred eighty-eight the  
53 scale specified in subparagraph (ii) of this paragraph shall be utilized  
54 to calculate individual hospital's nominal payment amounts on the basis  
55 of the percentage relationship between their nineteen hundred eighty-six  
56 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.

1 14-a. Supplementary bad debt and charity care adjustment. (a) Notwith-  
2 standing any inconsistent provision of this section, rates of payment  
3 for inpatient hospital services for persons eligible for payments made  
4 by state governmental agencies for the period April first, nineteen  
5 hundred eighty-nine to December thirty-first, nineteen hundred eighty-  
6 nine and for each annual period commencing January first during the  
7 period January first, nineteen hundred ninety to December thirty-first,  
8 nineteen hundred ninety-three applicable to patients eligible for feder-  
9 al financial participation under title XIX of the federal social securi-  
10 ty act in medical assistance provided pursuant to title eleven of arti-  
11 cle five of the social services law determined in accordance with this  
12 section for a major public general hospital, as defined in paragraph (a)  
13 of subdivision fourteen of this section, shall include a supplementary  
14 bad debt and charity care adjustment determined in accordance with para-  
15 graph (b) of this subdivision provided the state governmental agency or  
16 the county government in which such general hospital is located, or the  
17 city of New York for a general hospital operated by the New York city  
18 health and hospitals corporation, files in such time and manner as may  
19 be specified by the commissioner an election for such adjustment for  
20 such hospital for each period provided that such election is subject to  
21 the approval of the state director of the budget and provided all feder-  
22 al approvals necessary by federal law and regulation for federal finan-  
23 cial participation in payments made for beneficiaries eligible for  
24 medical assistance under title XIX of the federal social security act  
25 based upon the adjustment provided herein as a component of such  
26 payments are granted.

27 (b)(i) A supplementary bad debt and charity care adjustment for the  
28 period April first, nineteen hundred eighty-nine to December thirty-  
29 first, nineteen hundred eighty-nine and for each annual period commenc-  
30 ing January first during the period January first, nineteen hundred  
31 ninety to December thirty-first, nineteen hundred ninety-three for an  
32 eligible major public general hospital shall be determined for each  
33 period in accordance with rules and regulations adopted by the council  
34 and approved by the commissioner based upon the amount calculated by  
35 subtracting the amount projected to be distributed to such major public  
36 general hospital pursuant to paragraph (a) of subdivision seventeen of  
37 this section for such period from an amount calculated as the product of  
38 the projected bad debt and charity care nominal payment amount coverage  
39 ratio for such period for voluntary non-profit, private proprietary and  
40 public general hospitals other than major public general hospitals  
41 multiplied by the base year bad debt and charity care imputed nominal  
42 payment amount for such major public general hospital determined in  
43 accordance with the methodology provided in paragraph (c) of subdivision  
44 fourteen of this section for calculation of a nominal payment amount for  
45 voluntary non-profit, private proprietary and public general hospitals  
46 other than major public general hospitals. The coverage ratio shall be  
47 computed as the ratio between the sum of the dollar value of the amount  
48 committed to the regional pools in accordance with paragraph (c) of  
49 subdivision fourteen of this section and paragraph (a) of subdivision  
50 nineteen of this section for the rate period that would be allocated to  
51 voluntary non-profit, private proprietary and public general hospitals  
52 other than major public general hospitals in accordance with paragraph  
53 (b) of subdivision seventeen of this section and the base year nominal  
54 payment amount for such hospitals.

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

1 reflect actual distributions pursuant to paragraph (a) and (b) of subdi-  
2 vision seventeen of this section.

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

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

17 14-b. General health care services allowance. (a) With the exception  
18 of rates of payment for services provided to beneficiaries of title  
19 XVIII of the federal social security act (medicare), all rates and  
20 general hospital charges established for rate periods commencing on or  
21 after January first, nineteen hundred ninety-one in accordance with this  
22 section shall include a percentage allowance of the general hospital's  
23 reimbursable inpatient costs, excluding inpatient costs related to  
24 services provided to beneficiaries of title XVIII of the federal social  
25 security act (medicare), computed without consideration of inpatient  
26 uncollectible amounts, and after application of the trend factor, as  
27 follows:

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

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

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

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

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

42 (b) For rate periods beginning on or after January first, nineteen  
43 hundred ninety-one but prior to January first, nineteen hundred ninety-  
44 four, funds will be accumulated and made available in regional pools  
45 created by the commissioner for regional distributions in accordance  
46 with section twenty-eight hundred seven-bb of this chapter through the  
47 submission by or on behalf of general hospitals of the allowance  
48 included in rates and charges in accordance with paragraph (a) of this  
49 subdivision. Such regions shall be those established pursuant to para-  
50 graph (b) of subdivision sixteen of this section. The regional pools may  
51 be administered in accordance with the provisions of paragraph (c) of  
52 subdivision sixteen of this section applicable to bad debt and charity  
53 care regional pools. Payments by or on behalf of general hospitals to  
54 regional pools shall be due and arrearages shall be treated in accord-  
55 ance with the provisions of subdivision twenty of this section applica-  
56 ble to bad debt and charity care regional pools.

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

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

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

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

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

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



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

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

23 14-c. Bad debt and charity care allowance for financially distressed  
24 hospitals. (a) With the exception of rates of payment for services  
25 provided to beneficiaries of title XVIII of the federal social security  
26 act (medicare), all rates and general hospital charges established for  
27 rate periods commencing on or after January first, nineteen hundred  
28 ninety-one but prior to January first, nineteen hundred ninety-four in  
29 accordance with this section shall include an allowance of two hundred  
30 thirty-five thousandths of one percent; and for the rate periods during  
31 the period January first, nineteen hundred ninety-four through December  
32 thirty-first, nineteen hundred ninety-six an allowance of three hundred  
33 twenty-five thousandths of one percent of the general hospital's reim-  
34 bursable inpatient costs, excluding inpatient costs related to services  
35 provided to beneficiaries of title XVIII of the federal social security  
36 act (medicare), computed without consideration of inpatient uncollect-  
37 ible amounts, and after application of the trend factor.

38 (b) A statewide pool shall be created through the submissions by or on  
39 behalf of general hospitals of the allowance included in rates and  
40 charges in accordance with paragraph (a) of this subdivision. Funds  
41 accumulated in the statewide pool, including income from invested funds,  
42 shall be deposited by the commissioner and credited to a special reven-  
43 ue-other fund to be established by the comptroller. To the extent of  
44 funds appropriated therefor, funds shall be made available for distrib-  
45 utions by or on behalf of the state, as payments under the state medical  
46 assistance program provided pursuant to title eleven of article five of  
47 the social services law, from the statewide pool in the same manner as  
48 distributions made in accordance with paragraph (c) of subdivision nine-  
49 teen of this section. The statewide pools may be administered in accord-  
50 ance with the provisions of paragraph (c) of subdivision sixteen of this  
51 section applicable to bad debt and charity care regional pools. Payments  
52 by or on behalf of general hospitals to statewide pools shall be due and  
53 arrearages, interest and penalties shall be treated in accordance with  
54 the provisions of subdivision twenty of this section applicable to bad  
55 debt and charity care regional pools.

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

15 14-d. Supplementary low income patient adjustment. (a) Notwithstanding  
16 any inconsistent provision of this section, payment for inpatient hospi-  
17 tal services for persons eligible for payments made by state govern-  
18 mental agencies for rate periods during the period January first, nine-  
19 teen hundred ninety-one through December thirty-first, nineteen hundred  
20 ninety-six applicable to patients eligible for federal financial partic-  
21 ipation under title XIX of the federal social security act in medical  
22 assistance provided pursuant to title eleven of article five of the  
23 social services law determined in accordance with this section shall  
24 include for eligible general hospitals a supplementary low income  
25 patient adjustment determined in accordance with paragraph (b) of this  
26 subdivision, provided all federal approvals necessary by federal law and  
27 regulation for federal financial participation in payments made for  
28 beneficiaries eligible for medical assistance under title XIX of the  
29 federal social security act based upon the adjustment provided herein as  
30 a component of such payments are granted. The adjustment may be made to  
31 rates of payment or as aggregate payments to an eligible hospital.

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

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

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

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

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

Low Income		Supplemental Percentage
Patient 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%

36 (B) The scale utilized for development of a hospital's supplementary  
 37 low income adjustment shall be as follows for the period July first,  
 38 nineteen hundred ninety-one for a public general hospital through Decem-  
 39 ber thirty-first, nineteen hundred ninety-six and for a voluntary non-  
 40 profit or a private proprietary general hospital through September thir-  
 41 tieth, nineteen hundred ninety-two:

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

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

Low Income		Supplemental Percentage
Patient Percentage		Coverage of Need

1	35+	50%	10%
2	50+	55%	20%
3	55+	60%	25%
4	60+	65%	30%
5	65+	70%	37.5%
6	70+		45%

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

13 (iv) A supplementary low income patient adjustment determined accord-  
 14 ing to the scale specified in subparagraph (iii) of this paragraph shall  
 15 be limited for rate periods during the period January first, nineteen  
 16 hundred ninety-one through December thirty-first, nineteen hundred nine-  
 17 ty-three such that the amount of such adjustment for an eligible hospi-  
 18 tal, plus the amount committed to the regional pools in accordance with  
 19 paragraph (c) of subdivision fourteen of this section and paragraph (a)  
 20 of subdivision nineteen of this section for the rate period that would  
 21 be allocated to such hospital, plus, if applicable, any distribution for  
 22 the rate period pursuant to paragraph (d) of subdivision nineteen of  
 23 this section for such hospital, and plus for a major public general  
 24 hospital the amount of any supplementary bad debt and charity care  
 25 adjustment provided pursuant to subdivision fourteen-a of this section  
 26 for the rate period shall not exceed ninety percent of need.

