*** § 2807-j. Patient services payments.** 1. Payments to designated providers of services, as defined in paragraph (a) of subdivision one-a of this section, by all payors, including the state governmental agencies, corporations organized and operating in accordance with article forty-three of the insurance law, organizations operating in accordance with the provisions of article forty-four of this chapter, local governmental agencies, self-insured funds, commercial insurers, payors pursuant to the comprehensive motor vehicle insurance reparations act, the workers' compensation law, the volunteer firefighters' benefit law and the volunteer ambulance workers' benefit law, and any other rate, charge, or negotiated payment payor, for patient services provided to persons who are not eligible for payments as beneficiaries of title XVIII of the federal social security act (medicare) shall include a surcharge for an allowance on net patient service revenues in the percentage amount and for the periods specified in subdivision two of this section. Any such allowance shall be submitted by or on behalf of designated providers of services to the commissioner or the commissioner's designee in accordance with subdivision five of this section.

1-a. Definitions. (a) "Designated providers of services", for purposes of this section, shall mean providers of services in the following classes:

(i) general hospitals;

(ii) diagnostic and treatment centers that provide:

(A) a comprehensive range of primary health care services; or

(B) ambulatory surgical services; and

(iii) for periods prior to October first, two thousand, subject to the provisions of paragraph (d) of subdivision three of this section, free-standing clinical laboratories issued a permit pursuant to title five of article five of this chapter.

(b) "Third-party coverage", for purposes of this section, shall include, but not be limited to: payments by a governmental agency, insurer, health maintenance organization, self-insured fund, or other third-party entity making payments on behalf of a patient; whether made directly to a designated provider of services or indirectly as indemnity or similar payments made to the patient (or patient's representative

such as parent or family member) for services provided by a designated provider of services, or through the use of payments made payable to both the designated provider of services and the patient or patient's representative, or similar devices.

(c) "Third-party payors", for purposes of this section, shall include, but not be limited to: governmental agencies; corporations organized and operating in accordance with article forty-three of the insurance law; organizations operating in accordance with the provisions of article forty-four of this chapter; providers of coverage pursuant to the comprehensive motor vehicle insurance reparations act, the workers' compensation law, the volunteer firefighters' benefit law, and the volunteer ambulance workers' benefit law; self-insured funds and administrators acting on behalf of self-insured funds; and commercial insurers licensed to do business in this state and authorized to write accident and health insurance and whose policy provides coverage on an expense incurred basis.

2. (a) The total percentage allowance for any period during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand, for a designated provider of services applicable to a payor shall be determined in accordance with this subdivision and applied to net patient service revenues.

(b) The total percentage allowance for each payor, other than governmental agencies, or health maintenance organizations for services provided to subscribers eligible for medical assistance pursuant to title eleven of article five of the social services law, or approved organizations for services provided to subscribers eligible for the family health plus program pursuant to title eleven-D of article five of the social services law, and other than payments for a patient that has no third-party coverage in whole or in part for services provided by a designated provider of services, shall be:

(i) the sum of (A) eight and eighteen-hundredths percent, provided, however, that for services provided on and after July first, two thousand three, the percentage shall be eight and eighty-five hundredths percent, and further provided that for services provided on and after January first, two thousand six, the percentage shall be eight and

ninety-five hundredths percent, and further provided that for services provided on and after April first, two thousand nine, the percentage shall be nine and sixty-three hundredths percent, plus (B) twenty-four percent, provided, however, that for services provided on and after July first, two thousand three, the percentage shall be twenty-five and ninety-seven hundredths percent, and further provided that for services provided on and after January first, two thousand six, the percentage shall be twenty-six and twenty-six hundredths percent, and further provided that for services provided on and after April first, two thousand nine, the percentage shall be twenty-eight and twenty-seven hundredths percent, and plus (C) for a specified third-party payor as defined in subdivision one-a of section twenty-eight hundred seven-s of this article the percentage allowance applicable for a general hospital for inpatient hospital services pursuant to subdivision two of section twenty-eight hundred seven-s of this article;

(ii) unless (A) an election in accordance with paragraph (a) of subdivision five of this section to pay the allowance directly to the commissioner or the commissioner's designee is in effect for a third-party payor, and in addition (B) for a specified third-party payor an election to pay the assessment in accordance with section twenty-eight hundred seven-t of this article is in effect.

