§ 2807-a. General hospital nineteen hundred eighty-six and nineteen hundred eighty-seven inpatient rates and charges.

1. For the rate period from January first, nineteen hundred eighty-six through December thirty-first, nineteen hundred eighty-six and for the rate period from January first, nineteen hundred eighty-seven through December thirty-first, nineteen hundred eighty-seven, the rates of payment to general hospitals for services provided to persons eligible for payments made by state governmental agencies and subscribers to article forty-three insurance law corporations and subscribers of organizations organized under article forty-four of this chapter (unless application is made to the commissioner under subdivision three of this section) shall be based on the reimbursable operating costs used in determining payments for services provided during the rate period from January first, nineteen hundred eighty-five through December thirty-first, nineteen hundred eighty-five. Such operating costs shall include the annualized cost impact of rate revisions or adjustments made with respect to such services. In addition to the reimbursable operating costs identified in accordance with this subdivision, payment rates by governmental agencies and article forty-three insurance law corporations shall be adjusted each year to reflect:

(a) capital related expenses determined in accordance with subdivision seven of this section;

(b) additional financial needs or revenue requirements in accordance with subdivision eight of this section; and

(c) projection of reimbursable costs identified in accordance with this subdivision by a trend factor established by the panel of economists as set forth in subdivision fourteen of this section.

2. For the rate period from January first, nineteen hundred eighty-six through December thirty-first, nineteen hundred eighty-six and for the rate period from January first, nineteen hundred eighty-seven through December thirty-first, nineteen hundred eighty-seven, rates of payment pursuant to the provisions of the workers' compensation law, the volunteer firefighters' benefit law and the comprehensive motor vehicle insurance reparations act shall be established on the basis of one hundred twelve percent of the trended

nineteen hundred eighty-one average operating reimbursable per diem inpatient cost of the hospital, plus the additions specified in subdivisions seven and eight of this section and such revisions that may be made pursuant to subdivisions eleven and fourteen of this section.

3. Nothing in this section shall prohibit the negotiation by health maintenance organizations operating in accordance with the provisions of article forty-three of the insurance law or article forty-four of this chapter, of agreements with general hospitals for rates of payment other than those provided herein. Such contracts shall require approval by the commissioner and must include provision for special benefit packages or arrangements for providing inpatient services to encourage patient management behavior that will minimize the length of patient stay, such as special admission arrangements, bed leasing or other inpatient capitation arrangements.

4. Hospital inpatient services reimbursement provided to patients who are not beneficiaries or subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, eligible for payments made by state governmental agencies, eligible for payments as beneficiaries of subchapter XVIII of the federal social security act, enrolled in organizations operating in accordance with the provisions of article forty-four of this chapter, enrolled in a self-insured and self-administered group covered under the provisions of paragraph (b) of subdivision twelve of this section, or eligible for payments pursuant to the provisions of the workers' compensation law, the volunteer firefighters' benefit law or the comprehensive motor vehicle insurance reparations act shall be at charges established by the hospital in accordance with subdivision twelve of this section.

5. Specialty hospitals shall receive reimbursement for general hospital inpatient services in accordance with the provisions of this section unless other reimbursement methodologies are adopted by the council and approved by the commissioner. In such event the allowances provided in subdivision eight of this section shall be included in certified and approved inpatient rates.

6. The establishment of separate rates of payment for patients who require different levels or types of care shall require a reallocation of costs to insure that costs are equitably allocated to service areas and appropriate rate adjustments are made.

7. Capital related expenses. Capital related inpatient expenses, including but not limited to straight line depreciation on buildings and non-movable equipment, accelerated depreciation on 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 that article and article twenty-eight of this chapter), shall be included in rates established on a budget basis and subsequently reconciled to actual expenses 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 related inpatient expense generated by a capital expenditure which requires or required approval pursuant to this article, must have received such approval for the capital related expense to be included in the rates established. 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 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 council shall adopt, with the approval of the commissioner, regulations to:

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

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

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

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

8. Allowances. All rates established for the two years commencing on January first, nineteen hundred eighty-six in accordance with subdivisions one, two, three, four, five and six of this section shall include the allowances specified in paragraphs (a), (b), (c), (e) and (f) of this subdivision. The allowances shall be computed on the basis of the general hospitals' reimbursable inpatient costs after application of the trend factor. For the purposes of this subdivision and subdivisions sixteen and twenty-four of this section, major public general hospitals are defined as all state operated general hospitals, all general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended and all other public general hospitals having annual inpatient operating costs in excess of twenty-five million dollars.