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

30 (c) A supplementary low income patient adjustment provided in accord-  
 31 ance with this subdivision for rate periods during the period January  
 32 first, nineteen hundred ninety-one through December thirty-first, nine-  
 33 teen hundred ninety-three shall be adjusted to reflect actual distrib-  
 34 utions pursuant to paragraphs (a) and (b) of subdivision seventeen of  
 35 this section and paragraph (d) of subdivision nineteen of this section  
 36 and adjustments provided pursuant to subdivision fourteen-a of this  
 37 section.

38 (d) Notwithstanding any inconsistent provision of law, a voluntary  
 39 non-profit or proprietary general hospital where the low income patient  
 40 percentage, as determined in accordance with provisions of this subdivi-  
 41 sion, is between thirty-five and sixty-five percent shall be charged an  
 42 assessment which for the period July first, nineteen hundred ninety-one  
 43 through December thirty-first, nineteen hundred ninety-one shall equal  
 44 five percent of the general hospital's bad debt and charity care need as  
 45 determined in accordance with paragraph (b) of subdivision fourteen of  
 46 this section and for the period January first, nineteen hundred ninety-  
 47 two through September thirtieth, nineteen hundred ninety-two shall equal  
 48 seven and one-half percent of the general hospital's bad debt and chari-  
 49 ty care need as determined in accordance with paragraph (b) of subdivi-  
 50 sion fourteen of this section. Such assessment shall be paid to the  
 51 commissioner or his designee prior to October first, nineteen hundred  
 52 ninety-two in accordance with a schedule established by the commission-  
 53 er. The assessments may be administered in accordance with the  
 54 provisions of paragraph (c) of subdivision sixteen of this section  
 55 applicable to bad debt and charity care regional pools. Payments of the  
 56 assessments shall be due and arrearages shall be treated in accordance

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

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

10 14-f.] 6. Public general hospital indigent care adjustment. Notwith-  
11 standing any inconsistent provision of this section and subject to the  
12 availability of federal financial participation, payment for inpatient  
13 hospital services for persons eligible for payments made by state  
14 governmental agencies for the period [January first, nineteen hundred  
15 ninety-seven through December thirty-first, nineteen hundred ninety-nine  
16 and periods on and after January first, two thousand] ON AND AFTER JANU-  
17 ARY FIRST, TWO THOUSAND THIRTEEN applicable to patients eligible for  
18 federal financial participation under title XIX of the federal social  
19 security act in medical assistance provided pursuant to title eleven of  
20 article five of the social services law determined in accordance with  
21 this section shall include for eligible public general hospitals [a  
22 public general hospital indigent care adjustment equal to the aggregate  
23 amount of the adjustments provided for such public general hospital for  
24 the period January first, nineteen hundred ninety-six through December  
25 thirty-first, nineteen hundred ninety-six pursuant to subdivisions four-  
26 teen-a and fourteen-d of this section on an annualized basis, provided,  
27 however, that for periods on and after January first, two thousand thir-  
28 teen] an annual amount of four hundred twelve million dollars [shall be]  
29 allocated to eligible major public hospitals based on each hospital's  
30 proportionate share of medicaid and uninsured losses to total medicaid  
31 and uninsured losses for all eligible major public hospitals, net of any  
32 disproportionate share hospital payments received pursuant to sections  
33 twenty-eight hundred seven-k and twenty-eight hundred seven-w of this  
34 article. The adjustment may be made to rates of payment or as aggregate  
35 payments to an eligible hospital.

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

1 the increased amounts received under this subdivision to the extent that  
2 such increased amounts do not exceed distributions made. Funds in the  
3 statewide pool created in accordance with subdivision sixteen of this  
4 section, which would have been distributed in accordance with paragraph  
5 (c) of subdivision nineteen of this section if the provisions of this  
6 subdivision were not in effect, less any amounts not distributed as the  
7 result of the offset provisions of this subdivision shall be distributed  
8 to regional pools to the extent that such funds are available and neces-  
9 sary to maintain regional pool distributions, with consideration of the  
10 offset provisions in this subdivision, at the levels that would be  
11 available pursuant to the provisions of subdivision fourteen of this  
12 section if the provisions of this subdivision did not apply.

13 16. Bad debt and charity care regional pools and bad debt and charity  
14 care and capital statewide pool, general. (a) Funds will be made avail-  
15 able in bad debt and charity care regional pools created by the commis-  
16 sioner for distributions in accordance with subdivision seventeen of  
17 this section through the submissions by or on behalf of general hospi-  
18 tals of the allowance included in rates and charges in accordance with  
19 paragraph (c) of subdivision fourteen of this section and through the  
20 transfer of funds available from the bad debt and charity care and capi-  
21 tal statewide pool in accordance with paragraph (a) of subdivision nine-  
22 teen of this section. Funds will be made available for distributions in  
23 accordance with subdivision nineteen of this section from a bad debt and  
24 charity care and capital statewide pool created by the commissioner  
25 through the submissions by general hospitals of the amount of the  
26 assessments authorized in accordance with subdivision eighteen of this  
27 section.

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

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

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

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

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

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

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

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

32 [(f)] The council may adopt regulations subject to the approval of the  
33 commissioner to allow advanced distributions from these pools to a  
34 general hospital qualifying for distributions in accordance with para-  
35 graph (c) of subdivision nineteen of this section, based on a demon-  
36 stration by the hospital that there is an inability to finance current  
37 obligations and obtain needed working capital.

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

51 16-a. Pool administration, general. (a) If a general hospital fails to  
52 timely file a report with the department of funds due to a regional pool  
53 or a statewide pool established pursuant to this section, the commis-  
54 sioner may estimate the amount due from such hospital based on available  
55 financial and statistical data and may collect in accordance with subdi-  
56 vision twenty of this section any amount due based on such estimate as a

1 deficiency in payments to such regional pool or statewide pool with  
2 interest and penalties. The commissioner shall provide a general hospi-  
3 tal with notice of any estimate of the amount due pursuant to this para-  
4 graph at least three days prior to collection of a deficiency by the  
5 commissioner. Such notice shall contain the financial basis for the  
6 commissioner's estimate.

7 (b) Notwithstanding any inconsistent provision of section one hundred  
8 twelve or one hundred seventy-four of the state finance law or any other  
9 law, at the discretion of the commissioner and the commissioner of  
10 social services without a competitive bid or request for proposal proc-  
11 ess, regional pool and statewide pool administration contracts in effect  
12 for rate year nineteen hundred ninety-three may be extended for adminis-  
13 tration of regional pools and statewide pools established for rate years  
14 nineteen hundred ninety-four and nineteen hundred ninety-five and nine-  
15 teen hundred ninety-six to provide an uninterrupted continuation of  
16 services and may be amended as may be necessary.

17 17. Bad debt and charity care regional pool distributions. Funds accu-  
18 mulated in bad debt and charity care regional pools, including income  
19 from invested funds, from the allowance specified in paragraph (c) of  
20 subdivision fourteen of this section and funds accumulated in bad debt  
21 and charity care regional pools, including income from invested funds,  
22 from the transfer of funds available from the bad debt and charity care  
23 and capital statewide pool in accordance with paragraph (a) of subdivi-  
24 sion nineteen of this section shall be deposited by the commissioner and  
25 credited to a special revenue-other fund to be established by the comp-  
26 troller. To the extent of funds appropriated therefor, funds shall be  
27 made available for distribution by or on behalf of the state, as  
28 payments under the state medical assistance program provided pursuant to  
29 title eleven of article five of the social services law, from bad debt  
30 and charity care regional pools in accordance with the following method-  
31 ology and sequence:

32 (a) For the nineteen hundred eighty-eight, nineteen hundred eighty-  
33 nine and for that portion of the nineteen hundred ninety rate year  
34 beginning on January first and ending on June thirtieth, each eligible  
35 major public general hospital shall receive a portion of its bad debt  
36 and charity care need equal to one hundred two percent of the result of  
37 the application of its percentage of statewide inpatient reimbursable  
38 costs excluding costs related to services provided to beneficiaries of  
39 title XVIII of the federal social security act (medicare), developed on  
40 the basis of nineteen hundred eighty-five financial and statistical  
41 reports, to the total of all regional pools. For that portion of the  
42 nineteen hundred ninety rate year beginning on July first and ending on  
43 December thirty-first and in the annual rate years beginning on or after  
44 January first, nineteen hundred ninety-one, each eligible major public  
45 general hospital shall receive a portion of its bad debt and charity  
46 care need equal to one hundred ten percent of the result of the applica-  
47 tion of its percentage of statewide inpatient reimbursable costs exclud-  
48 ing costs related to services provided to beneficiaries of title XVIII  
49 of the federal social security act (medicare), developed on the basis of  
50 nineteen hundred eighty-five financial and statistical reports, to the  
51 total of all regional pools.

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



1 first, nineteen hundred eighty-eight, an individual hospital's targeted  
2 need share shall be defined as the relationship between each hospital's  
3 nineteen hundred eighty-six nominal payment amount as defined in subpar-  
4 agraph (i) of paragraph (c) of subdivision fourteen of this section to  
5 the nineteen hundred eighty-six nominal payment amounts for all hospi-  
6 tals in the region other than major public general hospitals. For annu-  
7 al rate years beginning on or after January first, nineteen hundred  
8 eighty-nine, the base need shall be the calendar year which is two years  
9 prior to the rate year. The amount of funds to be distributed in accord-  
10 ance with this paragraph and paragraph (a) of this subdivision shall be  
11 limited to the amount of funds accumulated in the pools.