(c) If an election in accordance with subdivision five of this section is in effect for a third-party payor and in addition in accordance with section twenty-eight hundred seven-t of this article for a specified third-party payor, the total percentage allowance factor shall be reduced to eight and eighteen-hundredths percent, provided, however, that for services provided on and after July first, two thousand three the total percentage allowance factor shall be reduced to eight and eighty-five hundredths percent, and further provided that for services provided on and after January first, two thousand six, the total percentage allowance factor shall be reduced to eight and ninety-five hundredths percent, and further provided that for services provided on and after April first, two thousand nine, the total percentage allowance factor shall be reduced to nine and sixty-three hundredths percent.

(d) The total percentage allowance for payments by governmental agencies, as determined in accordance with paragraphs (a) and (a-1) of subdivision one of section twenty-eight hundred seven-c of this article

as in effect on December thirty-first, nineteen hundred ninety-six, or health maintenance organizations for services provided to subscribers eligible for medical assistance pursuant to title eleven of article five of the social services law, or approved organizations for services provided to subscribers eligible for the family health plus program pursuant to title eleven-D of article five of the social services law, shall be five and ninety-eight-hundredths percent, provided, however, that for services provided on and after July first, two thousand three the total percentage allowance shall be six and forty-seven hundredths percent, and further provided that for services provided on and after January first, two thousand six, the total percentage allowance shall be six and fifty-four hundredths percent, and further provided that for services provided on and after April first, two thousand nine, the total percentage allowance shall be seven and four hundredths percent.

(e) The total percentage allowance for payments for services provided by designated providers of services for which there is no third-party coverage in whole or in part shall be eight and eighteen-hundredths percent, provided, however, that for services provided on and after July first, two thousand three the total percentage allowance shall be eight and eighty-five hundredths percent, and further provided that for services provided on and after January first, two thousand six, the total percentage allowance shall be eight and ninety-five hundredths percent, and further provided that for services provided on and after April first, two thousand nine, the total percentage allowance shall be nine and sixty-three hundredths percent. This paragraph shall not apply to patient deductibles and coinsurance amounts.

(f) The total percentage allowance for patient deductibles and coinsurance amounts shall be the same percentage allowance applicable to payments by the primary third-party payor covering the patient in each case determined in accordance with paragraphs (a), (b) and (c) of this subdivision.

(g) The total percentage allowance for secondary third-party payors under coordination of benefits principles shall be the same percentage allowance applicable to payments by the primary third-party payor in the case determined in accordance with paragraphs (a), (b) and (c) of this subdivision.

3. Net patient service revenues, for purposes of this section, shall mean:

(a) for general hospitals all moneys received for or on account of inpatient hospital services, outpatient services (including referred ambulatory services), emergency services, ambulatory surgical services, and other hospital or health-related services, including capitation payments allocable to inpatient hospital services, outpatient services (including referred ambulatory services), emergency services, ambulatory surgical services and other hospital or health-related services excluding services listed below, less refunds, for discharges occurring or for visits made or services performed on or after January first, nineteen hundred ninety-seven, or contracted service obligations for periods on or after January first, nineteen hundred ninety-seven excluding the following subject to the provisions of subdivision eleven of this section:

(i) revenue received for services provided to beneficiaries of title XVIII of the federal social security act (medicare);

(ii) revenue received by a general hospital for residential health care facility services, adult day care services, hospice services, and home care services;

(iii) revenue received from the allowances pursuant to this section and section twenty-eight hundred seven-s of this article;

(iv) revenue received from bad debt and charity care and indigent care rate adjustments and pool distributions pursuant to section twenty-eight hundred seven-c of this article, general hospital indigent care pool distributions pursuant to section twenty-eight hundred seven-k of this article, health care services pool distributions pursuant to section twenty-eight hundred seven-c of this article, health care initiatives pool distributions pursuant to section twenty-eight hundred seven-l of this article, professional education pool distributions pursuant to section twenty-eight hundred seven-m of this article, tobacco control and insurance initiatives pool distributions pursuant to section twenty-eight hundred seven-v of this article, and high need indigent care adjustment pool distributions pursuant to section twenty-eight hundred seven-w of this article, provided, however, that funds received as medical assistance payments which include state share amounts authorized pursuant to section twenty-eight hundred seven-v of this

article that are not disproportionate share hospital payments shall be included within the meaning of net patient service revenue for the purposes of this section;

(v) revenue received from physician practice or faculty practice plan discrete billings for physician services;

(vi) revenue received by a general hospital from a public hospital pursuant to an affiliation agreement contract for the delivery of health care services to such public hospital;

(vii) revenue received from governmental deficit financing;

(viii) subject to the provisions of paragraph (d) of this subdivision, revenue received for or on account of referred ambulatory clinical laboratory visits made or services performed on and after October first, two thousand.