(a) An allowance of one percent of the general hospitals' reimbursable inpatient costs computed in accordance with this section to be used at the discretion of hospital governing boards.

(b) For public general hospitals an additional allowance of up to two percent subject to the provisions of paragraph (d) of this subdivision.

(c) For voluntary non-profit and private proprietary general hospitals an additional allowance up to one percent subject to the provisions of paragraph (d) of this subdivision.

(d) The additional allowances in paragraphs (b) and (c) of this subdivision shall be available to general hospitals receiving approval from the commissioner as to the acceptable use of the allowance which uses shall include but not be limited to retirement of short term non-capital debt, meeting costs related to bad debts and charity care not met by the distributions as specified in subdivisions sixteen and twenty-four of this section, offsetting reductions in anticipated revenue resulting from charge limits below those applicable to the particular hospital immediately prior to the enactment of subdivision twelve of this section, and needed improvement of current ratio. Allowances authorized by paragraphs (b) and (c) of this subdivision are not to be considered as a substitute for operational funds that are otherwise reimbursable or subject to appeal.

(e) A percentage to reflect the needs for the financing of losses resulting from bad debts and the costs of charity care of general hospitals within article forty-three insurance law regions, or such other regions as adopted pursuant to subdivision fifteen of this section, and within a statewide determination of financial resources to be committed for this purpose. Regional needs shall be equal to the total of inpatient losses from bad debts reduced to cost and the inpatient costs of charity care increased by any deficit of such hospitals from providing ambulatory services, excluding any portion of such deficit resulting from governmental payments below average visit costs, and revenues and expenses related to the provision of referred ambulatory services. The regional amounts to be included in rates approved for the rate year commencing January first, nineteen hundred eighty-six and for the rate year commencing January first, nineteen hundred eighty-seven will be equal to the result of the application of the percentage of statewide need for voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, that can be met from available resources in regional pools, created in accordance with subdivision fifteen of this section computed without consideration of inpatient uncollectible amounts, to the regional need for voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, expressed in dollars plus the dollar amount resulting from the application of the ratio of major public general hospitals inpatient reimbursable costs within the region to total statewide general inpatient reimbursable cost (as computed on the basis of nineteen hundred eighty-four financial and statistical reports and excluding costs related to services to beneficiaries of subchapter XVIII of the federal social security act) to the statewide resources committed for this purpose to regional pools computed without consideration of inpatient uncollectible amounts and the ratio of these total dollars to the total regional reimbursable inpatient costs, excluding inpatient costs related to services provided to beneficiaries of subchapter XVIII of the federal social security act, after application of the trend factor. For each year of the two year period commencing on January first, nineteen hundred eighty-six the statewide amount to be available in regional pools for this purpose will equal four and one-half percent

of the total hospital reimbursable inpatient cost, excluding inpatient costs related to services provided to beneficiaries of subchapter XVIII of the federal social security act and inpatient uncollectible amounts, after application of the trend factor. The allocations of resources made available under this paragraph, as specified in subdivision sixteen of this section may be changed only as follows: An annual review shall be conducted pursuant to rules and regulations adopted by the council and approved by the commissioner with respect to bad debt and charity care need within each article forty-three insurance law region or such other regions as are adopted pursuant to subdivision fifteen of this section. If within such a region there is a definitive finding as a result of such review that there has been a change in the proportional amounts of bad debts and charity care provided by (i) major public general hospitals and (ii) voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, the allocation of resources made available under this paragraph shall be adjusted pursuant to the rules and regulations adopted pursuant to this paragraph so as to reflect this change.

(f) An additional allowance of fifty-eight hundredths of one percent shall be included in each rate established for each voluntary non-profit and private proprietary general hospital to be returned to a regional pool and distributed in accordance with paragraph (b) of subdivision sixteen of this section.