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

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

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

42 18.] 8. Bad debt and charity care and capital statewide pool funding.  
43 The commissioner shall create a bad debt and charity care and capital  
44 statewide pool which shall be funded [by a transfer of funds, which is  
45 hereby authorized, for the period January first, nineteen hundred nine-  
46 ty-five through December thirty-first, nineteen hundred ninety-five, the  
47 period January first, nineteen hundred ninety-six through June thirti-  
48 eth, nineteen hundred ninety-six and the period July first, nineteen  
49 hundred ninety-six through December thirty-first, nineteen hundred nine-  
50 ty-six equal to seven million five hundred thousand dollars for the  
51 nineteen hundred ninety-five period, three million seven hundred fifty  
52 thousand dollars for the January first, nineteen hundred ninety-six  
53 through June thirtieth, nineteen hundred ninety-six period and three  
54 million seven hundred fifty thousand dollars for the July first, nine-  
55 teen hundred ninety-six through December thirty-first, nineteen hundred  
56 ninety-six period to be submitted to a statewide pool, as designated by

1 the commissioner, from the medical malpractice insurance association  
2 pursuant to section five thousand five hundred sixteen-c of the insur-  
3 ance law and] through an assessment which shall be charged to general  
4 hospitals. [In the event that the transfers of funds authorized by  
5 section five thousand five hundred sixteen-c of the insurance law do not  
6 occur by January first, nineteen hundred ninety-five, January first,  
7 nineteen hundred ninety-six and August first, nineteen hundred ninety-  
8 six respectively, the commissioner for each period for which such trans-  
9 fer from the medical malpractice insurance association has not occurred  
10 shall transfer seven million five hundred thousand dollars for the nine-  
11 teen hundred ninety-five period, three million seven hundred fifty thou-  
12 sand dollars for the January first, nineteen hundred ninety-six through  
13 June thirtieth, nineteen hundred ninety-six period and three million  
14 seven hundred fifty thousand dollars for the July first, nineteen  
15 hundred ninety-six through December thirty-first, nineteen hundred nine-  
16 ty-six period from regional or statewide pool reserves for pools estab-  
17 lished pursuant to this section and section twenty-eight hundred eight-c  
18 or twenty-eight hundred seven-a of this article to the bad debt and  
19 charity care and capitol statewide pool established pursuant to this  
20 subdivision.] Such assessment shall be submitted to a statewide pool as  
21 designated by the commissioner and distributed on a monthly basis in  
22 accordance with subdivision [twenty] TEN of this section.

23 (A) The assessment shall be[:

24 (a) one and seventy-five thousandths percent of each general hospi-  
25 tal's gross revenue received for inpatient hospital services provided  
26 during the period January first, nineteen hundred eighty-eight through  
27 December thirty-first, nineteen hundred eighty-eight; one and five  
28 hundredths percent of each general hospital's gross revenue received for  
29 inpatient hospital services provided during the period January first,  
30 nineteen hundred eighty-nine through December thirty-first, nineteen  
31 hundred eighty-nine; and] one percent of each general hospital's gross  
32 revenue received for inpatient hospital services provided during annual  
33 periods beginning on or after January first, nineteen hundred ninety  
34 through December thirty-first, nineteen hundred ninety-nine and on or  
35 after January first, two thousand[,].

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

45 (c) provided further, however, subject to the provisions of paragraph  
46 (e) of this subdivision the assessment against those voluntary non-pro-  
47 fit and private proprietary general hospitals which qualified for  
48 distributions made in accordance with paragraph (c) of subdivision nine-  
49 teen of this section as of December thirty-first, nineteen hundred nine-  
50 ty-five shall for the annual assessment period January first, nineteen  
51 hundred ninety-eight through December thirty-first, nineteen hundred  
52 ninety-eight be abated in the amount of three-quarters of one percent of  
53 gross revenue received and for the annual assessment period January  
54 first, nineteen hundred ninety-nine through December thirty-first, nine-  
55 teen hundred ninety-nine be abated in the amount of one-quarter of one  
56 percent of gross revenue received.

1 (d)] (B) Gross revenue received shall mean all moneys received for or  
2 on account of inpatient hospital service, provided, however, that  
3 subject to the provisions of paragraph [(e)] (C) of this subdivision  
4 gross revenue received shall not include distributions from bad debt and  
5 charity care regional pools, health care services pools, bad debt and  
6 charity care for financially distressed hospitals statewide pools and  
7 bad debt and charity care and capital statewide pools created in accord-  
8 ance with this section or distributions from funds allocated in accord-  
9 ance with section twenty-eight hundred seven-l, twenty-eight hundred  
10 seven-k, twenty-eight hundred seven-v or twenty-eight hundred seven-w of  
11 this article [and shall not include the components of rates of payment  
12 or charges related to the allowances provided in accordance with subdi-  
13 visions fourteen, fourteen-b and fourteen-c of this section, the adjust-  
14 ment provided in accordance with subdivision fourteen-a of this section,  
15 the adjustment provided in accordance with subdivision fourteen-d of  
16 this section], the adjustment for health maintenance organization  
17 reimbursement rates provided in accordance with former subdivision two-a  
18 of this section, payments made pursuant to paragraph (i) of subdivision  
19 [thirty-five] SEVENTEEN of this section or[, if effective, the adjust-  
20 ment provided in accordance with subdivision fifteen of this section],  
21 the adjustment provided in accordance with section eighteen of chapter  
22 two hundred sixty-six of the laws of nineteen hundred eighty-six as  
23 amended, revenue received from physician practice or faculty practice  
24 plan discrete billings for private practicing physician services, reven-  
25 ue from affiliation agreements or contracts with public hospitals for  
26 the delivery of health care services at such public hospitals, revenue  
27 received as disproportionate share hospital payments in accordance with  
28 title nineteen of the federal social security act, or revenue from  
29 government deficit financing, provided, however, that funds received as  
30 medical assistance payments which include state share amounts authorized  
31 pursuant to section twenty-eight hundred seven-v of this article that  
32 are not disproportionate share hospital payments shall be included with-  
33 in the meaning of gross revenue for purposes of this subdivision.

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

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

3 [(f)] (D) Payments of assessments and allowances required to be  
4 submitted by general hospitals pursuant to this subdivision and [subdi-  
5 visions fourteen and fourteen-b of this section and] paragraph (a) of  
6 subdivision two of section twenty-eight hundred seven-d of this article  
7 shall be subject to audit by the commissioner for a period of six years  
8 following the close of the calendar year in which such payments are due,  
9 after which such payments shall be deemed final and not subject to  
10 further adjustment or reconciliation, including through offset adjust-  
11 ments or reconciliations made by general hospitals with regard to subse-  
12 quent payments, provided, however, that nothing herein shall be  
13 construed as precluding the commissioner from pursuing collection of any  
14 such assessments and allowances which are identified as delinquent with-  
15 in such six year period, or which are identified as delinquent as a  
16 result of an audit commenced within such six year audit period, or from  
17 conducting an audit of any adjustment or reconciliation made by a gener-  
18 al hospital within such six year period, or from conducting an audit of  
19 payments made prior to such six year period which are found to be  
20 commingled with payments which are otherwise subject to timely audit  
21 pursuant to this section. General hospitals which, in the course of  
22 such an audit, fail to produce data or documentation requested in furth-  
23 erance of such an audit, within thirty days of such request may be  
24 assessed a civil penalty of up to ten thousand dollars for each such  
25 failure, provided, however, that such civil penalty shall not be imposed  
26 if the hospital demonstrates good cause for such failure. The imposition  
27 of such civil penalties shall be subject to the provisions of section  
28 twelve-a of this chapter.

29 [(g)] (E) If a general hospital fails to produce data or documentation  
30 requested in furtherance of an audit for a month to which an assessment  
31 applies, the commissioner may estimate, based on available financial and  
32 statistical data as determined by the commissioner, the amount due for  
33 such month. If the impact of exemptions permitted pursuant to paragraph  
34 [(d)] (B) of this subdivision cannot be determined from such available  
35 financial and statistical data the estimated amount due may be calcu-  
36 lated on the basis of the general hospital's aggregate gross inpatient  
37 revenue amount, as determined from such available financial and statis-  
38 tical data for the year subject to audit. Estimated amounts due pursuant  
39 to this paragraph shall be paid by a general hospital within sixty days  
40 or within such other time period as agreed to by the commissioner and  
41 the facility. Thereafter the commissioner shall take all necessary steps  
42 to collect amounts owed pursuant to this paragraph, including by offset-  
43 ting, or by directing the state comptroller to offset, such amounts due  
44 from any other payments made by state governmental agencies to the  
45 general hospital pursuant to this article. Interest and penalties shall  
46 be applied to such amounts due in accordance with the provisions of  
47 paragraph (c) of subdivision [twenty] TEN of this section.

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

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

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

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

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

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

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

9 (b-1) An amount equal to: twenty million dollars annually for the  
10 period January first, nineteen hundred ninety-one through December thir-  
11 ty-first, nineteen hundred ninety-three; thirty million dollars for the  
12 period January first, nineteen hundred ninety-four through December  
13 thirty-first, nineteen hundred ninety-four; thirty-seven million five  
14 hundred thousand dollars for the period January first, nineteen hundred  
15 ninety-five through December thirty-first, nineteen hundred ninety-five;  
16 eighteen million seven hundred fifty thousand dollars for the period  
17 January first, nineteen hundred ninety-six through June thirtieth, nine-  
18 teen hundred ninety-six; and eighteen million seven hundred fifty thou-  
19 sand dollars for the period July first, nineteen hundred ninety-six  
20 through December thirty-first, nineteen hundred ninety-six shall annual-  
21 ly be reserved and accumulated from year to year by the commissioner for  
22 distributions to programs to provide health care coverage for uninsured  
23 or underinsured children. Such accumulated funds shall not be used for  
24 any other purpose other than those authorized in section twenty-five  
25 hundred ten and twenty-five hundred eleven of this chapter. If on March  
26 thirty-first, nineteen hundred ninety-eight, any funds accumulated  
27 during the period January first, nineteen hundred ninety-one through  
28 December thirty-first, nineteen hundred ninety-seven are unused or  
29 uncommitted for such distributions, such unused or uncommitted funds  
30 shall be immediately transferred by the commissioner to the health care  
31 initiatives pool established by the commissioner to provide additional  
32 funds for distribution to programs to provide health care coverage for  
33 uninsured or underinsured children pursuant to sections twenty-five  
34 hundred ten and twenty-five hundred eleven of this chapter. For cash  
35 flow purposes, the commissioner may borrow from regional or statewide  
36 pool reserves for pools established pursuant to this section such funds  
37 as shall be necessary not to exceed the amount authorized to be reserved  
38 annually to meet premium requirements pursuant to sections twenty-five  
39 hundred ten and twenty-five hundred eleven of this chapter for a rate  
40 year and shall refund such moneys when pool funds become available  
41 pursuant to this paragraph for such rate year.

