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I N S E N A T E

April 9, 2014

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

AN ACT to amend the public health law, in relation to general hospital
inpatient reimbursement for annual rate periods and the effectiveness
of certain provisions thereof; to amend the social services law, the
state finance law, the insurance law and the workers' compensation
law, in relation to technical conformity with changes to annual rate
periods; to amend chapter 639 of the laws of 1996, constituting the
"New York Health Care Reform Act of 1996", in relation to the 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;

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

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

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

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

27 (ii) Effective July first, two thousand seven, with the exception of
28 those enrollees covered under a payment rate methodology agreement nego-
29 tiated with a general hospital, payment for inpatient hospital services
30 provided to patients enrolled in the child health insurance program
31 pursuant to title one-A of article twenty-five of this chapter made by
32 organizations operating in accordance with the provisions of article
33 forty-four of this chapter or by health maintenance organizations organ-
34 ized and operating in accordance with article forty-three of the insur-
35 ance law shall be the rates of payment that would be paid under the
36 medical assistance program determined pursuant to this section, exclud-
37 ing adjustments pursuant to subdivision [fourteen-f] SIX of this
38 section.

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

40 (i) the commissioner shall establish, subject to the approval of the
41 director of the budget, discrete rates of payment for general hospitals
42 for the period July first, nineteen hundred ninety-six through December
43 thirty-first, nineteen hundred ninety-nine and periods on and after
44 January first, two thousand for payments under the medical assistance
45 program pursuant to title eleven of article five of the social services
46 law for persons eligible for medical assistance who are enrolled in
47 health maintenance organizations and for payments under the family
48 health plus program for persons enrolled in approved organizations
49 pursuant to title eleven-D of article five of the social services law
50 based on the components of rates of payment established pursuant to this
51 section for persons eligible for medical assistance who are not enrolled
52 in health maintenance organizations for a general hospital for such rate
53 period that reflect the estimated reimbursable costs of direct medical
54 education expenses and indirect medical education expenses in the deter-
55 mination 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 (1) 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-

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

3 (A) the amount determined in accordance with clause (B) of subpara-
4 graph (iii) of this paragraph, excluding the value of direct medical
5 education expenses, as defined in subparagraph (i) 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 group category average inpatient reimbursable operating
9 cost per discharge, and excluding the value of forty-five percent of the
10 indirect medical education expenses, as defined in subparagraph (ii) of
11 paragraph (c) of subdivision seven of this section, reflected in the
12 general hospital's hospital specific average reimbursable inpatient
13 operating cost per discharge, and excluding the value of fifty-five
14 percent of the indirect medical education expenses reflected in a gener-
15 al hospital's group category average inpatient reimbursable operating
16 cost per discharge in accordance with subdivision twenty-five of this
17 section as amended;

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

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

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

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

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

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

44 (A) the amount determined in accordance with clause (B) of subpara-
45 graph (iii) of this paragraph, excluding the value of direct medical
46 education expenses, as defined in subparagraph (i) of paragraph (c) of
47 subdivision seven of this section, reflected in the general hospital's
48 hospital-specific average reimbursable inpatient operating cost per
49 discharge and group category average inpatient reimbursable operating
50 cost per discharge, and excluding the value of forty-five percent of the
51 indirect medical education expenses, as defined in subparagraph (ii) of
52 paragraph (c) of subdivision seven of this section, reflected in the
53 general hospital's hospital specific average reimbursable inpatient
54 operating cost per discharge, and excluding the value of fifty-five
55 percent of the indirect medical education expenses reflected in a gener-
56 al 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 of article five of the social services law in the distribution to hospitals pursuant to subdivisions fourteen-c, seventeen and paragraphs (c) and (d) of subdivision nineteen of this section of pooled funds.

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

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

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

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

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

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

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

9 16-a. Pool administration, general. (a) If a general hospital fails to timely file a report with the department of funds due to a regional pool or a statewide pool established pursuant to this section, the commissioner may estimate the amount due from such hospital based on available financial and statistical data and may collect in accordance with subdivision twenty of this section any amount due based on such estimate as a

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

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

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

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

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

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

44 (iii) Notwithstanding any other law, rule or regulation to the contra-
45 ry, projections of each general hospital's disproportionate share limi-
46 tations as computed by the commissioner pursuant to applicable regu-
47 lations shall be adjusted to reflect any additional revenue received or
48 anticipated to be received by each such general hospital pursuant to
49 this paragraph.

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

53 6. A general hospital which is designated as a regional poison control
54 center shall submit a budget indicating the costs of operating such
55 center. Costs determined by the commissioner to be necessary and reason-
56 able 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 anothe-
17 r 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.