10. Special provisions for payments by governmental agencies. In the event that the allowances specified in subdivision eight of this section are not approved by the federal government for federal financial participation in payments made for beneficiaries eligible for medical assistance under subchapter XIX of the federal social security act, rates of payment by governmental agencies for the operating cost component of general hospital inpatient services shall be based on the reimbursable operating costs used in determining payments for services provided during the rate period from January first, nineteen hundred eighty-five through December thirty-first, nineteen hundred eighty-five, including the annualized cost impact of rate revisions or adjustments made with respect to such services, projected by a trend factor determined in accordance with subdivision fourteen of this section, and

adjusted by a base period adjustment factor to reflect the difference between the actual regional increase in inpatient general hospital operating cost for those regions as established pursuant to subdivision fifteen of this section between cost reporting periods for nineteen hundred eighty-one and nineteen hundred eighty-four and the trend factors developed to project costs for such period, provided, however, such base period adjustment factor shall not exceed an amount equal to the percentage allowances calculated in accordance with paragraphs (a), (b), (c), (e) and (f) of subdivision eight of this section. The commissioner shall assess all general hospitals within a region an amount equal to the regional allowance percentage as determined in accordance with paragraph (e) of subdivision eight of this section applied to actual inpatient revenues received from providing inpatient services to persons eligible for payments from state governmental agencies excluding inpatient revenues related to services provided to beneficiaries of subchapter XVIII of the federal social security act. The commissioner shall also assess an additional fifty-eight hundredths of one percent of actual inpatient revenues received by voluntary non-profit and private proprietary general hospitals for services provided to persons eligible for payments made by state governmental agencies excluding inpatient revenues related to services provided to beneficiaries of subchapter XVIII of the federal social security act. Such assessments shall be returned to regional pools in accordance with the methodology contained in subdivision fifteen of this section and distributed in accordance with the provisions of subdivision sixteen of this section.

11. Adjustments. (a) For the period from January first, nineteen hundred eighty-six through December thirty-first, nineteen hundred eighty-seven, 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 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 expenses to permit a more efficient and economical method of delivering a service; and

(v) increased costs for compensation of employees.

(c) In determining the reasonableness or justification of an adjustment to an established rate related to subparagraph (v) 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) The commissioner shall adjust a prospectively established inpatient rate on the basis of subsequent data that demonstrates a significant cost influencing change in patient mix or volume of service. Such adjustments shall be based on rules and regulations adopted by the council and approved by the commissioner. Such rules and regulations for a volume adjustment shall take into consideration only volume changes to other than beneficiaries of subchapter XVIII of the federal social security act.

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

(f) The commissioner shall act upon all properly documented appeals for adjustments concerning base year costs by November first of the calendar year for which the rate is effective provided that all information necessary to determine whether an adjustment is justified is

submitted by the facility prior to May first of such year. In the event such an appeal is filed by May first, but information necessary to determine whether an adjustment is justified is submitted after such date, the commissioner shall act on the appeal within six months after receiving the necessary information.

(g) The commissioner shall consider an adjustment to a hospital's reported base year costs in instances where it is demonstrated that recurring costs resulting from multi-year commitments beginning late in a base year should be calculated on an annual basis in establishing a rate in order to avoid a significant inequity. In making such an adjustment the commissioner shall consider the offset of non-recurring base year costs.

12. Hospital charge schedules. (a) Effective for the year commencing January first, nineteen hundred eighty-six and thereafter each general hospital shall establish a charge schedule for available and authorized services in accordance with a gross charge determination formula provided by the commissioner which shall establish gross inpatient charges such that the payment rate to be made on behalf of subscribers of article forty-three insurance law plans, adjusted for uncovered services shall be at a discount which shall not exceed twelve percent of the gross charge rate billed to or on behalf of charge paying patients. For general hospitals subject to the provisions of paragraphs (a) and (b) of subdivision twenty-one of this section, the costs (including all allowances specified in subdivision eight of this section) of services provided to charge paying patients shall not exceed a twelve percent discount from the gross charge rate billed to or on behalf of charge paying patients. In the event that a hospital's gross inpatient charges exceed the maximum inpatient charges computed in accordance with the gross charge determination formula prescribed by the commissioner, direct repayment or adjustment of subsequent charges for inpatient services shall be effectuated in accordance with regulations adopted by the council and approved by the commissioner.