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

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

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

7 (d) Funds shall be made available on a statewide basis for distrib-  
8 ution by the commissioner in accordance with rules and regulations  
9 adopted by the council and approved by the commissioner to assist volun-  
10 tary non-profit and private proprietary general hospitals which quali-  
11 fied for distributions made in accordance with paragraph (b) of subdivi-  
12 sion sixteen of section twenty-eight hundred seven-a of this article  
13 during the nineteen hundred eighty-seven rate period or qualified for  
14 distributions made in accordance with paragraph (c) of this subdivision  
15 during a rate period or rate periods but which do not continue to quali-  
16 fy for distributions made in accordance with paragraph (c) of this  
17 subdivision during a rate period or rate periods. Amounts to be distrib-  
18 uted to a general hospital pursuant to this paragraph for the initial  
19 rate period in which such general hospital does not continue to qualify  
20 for distributions made in accordance with paragraph (c) of this subdivi-  
21 sion shall be two-thirds of the amount such general hospital would have  
22 received in accordance with paragraph (c) of this subdivision for such  
23 initial rate period if the hospital had continued to be eligible for  
24 such distribution and for the next succeeding annual rate period one-  
25 third of the amount such general hospital would have received in accord-  
26 ance with paragraph (c) of this subdivision for such succeeding rate  
27 period.

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

47 (f) Any balance in the statewide pool shall be distributed in accord-  
48 ance with the following:

49 (i) Fifty percent of the balance shall be reserved and accumulated  
50 from year to year by the commissioner for distributions to regional  
51 pilot projects to provide health care coverage under insurance or equiv-  
52 alent mechanisms for uninsured or underinsured individuals and families  
53 and to provide health care coverage for catastrophic expenses provided  
54 legislation is enacted before July fifteenth, nineteen hundred eighty-  
55 eight authorizing such regional pilot projects and including an authori-  
56 zation 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



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

3 19-a. Health care services allowance statewide pool distribution.  
4 Funds accumulated in the statewide pool created by the allowance author-  
5 ized in accordance with subparagraphs (ii) and (iii) of paragraph (a) of  
6 subdivision fourteen-b of this section, including income from invested  
7 funds, shall be distributed or retained in accordance with the follow-  
8 ing:

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

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

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

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

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

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

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

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

4 (vi) provided, however, that the commissioner in the absence of quali-  
5 fied recipients within a category may reallocate any funds remaining or  
6 unallocated within such a category for distribution by the commissioner  
7 for the primary care practitioner scholarship program in accordance with  
8 section nine hundred four of this chapter and the primary care practi-  
9 tioner education program in accordance with section nine hundred five of  
10 this chapter.

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

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

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

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

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

6 (f) Distributions from the pools created in accordance with this  
7 subdivision and subdivision fourteen-b of this section, and the compo-  
8 nents of rates of payment or charges related to the allowances provided  
9 in accordance with subdivision fourteen-b of this section shall not be  
10 included in gross revenue received for purposes of the assessments  
11 pursuant to subdivision eighteen of this section, subject to the  
12 provisions of paragraph (e) of subdivision eighteen of this section, and  
13 shall not be included in gross receipts received for purposes of the  
14 assessments pursuant to section twenty-eight hundred seven-d of this  
15 article, subject to the provisions of subdivision twelve of section  
16 twenty-eight hundred seven-d of this article.

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

27 (h) Notwithstanding any inconsistent provision of this subdivision,  
28 prior to allocation of funds in accordance with paragraphs (a), (b), (c)  
29 and (d) of this subdivision from the allowance for the period July  
30 first, nineteen hundred ninety-five through December thirty-first, nine-  
31 teen hundred ninety-five and from the allowance for the period January  
32 first, nineteen hundred ninety-six through June thirtieth, nineteen  
33 hundred ninety-six, thirty-nine million five hundred thousand dollars  
34 from the nineteen hundred ninety-five pool and forty-four million five  
35 hundred thousand dollars from the nineteen hundred ninety-six pool  
36 respectively shall be reserved by the commissioner from the amount accu-  
37 mulated in the statewide pool, proportionally based on the total amount  
38 of funds projected to be accumulated in the pool for the year, for addi-  
39 tional distributions in accordance with paragraph (b-1) of subdivision  
40 nineteen of this section to programs to provide health care coverage for  
41 uninsured or underinsured children, and the balance of funds accumulated  
42 in the statewide pool shall be proportionally allocated in accordance  
43 with paragraphs (a), (b), (c) and (d) of this subdivision.

44 19-b.] 9. Funds accumulated in the statewide pool created by the  
45 assessment authorized in accordance with subdivision [eighteen] EIGHT of  
46 this section for a period during the period January first, nineteen  
47 hundred ninety-seven through December thirty-first, nineteen hundred  
48 ninety-nine and periods on and after January first, two thousand,  
49 including income from invested funds, shall be transferred by the  
50 commissioner and consolidated with funds accumulated from the allowance  
51 pursuant to subdivision two of section twenty-eight hundred seven-j of  
52 this article for such period and allocated in accordance with subdivi-  
53 sion nine of section twenty-eight hundred seven-j of this article.

54 [20.] 10. Payments to pools. (a) [Payments by or on behalf of general  
55 hospitals to bad debt and charity care regional pools of funds due based  
56 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

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

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

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

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

41 [21.] 11. Maximum distributions. (a) [No general hospital may receive  
42 in total from the distributions made in accordance with paragraph (b) of  
43 subdivision fourteen-c, paragraphs (a) and (b) of subdivision seventeen  
44 and paragraphs (c), (d) and (e) of subdivision nineteen of this section  
45 an amount which exceeds its need for financing losses related to bad  
46 debts and the costs of charity care as defined in paragraph (b) of  
47 subdivision fourteen of this section.

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

1 adjustments in accordance with subdivision [fourteen-f] SIX of this  
2 section for annual periods beginning on January first on and after Janu-  
3 ary first, nineteen hundred ninety-seven through December thirty-first,  
4 nineteen hundred ninety-nine and on and after January first, two thou-  
5 sand an amount which exceeds the costs incurred during such period of  
6 furnishing inpatient and ambulatory hospital services, net of medical  
7 assistance payments pursuant to title eleven of article five of the  
8 social services law, other than disproportionate share payments pursuant  
9 to [subdivision twenty-six of this section or] subdivision thirteen of  
10 section twenty-eight hundred seven-k of this article, and payments by  
11 uninsured patients, by the hospital to individuals who either are eligi-  
12 ble for medical assistance pursuant to title eleven of article five of  
13 the social services law or have no health insurance or other source of  
14 third party coverage; provided, however, that the commissioner shall  
15 make such increase to such maximum or to the manner in which the limita-  
16 tion on disproportionate share payments is applied as shall increase the  
17 maximum limit for a period or part of a period as authorized by federal  
18 law or regulation or the secretary of the department of health and human  
19 services for purposes of federal financial participation pursuant to  
20 title XIX of the federal social security act. For purposes of this para-  
21 graph, payments to a general hospital for services provided to indigent  
22 patients made by the state or a unit of local government within the  
23 state shall not be considered to be a source of third party payment.

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

26 (A) [for periods through December thirty-first, nineteen hundred nine-  
27 ty-six, adjustments in accordance with subdivision fourteen-d of this  
28 section; adjustments in accordance with subdivision fourteen-a of this  
29 section; and distributions in accordance with subdivision seventeen of  
30 this section, and

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

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

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

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

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

1 [made in accordance with paragraph (b) of subdivision fourteen-c, subdi-  
2 vision seventeen and paragraphs (c) and (d) of subdivision nineteen of  
3 this section and adjustments in accordance with subdivision fourteen-d  
4 of this section for the period April first, nineteen hundred ninety-five  
5 through December thirty-first, nineteen hundred ninety-five or for the  
6 annual rate period beginning on January first, nineteen hundred ninety-  
7 six through December thirty-first, nineteen hundred ninety-six, or] made  
8 in accordance with section twenty-eight hundred seven-k of this article  
9 for annual periods beginning on January first on and after January  
10 first, nineteen hundred ninety-seven through December thirty-first,  
11 nineteen hundred ninety-nine and on and after January first, two thou-  
12 sand an amount which exceeds the costs incurred during such period of  
13 furnishing inpatient and ambulatory hospital services, net of medical  
14 assistance payments pursuant to title eleven of article five of the  
15 social services law, other than disproportionate share payments pursuant  
16 to [subdivision twenty-six of this section or] subdivision thirteen of  
17 section twenty-eight hundred seven-k of this article, and payments by  
18 uninsured patients, by the hospital to individuals who either are eligi-  
19 ble for medical assistance pursuant to title eleven of article five of  
20 the social services law or have no health insurance or other source of  
21 third party coverage; provided, however, that the commissioner shall  
22 make such modifications to the manner in which the limitation on  
23 disproportionate share payments is applied to such hospitals as shall  
24 increase the maximum limit for a period or part of a period as author-  
25 ized by federal law or regulation or the secretary of the department of  
26 health and human services for purposes of federal financial partic-  
27 ipation pursuant to title XIX of the federal social security act. For  
28 purposes of this paragraph, payments to a general hospital for services  
29 provided to indigent patients made by the state or a unit of local  
30 government within the state shall not be considered to be a source of  
31 third party payment.