(b) for diagnostic and treatment centers providing services designated in subparagraph (ii) of paragraph (a) of subdivision one-a of this section all moneys received, including capitation payments allocable to diagnostic and treatment center services otherwise covered by the assessment, less refunds, for or on account of visits made or services performed on or after January first, nineteen hundred ninety-seven or contracted service obligations for periods on or after January first, nineteen hundred ninety-seven:

(i) for the following services:

(A) for diagnostic and treatment centers providing a comprehensive range of primary health care services, for all services;

(B) for diagnostic and treatment centers providing ambulatory surgical services, for all ambulatory surgical services;

(ii) excluding the following subject to the provisions of subdivision eleven of this section:

(A) revenue received for services provided to beneficiaries of title XVIII of the federal social security act (medicare);

(B) revenue received from the allowances pursuant to this section;

(C) revenue received from bad debt and charity care rate adjustments pursuant to paragraph (f) of subdivision two of section twenty-eight hundred seven of this article, health care services pool distributions pursuant to section twenty-eight hundred seven-c of this article, health care initiatives pool distributions pursuant to section twenty-eight hundred seven-l of this article, professional education pool

distributions pursuant to section twenty-eight hundred seven-m of this article, tobacco control and insurance initiatives pool distributions pursuant to section twenty-eight hundred seven-v of this article, and high need indigent care adjustment pool distributions pursuant to section twenty-eight hundred seven-w of this article;

(D) revenue received from physician practice or faculty practice plan discrete billings for physician services;

(E) for a diagnostic and treatment center operated by a health maintenance organization operating in accordance with the provisions of article forty-four of this chapter or article forty-three of the insurance law, revenue received for or on account of services provided to subscribers of such health maintenance organization;

(F) revenue received from governmental deficit financing; and

(G) subject to the provisions of paragraph (d) of this subdivision, revenue received for or on account of referred clinical laboratory visits made or services performed on and after October first, two thousand.

(c) for free-standing clinical laboratories, all moneys received, including capitation payments, less refunds, for or on account of visits made or services performed on or after January first, nineteen hundred ninety-seven and prior to October first, two thousand, subject to the provisions of paragraph (d) of this subdivision, or contracted service obligations for periods on or after January first, nineteen hundred ninety-seven and prior to October first, two thousand, subject to the provisions of paragraph (d) of this subdivision, for clinical laboratory services, excluding, subject to the provisions of subdivision eleven of this section:

(i) revenue received for services provided to beneficiaries of title XVIII of the federal social security act (medicare);

(ii) revenue received from the allowances pursuant to this section;

(iii) for a clinical laboratory operated by a health maintenance organization operating in accordance with the provisions of article forty-four of this chapter or article forty-three of the insurance law, revenue received for or on account of services provided to subscribers of such health maintenance organization; and

(iv) revenue received from governmental deficit financing.

(d) Provided, however, that if either the provisions of clause (G) of

subparagraph (ii) of paragraph (b) of this subdivision or subparagraph (viii) of paragraph (a) of this subdivision which exclude certain revenues from the definition of net patient service revenues for the purpose of imposing surcharges pursuant to this section, result in a determination of an impermissible provider tax by the secretary of the U.S. department of health and human services under the provisions of section 1903(w) of the federal social security act, then clause (G) of subparagraph (ii) of paragraph (b) of this subdivision, subparagraph (viii) of paragraph (a) of this subdivision, and sections forty-eight and forty-nine of chapter one of the laws of nineteen hundred ninety-nine are rendered null and void as of October first, two thousand. The commissioner will collect any retroactive amounts due as a result of surcharges imposed on such services on and after October first, two thousand, without interest or penalty.

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

(b) Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, at the discretion of the commissioner without a competitive bid or request for proposal process, contracts in effect for administration of bad debt and charity care pools for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred

ninety-six pursuant to section twenty-eight hundred seven-c of this article may be extended to provide for administration pursuant to this section and distributions of allowance and assessment funds pursuant to this article and may be amended as may be necessary.