(b) For the period January first, nineteen hundred eighty-six through December thirty-first, nineteen hundred eighty-seven, negotiated payment rate determination systems between self-insured and self-administered groups and hospitals which were in effect on May first, nineteen hundred

eighty-five may continue.

13. 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. Revenues received from such financing or working capital charges shall not be considered as a cost offset or as part of the hospital's gross inpatient charges. Financing or working capital charges shall not be applied to hospital billings to third party payors participating in a periodic interim payment system.

14. Trend factors. (a) The commissioner in accordance with the methodology developed by the consultants pursuant to paragraph (b) of this subdivision shall establish trend factors to project for the effects of inflation. The factors shall be applied to the appropriate portion of reimbursable costs as defined in subdivision one of this section, or, if effective, subdivision ten of this section. The methodology for developing the trend factor shall include the appropriate external price indicators and shall also include the data from major collective bargaining agreements as reported quarterly by the federal department of labor, bureau of labor statistics, for non-supervisory employees.

(b) The methodology shall be developed by four independent consultants with expertise in health economics appointed by the commissioner. Not later than September first of each year, the consultants shall provide to the commissioner and the council, the methodology to be used to determine the trend factors for the subsequent twelve month period commencing January first. The commissioner shall monitor the actual price movement during this twelve month period of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants, and shall implement, semi-annually, the recommendations of the consultants for adjustments to the trend factor, provided, however, that adjustments, except for the final adjustment of the trend factor, shall not be required unless such adjustment would result in the weighted average of the operating cost component of the rates differing by more than one-half of one percent from that which was

previously determined.

15. Regional and statewide pools, general. Funds will be made available in regional pools for regional distributions through the submissions by general hospitals of the allowances included in rates and charges in accordance with paragraphs (e) and (f) of subdivision eight of this section and, if effective, the amount of the assessment in accordance with subdivision ten of this section. Funds will be made available for distribution from a statewide pool in accordance with the assessments authorized in subdivision twenty-three of this section. The regions are established as the article forty-three insurance plan regions, with the exception that the southern sixteen counties shall be divided into three regions for the purposes of subdivisions eight and sixteen of this section with separate regions consisting of Richmond, Manhattan, Bronx, Queens and Kings counties; Nassau and Suffolk counties, and Delaware, Columbia, Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland and Westchester counties. Such regions shall be the same regions established and in effect January first, nineteen hundred eighty-five. The council with the approval of the commissioner may combine regions, with the exception of the above specified regions for the southern sixteen counties, upon application of the article forty-three insurance law plans involved and a demonstration that significant inequities would not occur. The commissioner is authorized to contract with the article forty-three insurance law plans to receive funds for the pools and distribute such funds. In the event contracts with the article forty-three insurance law plans are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of the pooled funds. In order for general hospitals to participate in the distribution of funds from the pools the general hospital must implement collection policies and procedures approved by the commissioner.

16. Regional pools. Funds accumulated in regional pools, including income from invested funds, shall be distributed in accordance with the following methodology and sequence:

(a) Funds accumulated in regional pools, including income from invested funds, from the allowance specified in paragraph (e) of

subdivision eight of this section and, if effective, the assessment against all general hospitals as authorized in subdivision ten of this section shall be distributed as follows:

(i) Each eligible major public general hospital as defined in subdivision eight of this section shall receive a portion of its bad debt and charity care need equal to the result of the application of its percentage of statewide inpatient reimbursable costs excluding costs related to services to beneficiaries of subchapter XVIII of the federal social security act, developed on the basis of nineteen hundred eighty-four financial and statistical reports to the total of all regional pools.

(ii) Funds remaining in the regional pools after distribution in accordance with subparagraph (i) of this paragraph shall be distributed proportionately to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, on the basis of need within the region as defined in paragraph (e) of subdivision eight of this section.