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

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

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

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

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

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

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

26 (ii) In the event a general hospital is disqualified pursuant to  
27 subparagraph (i) of this paragraph from receiving disproportionate share  
28 payments for a period, such general hospital shall receive distributions  
29 not as disproportionate share payments and not subject to federal finan-  
30 cial participation from funds available [pursuant to subdivision seven-  
31 teen of this section for periods through December thirty-first, nineteen  
32 hundred ninety-six, and] pursuant to section twenty-eight hundred  
33 seven-k of this article for periods during the period January first,  
34 nineteen hundred ninety-seven through December thirty-first, nineteen  
35 hundred ninety-nine and on and after January first, two thousand equal  
36 to one-half of the distributions for which such general hospital would  
37 have been qualified pursuant to subdivision seventeen of this section  
38 for periods through December thirty-first, nineteen hundred ninety-six,  
39 and pursuant to section twenty-eight hundred seven-k of this article for  
40 periods during the period January first, nineteen hundred ninety-seven  
41 through December thirty-first, nineteen hundred ninety-nine and on and  
42 after January first, two thousand without consideration of subparagraph  
43 (i) of this paragraph.

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



1 statistics in accordance with a methodology established by the commis-  
2 sioner, and costs incurred of furnishing hospital services shall be  
3 determined in accordance with a methodology established by the commis-  
4 sioner consistent with requirements of the secretary of the department  
5 of health and human services for purposes of federal financial partic-  
6 ipation pursuant to title XIX of the federal social security act in  
7 disproportionate share payments.

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

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

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

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

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

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

10 23.] 12. Reimbursement rates. The assessments pursuant to subdivision  
11 [eighteen] EIGHT of this section shall not be an allowable cost in the  
12 determination of general hospital inpatient reimbursement rates in  
13 accordance with this section and section twenty-eight hundred seven of  
14 this article.

15 [24.] 13. Federal financial participation. The council may adopt rules  
16 and regulations, subject to the approval of the commissioner, to adjust  
17 rates of payment by governmental agencies for general hospital inpatient  
18 services determined in accordance with this section as necessary to meet  
19 federal requirements for securing federal financial participation pursu-  
20 ant to title XIX of the federal social security act in the event the  
21 state cannot provide assurances satisfactory to the secretary of health  
22 and human services related to a comparison of rates of payment in the  
23 aggregate to maximum aggregate payments determined in accordance with  
24 federal law and regulation which are substantially the same as such  
25 assurances as in effect on October twenty-sixth, nineteen hundred eight-  
26 y-seven for securing such federal financial participation. Notwith-  
27 standing any other law, the state reserves the right to recoup any  
28 payments by governmental agencies for general hospital inpatient  
29 services authorized by this section for which federal financial partic-  
30 ipation has been denied in connection with that determination by the  
31 department of health and human services.

32 [25.] 14. Medical education expenses. [(a) Notwithstanding any incon-  
33 sistent provision of this section, to encourage the training of more  
34 primary care physicians, for annual rate periods beginning on or after  
35 January first, nineteen hundred ninety-two, indirect medical education  
36 expenses, as defined in subparagraph (ii) of paragraph (c) of subdivi-  
37 sion seven of this section, of a general hospital included in the deter-  
38 mination of the operating cost component of general hospital rates of  
39 payment for a rate period in accordance with subdivisions six and seven  
40 of this section or in accordance with paragraph (e), (g) or (i) of  
41 subdivision four of this section for general hospitals or distinct units  
42 of general hospitals not reimbursed on the basis of case based payments  
43 per discharge shall be adjusted to reflect the following modifications:

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

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

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

30 (b)] Hospitals shall furnish to the department such reports and infor-  
31 mation as may be required by the commissioner to assess the cost, quali-  
32 ty and health system needs for medical education provided.

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

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

48 (i) For periods on and after April first, two thousand four, the  
49 commissioner shall adjust inpatient medical assistance rates of payment  
50 established pursuant to this section, including discrete rates of  
51 payment calculated pursuant to paragraph a-three of subdivision one of  
52 this section, for non-public general hospitals, and for periods on and  
53 after April first, two thousand seven, for public and non-public general  
54 hospitals, in accordance with subparagraph (ii) of this paragraph, for  
55 purposes of reimbursing graduate medical education costs based on the  
56 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

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

14 26. Disproportionate share payments. Distributions to general hospi-  
15 tals from bad debt and charity care regional pools pursuant to subdivi-  
16 sion seventeen of this section, distributions to general hospitals from  
17 the bad debt and charity care and capital statewide pool pursuant to  
18 paragraphs (c) and (d) of subdivision nineteen of this section, distrib-  
19 utions to general hospitals from the bad debt and charity care for  
20 financially distressed hospitals statewide pool pursuant to subdivision  
21 fourteen-c of this section and the adjustment provided in accordance  
22 with subdivision fourteen-a of this section and the adjustment provided  
23 in accordance with subdivision fourteen-d of this section shall be  
24 considered disproportionate share payments for inpatient hospital  
25 services to general hospitals serving a disproportionate number of low  
26 income patients with special needs for purposes of providing assurances  
27 to the secretary of health and human services as necessary to meet  
28 federal requirements for securing federal financial participation pursu-  
29 ant to title XIX of the federal social security act.

30 27. Reports. (a) The commissioner of health shall submit a report to  
31 the legislature and the council on health care financing on or before  
32 February first, nineteen hundred eighty-eight detailing the objective,  
33 impact, design and computation for an inpatient pricing component. In  
34 terms of the design and computation for a pricing system such report  
35 shall include but not be limited to: a description and methodology for  
36 developing peer groups, identification of costs included in the calcu-  
37 lation of a group average and any adjustments made to such costs, the  
38 methodology developed to reflect outliers, any teaching or dispropor-  
39 tionate share adjustments made, the calculation of wage and power equal-  
40 ization factors, and identification of any adjustments made to the  
41 service intensity weights or diagnosis-related group categories. The  
42 commissioner shall explore methodologies for the inclusion of severity  
43 of illness considerations in determining group average costs and rates  
44 and shall include all details of his analysis in the report required  
45 under this subparagraph. If it is determined that a severity of illness  
46 adjustment cannot be developed for incorporation in the computations,  
47 the report filed shall include the specific reasons for this conclusion.  
48 With regard to a fiscal impact analysis such report shall include but  
49 not be limited to the impact on major types of general hospitals includ-  
50 ing rural, urban, teaching, non-teaching, plus a regional analysis; and  
51 should indicate any characteristics which can be observed regarding  
52 general hospitals which would be significantly impacted by the introduc-  
53 tion of a pricing component. The commissioner shall expeditiously make  
54 available for inspection by interested parties pertinent data used in  
55 the development of the inpatient pricing component consistent with

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

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

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

36 28. Notwithstanding any inconsistent provision of this section:

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

51 (b) the allowances percentages established pursuant to this article in  
52 effect for a rate period shall be applied to hospital charges or negoti-  
53 ated rates plus the prospectively adjusted payment of rates of payment  
54 of a general hospital in accordance with paragraph (a) of this subdivi-  
55 sion;

(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

1 such reported costs for all non-public general hospitals, provided,  
2 however, that for periods on and after July first, two thousand seven,  
3 fifty percent of such increases shall be allocated proportionally, based  
4 on each non-public hospital's reported total gross salary and fringe  
5 benefit costs, as reported on exhibit 11 of the nineteen hundred nine-  
6 ty-nine institutional cost report as submitted to the department prior  
7 to November first, two thousand one, to the total of such reported costs  
8 for all non-public general hospitals, and fifty percent of such  
9 increases shall be allocated proportionally, based on each such hospi-  
10 tal's total reported medicaid inpatient discharges, as reported in the  
11 two thousand four institutional cost report as submitted to the depart-  
12 ment prior to November first, two thousand six, to the total of such  
13 reported medicaid inpatient discharges for all non-public general hospi-  
14 tals, as weighted proportionally to reflect the relative medicaid case  
15 mix of each such hospital. These amounts shall be included as a reim-  
16 bursable cost add-on to medical assistance inpatient rates of payment  
17 established pursuant to this section for non-public general hospitals  
18 based on medical assistance utilization data in each hospital's annual  
19 cost report submitted two years prior to the rate year. Such amounts  
20 shall be reconciled to reflect changes in medical assistance utilization  
21 between the year two years prior to the rate year and the rate year  
22 based on data reported in each hospital's cost report for the respective  
23 rate year. These amounts shall be included as a reimbursable cost add-on  
24 to medical assistance inpatient rates of payment established pursuant to  
25 this section for non-public general hospitals based on medical assist-  
26 ance utilization data in each facility's annual cost report submitted  
27 two years prior to the rate year. For rate adjustments effective May  
28 first, two thousand five and thereafter such amounts shall be reconciled  
29 to reflect changes in medical assistance utilization between the year  
30 two years prior to the rate year and the rate year based upon data  
31 reported in each hospital's institutional cost report for the respective  
32 rate year.

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

39 (A) eighteen million five hundred thousand dollars on an annualized  
40 basis for the period April first, two thousand two through December  
41 thirty-first, two thousand two; thirty-seven million four hundred thou-  
42 sand dollars on an annualized basis for the period January first, two  
43 thousand three through December thirty-first, two thousand three;  
44 fifty-two million two hundred thousand dollars on an annualized basis  
45 for the period January first, two thousand four through December thir-  
46 ty-first, two thousand six; twenty-six million one hundred thousand  
47 dollars for the period January first, two thousand seven through June  
48 thirtieth, two thousand seven, forty-nine million dollars for the period  
49 July first, two thousand seven through March thirty-first, two thousand  
50 eight, and forty-nine million dollars for the period April first, two  
51 thousand eight through March thirty-first, two thousand nine.