(c) The commissioner shall contract with an independent certified public accountant to conduct an annual independent audit, in conformance with generally accepted auditing standards, of the receipts, disbursements, revenues, expenditures and cash flows of funds, for each calendar year beginning with nineteen hundred eighty-three, through the most recent calendar year. As used in this section, "funds" shall mean:

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

(ii) Funds accumulated and pooled pursuant to chapters five hundred thirty-six, five hundred thirty-seven and five hundred thirty-eight of the laws of nineteen hundred eighty-two, chapters eight hundred seven and nine hundred six of the laws of nineteen hundred eighty-five, chapters two and six hundred five of the laws of nineteen hundred eighty-eight, chapters nine hundred twenty-two and nine hundred twenty-three of the laws of nineteen hundred ninety, chapter seven hundred thirty-one of the laws of nineteen hundred ninety-three and chapter eighty-one of the laws of nineteen hundred ninety-five.

Such annual independent audit shall be submitted to the director of the budget, the temporary president of the senate and the speaker of the assembly no later than April fifteenth of each year.

5. (a) Any third-party payor for services provided by a designated provider of services may make an election to make payments on an aggregated basis of funds due from the allowance determined pursuant to subdivision two of this section directly to the commissioner or the commissioner's designee on behalf of designated providers of services.

(i) The election pursuant to this paragraph to be effective must be in writing, filed with the commissioner or the commissioner's designee on such forms and in such manner as the commissioner shall require. An election must apply to all classes of designated providers of service

and to all providers within each class. An election by a payor shall take effect for nineteen hundred ninety-seven, on the next following January first, April first, July first, or October first, and for each calendar year thereafter on the next following January first, not less than thirty days after the election is filed. Beginning December first, nineteen hundred ninety-seven, an election pursuant to this paragraph must be made no later than December first of the year prior to the assessment year. However, any payor licensed pursuant to the insurance law or certified pursuant to article forty-four of this chapter between December first of the year prior to the assessment year and December thirty-first of the assessment year may make an election subsequent to such licensure, and during said time period, to take effect on the next following January first, April first, July first or October first not less than thirty days after such election is filed. Payors other than those licensed pursuant to the insurance law or certified pursuant to this chapter which have not provided third-party coverage prior to December first of the year prior to the assessment year may make an election at any time from December first of the year prior to said assessment year to December thirty-first of the assessment year, to take effect on the next following January first, April first, July first or October first not less than thirty days after the election is filed. Beginning June first, two thousand three an election by any payor or organization shall begin on the first day of the month following the date it was received by the commissioner.

(ii) An election shall remain in effect unless revoked in writing by a specified third-party payor, which revocation shall be effective on the first day of the next month, provided that such payor has provided notice of its intention to so revoke at least twenty days prior to the beginning of such month.

(iii) A payor filing an election pursuant to this paragraph must agree:

(A) to provide reports in accordance with the provisions of paragraph (b) of subdivision seven of this section;

(B) to provide such certification of data and access to allowance expenditure data for audit verification purposes as the commissioner shall require for purposes of this section; and

(C) to the jurisdiction of the state to maintain an action in the

courts of the state of New York to enforce any provision of this section related to payment of the allowances.

(D) for periods on and after January first, two thousand nine, to provide the commissioner or the commissioner's designee the payor's federal tax identification number and agree to the use of such identification number in connection with identifying the payor's election status to designated providers of services, including the posting of such identification numbers on secure websites maintained by the commissioner or the commissioner's designee in furtherance of the purposes of this section. The commissioner shall include for periods on and after January first, two thousand nine on such secure websites, the date such payor was first posted.

(iv) If a payor is acting in an administrative services capacity on behalf of an organization, such as a self-insured fund, the consent of the organization to the election and the conditions pursuant to subparagraph (iii) of this paragraph must be submitted with the election. Such consent may be set forth in writing in the agreement between the payor and the organization and a photocopy of that portion of the agreement submitted by the payor, together with a photocopy of the signatures of the organization and the payor on the agreement, shall be accepted in lieu of a separate election form from the organization. On and after January first, two thousand four, the commissioner shall have discretion to accept payments made on a timely basis if the reports and information reports are routinely submitted, notwithstanding the fact that the full and complete election form by or on behalf of an organization was not filed on a timely basis. In the event the commissioner accepts payments pursuant to this section where an election form is missing or incomplete but the payments and information reports were routinely submitted as if the election forms had been filed, the election form from the payor and organization shall be deemed to have been filed (and the organization and the payor shall be as legally bound by the terms of the election form as if it had signed and filed the election) and neither the payor nor the organization shall subsequently refuse to abide by the terms of the election form for any year in which payments were submitted and accepted pursuant to this section.

(v) If a payor, including a payor operating in accordance with the insurance law or article forty-four of this chapter, making an election

pursuant to this paragraph is acting in an administrative services capacity on behalf of an organization or organizations, such payor must specify whether such election applies to payments on behalf of all such organizations and establish, in accordance with guidelines established by the superintendent of financial services, a system through which designated providers of services and the commissioner can identify the status of a patient as a patient for whom the election does not apply.