(b) Funds accumulated in regional pools, including income from invested funds, created by the allowance specified in paragraph (f) of subdivision eight of this section and, if effective, the fifty-eight hundredths of one percent assessment against voluntary non-profit and private proprietary general hospitals as authorized by subdivision ten of this section, shall be available for distribution by the commissioner in accordance with rules adopted by the council to assist in offsetting losses resulting from bad debts and the costs of charity care of voluntary non-profit and private proprietary general hospitals experiencing severe fiscal hardship because of insufficient resources to finance such losses and costs. Such losses and costs may include losses and costs incurred prior to the year used in determining hospital need pursuant to paragraph (e) of subdivision eight of this section. Amounts to be distributed shall be determined after consideration of amounts to be distributed from regional pools in accordance with paragraph (a) of this subdivision and from the statewide pool in accordance with subparagraph (iii) of paragraph (a) of subdivision twenty-four of this section.

(c) Any balance in the portion of regional pools created by the allowance in paragraph (f) of subdivision eight of this section, and if

effective, the fifty-eight hundredths of one percent assessment as authorized by subdivision ten of this section, including income from invested funds, after distribution in accordance with paragraph (b) of this subdivision shall be distributed to voluntary non-profit and private proprietary general hospitals within the region on a basis related to specific hospital need as defined in paragraph (e) of subdivision eight of this section.

20. Unit of service. For the rate period from January first, nineteen hundred eighty-six through December thirty-first, nineteen hundred eighty-six and for the rate period from January first, nineteen hundred eighty-seven through December thirty-first, nineteen hundred eighty-seven the unit of service on which payment is made to general hospitals for inpatient services shall be the unit of service in effect during the rate period from January first, nineteen hundred eighty-five through December thirty-first, nineteen hundred eighty-five unless specifically provided otherwise in this section or modified pursuant to a subsequent chapter.

21. Provisions for article forty-three insurance law corporations and article forty-four of this chapter organizations. Except as provided in paragraphs (a) and (b) of this subdivision, general hospital charges for inpatient and outpatient services to subscribers or beneficiaries of contracts entered into pursuant to the provisions of article forty-three of the insurance law or to members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter for patient services rendered shall not exceed the rates of payment approved by the superintendent of financial services or approved or certified by the commissioner, whichever is applicable and required by this section, for payments by such article forty-three insurance law corporations or article forty-four of this chapter organizations. No general hospital may demand or request any charge for such covered services in addition to the charges or rates authorized by this article.

(a) Any general hospital which terminated its contract with an article forty-three insurance law corporation or a comprehensive health services plan after October first, nineteen hundred seventy-six and prior to May first, nineteen hundred seventy-eight, may not charge subscribers or

beneficiaries of contracts entered into pursuant to the provisions of article forty-three of the insurance law, or members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter, amounts in excess of the schedule of charges established by such hospital for patient services in accordance with the provisions of subdivision twelve of this section.

(b) Any general hospital which has notified in writing an article forty-three insurance law corporation or a comprehensive health services plan prior to June first, nineteen hundred seventy-eight of its intention to terminate its contract with such corporation or plan in accordance with the terms of such contract, except a general hospital subject to the provisions of paragraph (a) of this subdivision may not charge a subscriber or beneficiary of a contract entered into pursuant to the provisions of article forty-three of the insurance law, or a member of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter, after the effective date of termination of such contract, amounts in excess of the schedule of charges established by such hospital for patient services in accordance with the provisions of subdivision twelve of this section.

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

22. Restitution authorization. In enforcing the provisions of subdivisions twelve and twenty-one of this section, the commissioner may, in addition to the penalties and injunctions set forth in section twelve of this chapter, order that any general hospital provide restitution for any overpayments made by any party. Any hospital may request a formal hearing pursuant to the provisions of section twelve-a of this chapter in the event the hospital does not consent to any order of the commissioner hereunder. The commissioner may direct that such a hearing be held without any request by a hospital.