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



1 (c) From amounts available pursuant to paragraph (gg) of subdivision  
2 one of section twenty-eight hundred seven-v of this article, allocations  
3 shall be made to non-public general hospitals whose allocated labor  
4 adjustments pursuant to paragraphs (a) and (e) of this subdivision and  
5 adjustment pursuant to subdivision thirty-two of this section results in  
6 the general hospital exceeding its applicable disproportionate share  
7 payment limit. Each such hospital's allocation of available funds pursu-  
8 ant to this paragraph within a year shall be determined based on its  
9 proportionate share of the aggregate reduction of federal dispropor-  
10 tionate share funding for all such hospitals for the year resulting from  
11 the allocated labor adjustments pursuant to paragraphs (a) and (e) of  
12 this subdivision and from the adjustment pursuant to subdivision thir-  
13 ty-two of this section.

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

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

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

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

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

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

19 (f) In the event that a hospital entitled to an adjustment pursuant to  
20 paragraph (a) or (e) of this subdivision closes or otherwise experiences  
21 a change in status that eliminates its ability to continue to receive  
22 such adjustments, the commissioner shall allocate the amount determined  
23 under subparagraph (ii) of paragraph (a) and subparagraph (ii) of para-  
24 graph (e) of this subdivision for such hospital to hospitals in the  
25 immediate region of the closing hospital based upon the remaining hospi-  
26 tals' reported gross salary and fringe benefit costs as reported on  
27 exhibit eleven of the two thousand four institutional cost report  
28 submitted as of November first, two thousand five to the total of such  
29 reported costs for all general hospitals in the region, provided, howev-  
30 er, that for periods on and after July first, two thousand seven, such  
31 allocations shall be based on such remaining hospitals' reported medi-  
32 caid inpatient discharges, as reported in the two thousand four institu-  
33 tional cost report submitted to the department prior to November first,  
34 two thousand six, to the total of such reported medicaid inpatient  
35 discharges for all such remaining hospitals. The commissioner shall  
36 define the immediate region as the county or counties within which work-  
37 ers displaced from the closing hospital are likely to seek re-employ-  
38 ment.

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

49 (b) Such eligible projects may include:

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

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

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

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

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

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

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

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

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

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

38 seven million dollars for the period May first, two thousand five  
39 through December thirty-first, two thousand five, seven million dollars  
40 for the period January first, two thousand six through December thirty-  
41 first, two thousand six, seven million dollars for the period April  
42 first, two thousand seven through December thirty-first, two thousand  
43 seven, seven million dollars for calendar year two thousand eight, and  
44 six million four hundred seventeen thousand dollars for the period Janu-  
45 ary first, two thousand nine through November thirtieth, two thousand  
46 nine.

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

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

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

8 33.] 16. Notwithstanding any provision of law which is inconsistent  
9 with or contrary to the structure established by this subdivision and  
10 subdivision two-a of section twenty-eight hundred seven of this article  
11 in order to transition from nineteen hundred eighty-one base year costs  
12 to two thousand five base year costs by no later than December thirty-  
13 first, two thousand twelve, and subject to the availability of federal  
14 financial participation, medicaid per diem and per discharge rates of  
15 payment for general hospital inpatient services for discharges and days  
16 occurring on and after December first, two thousand eight, shall be  
17 computed in accordance with the following:

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

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

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

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

1 inpatient rates of payment for periods on and after April first, two  
2 thousand nine, which phased transition shall be authorized in accordance  
3 with a chapter of the laws of two thousand nine. The technical advisory  
4 committee shall consist of three representatives of hospital associ-  
5 ations, two representatives of the health care industry and three repre-  
6 sentatives of community providers and consumers as determined by the  
7 commissioner. By no later than August first, two thousand eight, the  
8 commissioner shall make available to the technical advisory committee  
9 updated data and documentation relevant to the projected phased transi-  
10 tion to utilization of reported allowable two thousand five operating  
11 costs for rate-setting purposes. The issues to be examined by the tech-  
12 nical advisory committee shall include, but not be limited to, hospital  
13 re-basing, workforce recruitment and retention funding, graduate medical  
14 education funding, peer group pricing, wage equalization factors, case  
15 mix and such other related elements of the general hospital inpatient  
16 reimbursement system as deemed appropriate by the commissioner. The  
17 technical advisory committee shall also examine the scope and volume of  
18 hospital out-patient services. By no later than November first, two  
19 thousand eight the commissioner shall issue a report setting forth find-  
20 ings and recommendations, including divergent views of members of the  
21 technical advisory committee members concerning the matters examined by  
22 the technical advisory committee and the projected phased transition to  
23 utilization of two thousand five base year reported allowable operating  
24 costs for inpatient rates of payments on and after April first, two  
25 thousand nine.

26 (c) Paragraph (a) of this subdivision shall be effective the later of:  
27 (i) December first, two thousand eight; (ii) after the commissioner  
28 receives final approval of federal financial participation in payments  
29 made for beneficiaries eligible for medical assistance under title XIX  
30 of the federal social security act for the rate methodology established  
31 pursuant to subdivision two-a of section twenty-eight hundred seven of  
32 this article; or (iii) after the commissioner determines that the  
33 department of health has the capability, for payments made pursuant to  
34 subdivision two-a of section twenty-eight hundred seven of this article,  
35 to electronically receive and process claims and transmit payments with  
36 remittance statements. Prior to the commissioner making such a determi-  
37 nation, the department shall provide training sessions on the rate meth-  
38 odology and billing requirements for services pursuant to subdivision  
39 two-a of section twenty-eight hundred seven of this article and opportu-  
40 nity for hospitals to perform end-to-end testing on claims submission,  
41 processing and payment.

42 [35.] 17. Notwithstanding any inconsistent provision of this section,  
43 or any other contrary provision of law and subject to the availability  
44 of federal financial participation, rates of payment by governmental  
45 agencies for general hospital inpatient services with regard to  
46 discharges occurring on and after December first, two thousand nine  
47 shall be in accordance with the following:

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

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

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

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

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

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

22 (v) such regulations shall incorporate quality related measures,  
23 including, but not limited to, potentially preventable re-admissions  
24 (PPRs) and provide for rate adjustments or payment disallowances related  
25 to PPRs and other potentially preventable negative outcomes (PPNOs),  
26 which shall be calculated in accordance with methodologies as determined  
27 by the commissioner, provided, however, that such methodologies shall be  
28 based on a comparison of the actual and risk adjusted expected number of  
29 PPRs and other PPNOs in a given hospital and with benchmarks established  
30 by the commissioner and provided further that such rate adjustments or  
31 payment disallowances shall result in an aggregate reduction in Medicaid  
32 payments of no less than thirty-five million dollars for the period July  
33 first, two thousand ten through March thirty-first, two thousand eleven  
34 and no less than fifty-one million dollars for annual periods beginning  
35 April first, two thousand eleven through March thirty-first, two thou-  
36 sand fourteen, provided further that such aggregate reductions shall be  
37 offset by Medicaid payment reductions occurring as a result of decreased  
38 PPRs during the period July first, two thousand ten through March thir-  
39 ty-first, two thousand eleven and the period April first, two thousand  
40 eleven through March thirty-first, two thousand fourteen and as a result  
41 of decreased PPNOs during the period April first, two thousand eleven  
42 through March thirty-first, two thousand fourteen; and provided further  
43 that for the period July first, two thousand ten through March thirty-  
44 first, two thousand fourteen, such rate adjustments or payment disallow-  
45 ances shall not apply to behavioral health PPRs; or to readmissions that  
46 occur on or after fifteen days following an initial admission. By no  
47 later than July first, two thousand eleven the commissioner shall enter  
48 into consultations with representatives of the health care facilities  
49 subject to this section regarding potential prospective revisions to  
50 applicable methodologies and benchmarks set forth in regulations issued  
51 pursuant to this subparagraph;

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

54 (vii) Such rates shall continue to reflect trend factor adjustments as  
55 otherwise provided in paragraph (c) of subdivision [ten] FOUR of this  
56 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-

1 ation to develop the specifications for the diagnosis-related groups  
2 methodology as provided for in regulations promulgated pursuant to para-  
3 graph (b) of this subdivision if the commissioner certifies to the comp-  
4 troller that such contract is in the best interest of the health of the  
5 people of the state. Notwithstanding that such specifications shall be  
6 available pursuant to article six of the public officers law, such  
7 contract may provide that the specifications for such adjusted or addi-  
8 tional diagnosis-related groups provided by the vendor shall be subject  
9 to copyright protection pursuant to federal copyright law.

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

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

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

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

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

32 (B) for the period April first, two thousand ten through March thir-  
33 ty-first, two thousand eleven, up to seventy-five million dollars,  
34 provided, however, that, notwithstanding subparagraph (ii) of this para-  
35 graph, no facility shall receive an amount pursuant to this clause that  
36 is less than such facility received pursuant to clause (A) of this  
37 subparagraph;

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

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

42 (iv) Payments made pursuant to this paragraph shall be added to rates  
43 of payments and not be subject to retroactive adjustment or reconcil-  
44 iation.