23. Bad debt and charity care assessments. The commissioner shall create a bad debt and charity care statewide pool through assessments which shall be charged to general hospitals to reflect the needs for the financing of losses resulting from bad debts and the costs of charity

care. Such assessments will be submitted to a statewide pool as designated by the commissioner and distributed on a monthly basis in accordance with subdivision twenty-four of this section. The bad debt and charity care assessments shall be:

(a) Three and eight-tenths percent aggregate assessment of each general hospital's gross revenue received for inpatient hospital service provided during the period July first, nineteen hundred eighty-six through December thirty-first nineteen hundred eighty-six composed of the following: (i) an assessment of three and eight hundredths percent to be allocated to a statewide bad debt and charity care account in the statewide pool and distributed in accordance with paragraph (a) of subdivision twenty-four of this section, (ii) an assessment of thirty-eight hundredths of one percent to be allocated to a statewide financially distressed hospital account in the statewide pool and distributed in accordance with paragraph (b) of subdivision twenty-four of this section, and (iii) an assessment of thirty-four hundredths of one percent to be allocated to a statewide transition account in the statewide pool and distributed in accordance with paragraph (c) of subdivision twenty-four of this section;

(b) One and nine-tenths percent aggregate assessment of each general hospital's gross revenue received for inpatient hospital service provided during the period January first, nineteen hundred eighty-seven through December thirty-first, nineteen hundred eighty-seven composed of the following: (i) an assessment of one and fifty-four hundredths percent to be allocated to a statewide bad debt and charity care account in the statewide pool and distributed in accordance with paragraph (a) of subdivision twenty-four of this section, (ii) an assessment of nineteen hundredths of one percent to be allocated to a statewide financially distressed hospital account in the statewide pool and distributed in accordance with paragraph (b) of subdivision twenty-four of this section, and (iii) an assessment of seventeen hundredths of one percent to be allocated to a statewide transition account in the statewide pool and distributed in accordance with paragraph (c) of subdivision twenty-four of this section;

(c) Provided, however, there shall be no assessment against those voluntary non-profit and private proprietary general hospitals which qualify for distributions made in accordance with paragraph (b) of

subdivision sixteen of this section and paragraph (b) of subdivision twenty-four of this section.

(d) For the purposes of this subdivision and subdivision twenty-four of this section, gross revenue received is defined as all monies received for or on account of inpatient hospital service, provided, however, that gross revenue received shall not include distributions from regional and statewide pools established in accordance with this section and shall not include the component of rates of payment related to the allowances provided in accordance with subdivision eight or, if effective, the base period adjustment factor provided in accordance with subdivision ten of this section.

24. Statewide pool distribution. (a) Funds accumulated in the statewide bad debt and charity care account in the statewide pool, including income from invested funds, shall be distributed in accordance with the following methodology:

(i) There shall be set aside within such account, from accumulated funds, from the total allocation to the statewide bad debt and charity care account of the assessment of three and eight hundredths percent of gross revenue received in accordance with subparagraph (i) of paragraph (a) of subdivision twenty-three of this section an amount equal to eighty-six hundredths of one percent of gross revenue received, as defined in paragraph (d) of subdivision twenty-three of this section, and from the total allocation to the statewide bad debt and charity care account of the assessment of one and fifty-four hundredths percent of gross revenue received in accordance with subparagraph (i) of paragraph (b) of subdivision twenty-three of this section an amount equal to forty-three hundredths of one percent of gross revenue received, as defined in paragraph (d) of subdivision twenty-three of this section. Each eligible major public general hospital, as defined in subdivision eight of this section, shall receive from such funds a portion of its bad debt and charity care need equal to the result of the application of its percentage of statewide major public general hospital gross revenue received to such funds.

(ii) Any funds within the statewide bad debt and charity care account set aside for major public general hospitals and not distributed in accordance with subparagraph (i) of this paragraph shall be distributed

in accordance with subparagraph (iii) of this paragraph.

(iii) Funds remaining in the statewide bad debt and charity care account, after allocation in accordance with subparagraph (i) of this paragraph, including funds available pursuant to subparagraph (ii) of this paragraph, and including income from invested funds, shall be distributed proportionately on a statewide basis to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, on the basis of need as defined in paragraph (e) of subdivision eight of this section. Amounts to be distributed shall be determined after consideration of amounts to be distributed from regional pools in accordance with paragraph (a) of subdivision sixteen of this section.

(b) Funds accumulated in the statewide financially distressed general hospital account in the statewide pool, including income from invested funds, shall be distributed or retained in accordance with the following methodology:

(i) Funds in the statewide financially distressed general hospital account, including income from invested funds, shall be made available on a statewide basis for distribution by the commissioner in accordance with rules and regulations adopted by the council and approved by the commissioner to assist voluntary non-profit and private proprietary general hospitals experiencing severe fiscal hardship because of insufficient resources to finance losses resulting from bad debts and the costs of charity care, and to meet reasonable and necessary costs related to securing financing of capital improvement projects for such general hospitals. Such losses and costs may include losses and costs incurred prior to the year used in determining hospital need pursuant to paragraph (e) of subdivision eight of this section. Amounts to be distributed shall be determined after consideration of amounts to be distributed from regional pools in accordance with subdivision sixteen of this section and from the statewide bad debt and charity care account in accordance with subparagraph (iii) of paragraph (a) of this subdivision. The commissioner, in accordance with rules and regulations adopted by the council and approved by the commissioner, may allocate a portion of the accumulated funds for the purpose of securing financing of capital improvement projects for such general hospitals.

(ii) Any balance remaining in the statewide financially distressed

general hospital account, including income from invested funds, not including that portion of accumulated funds allocated for the purpose of securing financing of capital improvement projects, after distribution in accordance with subparagraph (i) of this paragraph shall be distributed to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, on a basis related to need as defined in paragraph (e) of subdivision eight of this section.

(c) (i) Funds accumulated in the statewide transition account in the statewide pool, including income from invested funds, shall be distributed to voluntary non-profit, private proprietary and public general hospitals that have high percentages of gross revenue received from payors whose rates and maximum charges are determined in accordance with this section compared to total gross revenue received. For purposes of this subparagraph, major public general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended shall be considered on a consolidated basis. Rules for such distribution will be those adopted by the state hospital review and planning council and approved by the commissioner.

(ii) Any balance remaining in the statewide transition account, including income from invested funds, after distribution in accordance with subparagraph (i) of this paragraph shall be distributed to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals, on a basis related to need as defined in paragraph (e) of subdivision eight of this section.

25. Maximum distributions. No general hospital may receive in total from the distributions made in accordance with paragraphs (a) and (c) of subdivision sixteen of this section and paragraph (a), subparagraph (ii) of paragraph (b) and subparagraph (ii) of paragraph (c) of subdivision twenty-four of this section an amount which exceeds its need for financing losses related to bad debts and the costs of charity care as defined in paragraph (e) of subdivision eight of this section.

26. Undistributed funds. Any funds, including income from invested funds, remaining in the statewide pool after distributions in accordance

with paragraphs (a), (b) and (c) of subdivision twenty-four of this section shall be distributed proportionately to voluntary non-profit, private proprietary and public general hospitals, excluding major public general hospitals, on the basis of hospital specific assessments submitted to the pool.

27. Payment of assessments. Payments by or on behalf of general hospitals of funds due for the bad debt and charity care assessments pursuant to subdivision twenty-three of this section shall be made on a time schedule established by the council, subject to the approval of the commissioner, by regulation. Upon receipt of notification from the commissioner, the comptroller or a fiscal intermediary designated by the director of the budget shall withhold from the amount of any payment to be made by the state to a general hospital the amount of any arrearage resulting from such general hospital's failure to make a timely payment of the bad debt and charity care assessments. Upon withholding such amount, the comptroller or a designated fiscal intermediary shall pay the commissioner, or his designee, such amount withheld. Any general hospital in arrears resulting from failure to make a timely payment shall not be eligible for a distribution from the statewide pool in accordance with subdivision twenty-four of this section until such arrearage is satisfied.

28. Reimbursement rates. The assessments pursuant to subdivision twenty-three of this section shall not be an allowable cost in the determination of general hospital inpatient reimbursement rates in accordance with this section and section twenty-eight hundred seven of this chapter.