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



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

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

16 (i) (i) Notwithstanding any inconsistent provision of this subdivision  
17 or any other contrary provision of law and subject to the availability  
18 of federal financial participation, for the period July first, two thou-  
19 sand ten through March thirty-first, two thousand eleven, and each state  
20 fiscal year period thereafter, the commissioner shall make additional  
21 inpatient hospital payments up to the aggregate upper payment limit for  
22 inpatient hospital services after all other medical assistance payments,  
23 but not to exceed two hundred thirty-five million five hundred thousand  
24 dollars for the period July first, two thousand ten through March thir-  
25 ty-first, two thousand eleven, three hundred fourteen million dollars  
26 for each state fiscal year beginning April first, two thousand eleven,  
27 through March thirty-first, two thousand thirteen, and no less than  
28 three hundred thirty-nine million dollars for each state fiscal year  
29 thereafter, to general hospitals, other than major public general hospi-  
30 tals, providing emergency room services and including safety net hospi-  
31 tals, which shall, for the purpose of this paragraph, be defined as  
32 having either: a Medicaid share of total inpatient hospital discharges  
33 of at least thirty-five percent, including both fee-for-service and  
34 managed care discharges for acute and exempt services; or a Medicaid  
35 share of total discharges of at least thirty percent, including both  
36 fee-for-service and managed care discharges for acute and exempt  
37 services, and also providing obstetrical services. Eligibility to  
38 receive such additional payments shall be based on data from the period  
39 two years prior to the rate year, as reported on the institutional cost  
40 report submitted to the department as of October first of the prior rate  
41 year. Such payments shall be made as medical assistance payments for  
42 fee-for-service inpatient hospital services pursuant to title eleven of  
43 article five of the social services law for patients eligible for feder-  
44 al financial participation under title XIX of the federal social securi-  
45 ty act and in accordance with the following:

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

54 (B) Seventy percent of such payments shall be allocated to eligible  
55 general hospitals based on each such hospital's proportionate share of  
56 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

1 reimbursable and shall be allocated to costs of general hospital emer-  
2 gency services. Such reimbursable costs for a rate period shall be  
3 considered in the calculation of rates of payment for emergency services  
4 of a general hospital for such rate period in accordance with subdivi-  
5 sion two of section twenty-eight hundred seven of this chapter without  
6 application of the maximum payment for the operating cost component of  
7 rates of payment for emergency services. Notwithstanding any inconsis-  
8 tent provision of law, reimbursable costs of a general hospital of oper-  
9 ating a regional poison control center determined pursuant to this  
10 subdivision for annual rate periods beginning on or after January first,  
11 nineteen hundred ninety-one through December thirty-first, nineteen  
12 hundred ninety-six allocable to emergency services provided to persons  
13 within such payor categories as specified in paragraphs (a)[, (b) and  
14 (c)] AND (E) of subdivision one of section twenty-eight hundred seven-c  
15 of this chapter for inpatient hospital services, excluding governmental  
16 agencies, shall be included in the determination of inpatient rates of  
17 payment for such payors, excluding governmental agencies, and rates of  
18 payment determined in accordance with section twenty-eight hundred  
19 seven-c of this chapter shall be adjusted on a hospital-specific basis  
20 in accordance with rules and regulations adopted by the state hospital  
21 review and planning council, subject to the approval of the commission-  
22 er, to reflect such costs and maximum inpatient charges of such general  
23 hospital computed in accordance with such section shall be adjusted  
24 accordingly; and cost based rates of payment for emergency services for  
25 such payors, other than governmental agencies, shall be calculated  
26 excluding costs of operating a regional poison control center.

27 S 3. Subparagraph (iii) of paragraph (a) of subdivision 2 of section  
28 2803 of the public health law, as amended by chapter 639 of the laws of  
29 1996, is amended to read as follows:

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

38 S 4. Subparagraph (ii) of paragraph (c) of subdivision 2 of section  
39 2803-i of the public health law, as added by chapter 2 of the laws of  
40 1988, is amended to read as follows:

41 (ii) Notwithstanding any inconsistent provision of law, general hospi-  
42 tal contract costs incurred in accordance with subparagraph (i) of this  
43 paragraph may be included as an additional charge for general hospital  
44 inpatient services in determining patient charges for payors included in  
45 the payor categories specified in paragraph (c) of subdivision one of  
46 section twenty-eight hundred seven-c of this article, or as a charge in  
47 addition to rates of payment for general hospital inpatient services in  
48 determining payment due for payors included in the payor categories  
49 specified in paragraph [(b)] (E) of subdivision one of section twenty-  
50 eight hundred seven-c of this article, or paragraph (a) of such subdivi-  
51 sion one if a payor has not designated a review agent for such payor's  
52 subscribers or beneficiaries or enrolled members[, or paragraph (a) or  
53 (b) of subdivision two of section twenty-eight hundred seven-c of this  
54 article]. Such additional charges shall not be subject to maximum charge  
55 or rate of payment ceilings determined in accordance with section twen-  
56 ty-eight hundred seven-c of this article for such payors.

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

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

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

19 3. Commissioner rate certification, governmental payments. Prior to  
20 the approval of such rates, as provided in subdivision two of this  
21 section, the commissioner shall determine, and in the case of approvals  
22 by the state director of the budget, certify to such official that the  
23 proposed rate schedules for payments to hospitals for hospital and  
24 health-related services are reasonable and adequate to meet the costs  
25 which must be incurred by efficiently and economically operated facili-  
26 ties. In making such certification, the commissioner shall take into  
27 consideration the elements of cost, geographical differentials in the  
28 elements of cost considered, economic factors in the area in which the  
29 hospital is located, the rate of increase or decrease of the economy in  
30 the area in which the hospital is located, costs of hospitals of compa-  
31 rable size, and the need for incentives to improve services and insti-  
32 tute economies. The commissioner shall also take into consideration the  
33 economies and improvements in service to be anticipated from the opera-  
34 tion of joint central service or use of facilities or services which may  
35 serve as alternatives or substitutes for the whole or any part of  
36 in-hospital service, including, but not limited to, obstetrical, pedia-  
37 tric, laboratory, training, radiology, pharmacy, laundry, purchasing,  
38 preadmission, nursing home, ambulatory or home care services. The  
39 commissioner shall exclude costs for research and those parts of the  
40 costs for educational salaries which the commissioner shall determine to  
41 be not directly related to hospital service, and allowances for costs  
42 which are not specifically identified except for allowances authorized  
43 under section twenty-eight hundred seven-a [or twenty-eight hundred  
44 seven-c] of this article. In determining and certifying to the state  
45 director of the budget rates of payment, including rates of payment for  
46 residential health care facilities, the commissioner shall take into  
47 consideration the different levels of care authorized to be provided in  
48 such hospital or health-related service and determine and certify  
49 distinct rates of payment for each such level of care. If the modifica-  
50 tion of an operating certificate of a hospital pursuant to subdivision  
51 six of section twenty-eight hundred six of this article requires the  
52 establishment of a rate for a level of service not previously provided  
53 in such hospital during the rate period existing at the time of such  
54 modification, a new rate period for that portion of the hospital reclas-  
55 sified as a result of such modification may be established upon sixty  
56 days' prior notice.

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

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

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

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

29 (b) Subject to the provisions of subdivision twelve of this section,  
30 the following categories of hospitals shall not be charged assessments  
31 pursuant to this section: (i) [voluntary nonprofit and private proprie-  
32 tary general hospitals which qualify for distributions made in accord-  
33 ance with paragraph (c) of subdivision nineteen of section twenty-eight  
34 hundred seven-c of this article, or for assessments during the period  
35 January first, nineteen hundred ninety-seven through December thirty-  
36 first, nineteen hundred ninety-seven voluntary nonprofit and private  
37 proprietary general hospitals which qualified for distributions made in  
38 accordance with paragraph (c) of subdivision nineteen of section twen-  
39 ty-eight hundred seven-c of this article as of December thirty-first,  
40 nineteen hundred ninety-five; (ii)] voluntary nonprofit hospitals total-  
41 ly financed by charitable contributions or by the income thereon dedi-  
42 cated to free care of low income patients; and [(iii)] (II) any facility  
43 dedicated solely to the care of police, firefighters, volunteer fire-  
44 fighters, and emergency service personnel.

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

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

1 seven-c of this article and the components of rates of payment or charg-  
2 es related to the allowances provided in accordance with subdivisions  
3 fourteen, fourteen-b and fourteen-c, the adjustment provided in accord-  
4 ance with subdivision fourteen-a, the adjustment provided in accordance  
5 with subdivision fourteen-d, the adjustment for health maintenance  
6 organization reimbursement rates provided in accordance with section  
7 twenty-eight hundred seven-f of this article, the adjustment for commer-  
8 cial insurer reimbursement rates provided in accordance with paragraph  
9 (i) of subdivision eleven of section twenty-eight hundred seven-c of  
10 this article or, if effective, the adjustment provided in accordance  
11 with subdivision fifteen of section twenty-eight hundred seven-c of this  
12 article or the adjustment provided in accordance with section eighteen  
13 of chapter two hundred sixty-six of the laws of nineteen hundred eight-  
14 y-six as amended and physician practice or faculty practice plan revenue  
15 received by a general hospital based on discrete billings for private  
16 practicing physician services, revenue received by a general hospital  
17 from a public hospital pursuant to an affiliation agreement contract for  
18 the delivery of health care services to such public hospital, revenue  
19 received pursuant to paragraph (i) of subdivision [thirty-five] SEVEN-  
20 TEEN of section twenty-eight hundred seven-c of this article, revenue  
21 received pursuant to section twenty-eight hundred seven-w of this arti-  
22 cle, all revenue received as disproportionate share hospital payments,  
23 in accordance with title nineteen of the federal Social Security Act,  
24 revenue received pursuant to sections eleven, twelve, thirteen and four-  
25 teen of part A of chapter one of the laws of two thousand two, revenue  
26 received pursuant to sections thirteen and fourteen of part B of chapter  
27 one of the laws of two thousand two, revenue from patient personal fund  
28 allowances, revenue from income earned on patient funds, investment  
29 income from externally restricted funds, revenue from investment sinking  
30 funds, revenue from investment operating escrow accounts, investment  
31 income from funded depreciation, investment income from mortgage repay-  
32 ment escrow accounts, revenue derived from the operation of schools  
33 leading to licensure, and revenue from the collection of sales and  
34 excise taxes;

35 S 10. Paragraph (c) of subdivision 1 and paragraph (a) of subdivision  
36 2 of section 2807-e of the public health law, as added by chapter 731 of  
37 the laws of 1993, paragraph (a) of subdivision 2 as further amended by  
38 section 104 of part A of chapter 62 of the laws of 2011, are amended to  
39 read as follows:

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

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

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

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

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

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

25 S 13. Paragraph (a) and subparagraph (i) of paragraph (c) of subdivi-  
26 sion 4 of section 2807-j of the public health law, paragraph (a) as  
27 amended by section 62 of part B of chapter 58 of the laws of 2005,  
28 subparagraph (i) of paragraph (c) as added by chapter 1 of the laws of  
29 1999, are amended to read as follows:

30 (a) For periods prior to January first, two thousand five, the commis-  
31 sioner is authorized to contract with the article forty-three insurance  
32 law plans, or such other contractors as the commissioner shall desig-  
33 nate, to receive and distribute funds from the allowances established  
34 pursuant to this section, and funds from the assessments established  
35 pursuant to subdivision [eighteen] EIGHT of section twenty-eight hundred  
36 seven-c of this article. In the event contracts with the article forty-  
37 three insurance law plans or other commissioner's designees are effectu-  
38 ated, the commissioner shall conduct annual audits of the receipt and  
39 distribution of the funds. The reasonable costs and expenses of an  
40 administrator as approved by the commissioner, not to exceed for person-  
41 nel services on an annual basis two million two hundred thousand dollars  
42 for collection and distribution of allowances and assessments estab-  
43 lished pursuant to this section and subdivision [eighteen] EIGHT of  
44 section twenty-eight hundred seven-c of this article, shall be paid from  
45 the allowance and assessment funds.

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

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

53 Funds accumulated, including income from invested funds, from the  
54 allowances specified in this section, and the assessments pursuant to  
55 subdivision [eighteen] EIGHT of section twenty-eight hundred seven-c of  
56 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:



1 15. Revenue from distributions pursuant to this section and adjust-  
2 ments pursuant to subdivision [fourteen-f] SIX of section twenty-eight  
3 hundred seven-c of this article shall not be included in gross revenue  
4 received for purposes of the assessments pursuant to subdivision [eigh-  
5 teen] EIGHT of section twenty-eight hundred seven-c of this article,  
6 subject to the provisions of paragraph (e) of subdivision [eighteen]  
7 EIGHT of section twenty-eight hundred seven-c of this article, and shall  
8 not be included in gross revenue received for purposes of the assess-  
9 ments pursuant to section twenty-eight hundred seven-d of this article,  
10 subject to the provisions of subdivision twelve of section twenty-eight  
11 hundred seven-d of this article.

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

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

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

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

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

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

53 S 24. Subparagraph (i) of paragraph (s) of subdivision 1 of section  
54 2807-m of the public health law, as amended by section 16 of part B of  
55 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;

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

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

16 S 30. Clause (A) of subparagraph (i) of paragraph (b) of subdivision  
17 2-b of section 2808 of the public health law, as amended by section 61  
18 of part A of chapter 56 of the laws of 2013, is amended to read as  
19 follows:

20 (A) Subject to the provisions of subparagraphs (ii) through (xiv) of  
21 this paragraph, for periods on and after April first, two thousand nine  
22 the operating cost component of rates of payment shall reflect allowable  
23 operating costs as reported in each facility's cost report for the two  
24 thousand two calendar year, as adjusted for inflation on an annual basis  
25 in accordance with the methodology set forth in paragraph (c) of subdi-  
26 vision [ten] FOUR of section twenty-eight hundred seven-c of this arti-  
27 cle, provided, however, that for those facilities which are determined  
28 by the commissioner to be qualifying facilities in accordance with the  
29 provisions of clause (B) of this subparagraph, rates shall be further  
30 adjusted to include the proportionate benefit, as determined by the  
31 commissioner, of the expiration of the opening paragraph and paragraph  
32 (a) of subdivision sixteen of this section and of paragraph (a) of  
33 subdivision fourteen of this section, and provided further that the  
34 operating cost component of rates of payment for those facilities which  
35 are determined by the commissioner to be qualifying facilities in  
36 accordance with the provisions of clause (B) of this subparagraph shall  
37 not be less than the operating component such facilities received in the  
38 two thousand eight rate period, as adjusted for inflation on an annual  
39 basis in accordance with the methodology set forth in paragraph (c) of  
40 subdivision [ten] FOUR of section twenty-eight hundred seven-c of this  
41 article and further provided, however, that rates for facilities whose  
42 operating cost component reflects base year costs subsequent to January  
43 first, two thousand two shall have rates computed in accordance with  
44 this paragraph, utilizing allowable operating costs as reported in such  
45 subsequent base year period, and trended forward to the rate year in  
46 accordance with applicable inflation factors.

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

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

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

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

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

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

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

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

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

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

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

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

20 S 36. Subparagraph 4 of paragraph (c) of subdivision 5 of section 366  
21 of the social services law, as amended by chapter 41 of the laws of  
22 1992, is amended to read as follows:

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

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

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

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

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

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

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

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

34 S 335. Implementation of hospital reimbursement methodology. The  
35 superintendent shall have the power to prescribe rules and regulations  
36 governing insurer procedures and subscriber contract provisions neces-  
37 sary to implement a hospital reimbursement methodology established in  
38 accordance with the provisions of article twenty-eight of the public  
39 health law, and insurer procedures and subscriber contract provisions  
40 necessary to implement a hospital inpatient discharge review program  
41 established in accordance with the provisions of section twenty-eight  
42 hundred three-i of the public health law, and to establish standards,  
43 criteria and procedures for evaluation of insurer performance in offer-  
44 ing contracts for hospital and medical benefits on an open enrollment  
45 basis necessary for a determination of the hospital payment rate conver-  
46 sion factor [in accordance with the provisions of paragraph (i) of  
47 subdivision eleven of section twenty-eight hundred seven-c of the public  
48 health law].

49 The superintendent shall periodically report his findings and conclu-  
50 sions to the commissioner of health and to the chairman and vice-chair-  
51 man of the council on health care financing concerning insurer perform-  
52 ance in offering contracts for hospital and medical benefits on an open  
53 enrollment basis.

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

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

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

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

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

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

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

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

1 fee shall not exceed one-tenth of one percent of the total costs  
2 reported by such general hospital. Where rates of payment for general  
3 hospital services established pursuant to section twenty-eight hundred  
4 seven-a of the public health law or pursuant to section twenty-eight  
5 hundred seven-c of the public health law have not been adjusted to  
6 reflect the proportionate share of costs associated with such annual  
7 fee, rates shall be so adjusted. The commissioner of health shall  
8 promulgate regulations establishing a time schedule for payment of annu-  
9 al fees assessed on general hospitals. The commissioner of health shall  
10 charge a user fee for the production of any data to any person or organ-  
11 ization, provided, however, that the commissioner of health may waive  
12 such fee for the provision of reports, to be defined in regulation, to a  
13 general hospital or its designee as approved by the commissioner of  
14 health or third-party payor or health systems agency to perform duties  
15 and functions provided for in subdivision seven, excluding paragraph (s)  
16 of such subdivision, of section twenty-nine hundred four-b of the public  
17 health law. Notwithstanding any inconsistent provisions of any general  
18 or special law, charges established pursuant to subdivision twelve of  
19 section twenty-eight hundred seven-a of the public health law or pursu-  
20 ant to paragraph [(c)] (H) of subdivision one of section twenty-eight  
21 hundred seven-c of the public health law shall be permitted to increase  
22 to reflect increased costs resulting from the proportionate cost of the  
23 annual fees assessed pursuant to this subdivision.

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

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



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

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

8 5. sections [2807-c,] 2807-j, 2807-s and 2807-t of the public health  
9 law, [as amended or] as added by this act, shall expire on December 31,  
10 2014, and shall be thereafter effective only in respect to any act done  
11 on or before such date or action or proceeding arising out of such act  
12 including continued collections of funds from assessments and allowances  
13 and surcharges established pursuant to sections [2807-c,] 2807-j, 2807-s  
14 and 2807-t of the public health law, and administration and distrib-  
15 utions of funds from pools established pursuant to sections [2807-c,]  
16 2807-j, 2807-k, 2807-l, 2807-m, 2807-s and 2807-t of the public health  
17 law related to patient services provided before December 31, 2014, and  
18 continued expenditure of funds authorized for programs and grants until  
19 the exhaustion of funds therefor;

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

24 1. sections [2807-c,] 2807-j, 2807-s, and 2807-t of the public health  
25 law, as amended by this act, shall expire on December 31, 2014, and  
26 shall be thereafter effective only in respect to any act done before  
27 such date or action or proceeding arising out of such act including  
28 continued collections of funds from assessments and allowances and  
29 surcharges established pursuant to sections [2807-c,] 2807-j, 2807-s and  
30 2807-t of the public health law, and administration and distributions of  
31 funds from pools established pursuant to sections [2807-c,] 2807-j,  
32 2807-k, 2807-l, 2807-m, 2807-s, 2807-t, 2807-v and 2807-w of the public  
33 health law, as amended or added by this act, related to patient services  
34 provided before December 31, 2014, and continued expenditure of funds  
35 authorized for programs and grants until the exhaustion of funds there-  
36 for;

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

41 2. Sections five, seven through nine, twelve through fourteen, and  
42 eighteen of this act shall be deemed to have been in full force and  
43 effect on and after April 1, 1995 through March 31, 1999 and on and  
44 after July 1, 1999 through March 31, 2000 and on and after April 1, 2000  
45 through March 31, 2003 and on and after April 1, 2003 through March 31,  
46 2006 and on and after April 1, 2006 through March 31, 2007 and on and  
47 after April 1, 2007 through March 31, 2009 and on and after April 1,  
48 2009 through March 31, 2011 and sections twelve, thirteen and fourteen  
49 of this act shall be deemed to be in full force and effect on and after  
50 April 1, 2011 [through March 31, 2015];

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