(b) The commissioner may deny a payor the opportunity to remit directly to the commissioner or the commissioner's designee based on repeated late payments, failure to remit correct amounts, or failure to provide adequate verification of the accuracy of payments. The percentage allowance for any such payor shall be the percentage determined in accordance with paragraph (b) of subdivision two of this section.

(c) The commissioner or the commissioner's designee shall make available to all designated providers of services a list of the payors which have elected pursuant to this paragraph to remit payments directly.

5-a. (a) Payments by or on behalf of designated providers of services to the commissioner or the commissioner's designee of funds due from the allowances pursuant to subdivision two of this section or pursuant to payment obligations incurred pursuant to section twenty-eight hundred seven-s of this article or section twenty-eight hundred seven-t of this article shall be made on a monthly basis, provided, however, that for reporting periods relating to payments for services provided or dates of inpatient discharge or contracted service obligations occurring on or after January first, two thousand one, the commissioner may permit certain third-party payors which have at least one full year of pool payment experience to submit such payments on an annual basis, based on an annual demonstration by a payor through its prior year's pool payment experience that total pool obligations under this section and sections twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article are not expected to exceed ten thousand dollars for annual periods prior to January first, two thousand four, and twenty-five thousand dollars for annual periods on and after January first, two thousand four. Payments due by designated providers of services on

account of payors in accordance with paragraph (b) of subdivision two of this section shall be two percentage points less than the percentage specified in such paragraph. The designated provider of services shall retain for compensation for such provider's administrative responsibilities the amount that represents the difference. Payments due by designated providers of services on account of all other payors shall be calculated on the basis of the percentage allowance applicable to such payor pursuant to paragraphs (d), (e), (f) and (g) of subdivision two of this section. Payments shall be due on or before the thirtieth day following the end of a calendar month to which an allowance applies.

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

6. (a) If a payment made by a designated provider of services for a month to which an allowance applies is less than seventy percent of the amount due or which the commissioner estimates is due, based on available financial and statistical data, the commissioner may collect the deficiency pursuant to paragraph (c) of this subdivision.

(b) If a payment made by a designated provider of services for a month to which an allowance applies is less than ninety percent of the amount due or which the commissioner estimates is due, based on available

financial and statistical data, and at least two previous payments within the preceding six months were less than ninety percent of the amount due, based on similar evidence, the commissioner may collect the deficiency pursuant to paragraph (c) of this subdivision.

(c) Upon receipt of notification from the commissioner of a designated provider of services' deficiency under this section, the comptroller or a fiscal intermediary designated by the director of the budget, or the commissioner of the office of temporary and disability assistance, 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 by such article forty-three corporation or article forty-four organization to the designated provider of services the amount of the deficiency determined under paragraph (a), (b) or (e) of this subdivision or paragraph (d) of subdivision eight-a of this section. Upon withholding such amount, the comptroller or a designated fiscal intermediary, or the commissioner of the office of temporary and disability assistance, or corporation organized and operating in accordance with article forty-three of the insurance law or organization operating in accordance with article forty-four of this chapter shall pay the commissioner, or the commissioner's designee, such amount withheld on behalf of the designated provider of services. Such amount shall represent, in whole or in part, the amounts due from the designated provider of services.

(d) The commissioner shall provide a designated provider of services with notice of any estimate of an amount due for an allowance pursuant to paragraph (a) or (b) of this subdivision or paragraph (d) of subdivision eight-a of this section at least three days prior to collection of such amount by the commissioner. Such notice shall contain the financial basis for the commissioner's estimate.

(e) In the event a designated provider of services objects to an estimate by the commissioner pursuant to paragraph (a) or (b) of this subdivision or paragraph (d) of subdivision eight-a of this section of the amount due for an allowance, the designated provider of services, within sixty days of notice of an amount due, may request a public hearing. If a hearing is requested, the commissioner shall provide the designated provider of services an opportunity to be heard and to

present evidence bearing on the amount due for an allowance within thirty days after collection of an amount due or receipt of a request for a hearing, whichever is later. An administrative hearing is not a prerequisite to seeking judicial relief.

(f) The commissioner may direct that a hearing be held without any request by a designated provider of services.

(g) In the event a hearing pursuant to paragraph (e) of this subdivision is not requested and the delinquent amounts in question have been referred for recoupment or offset pursuant to paragraph (c) of this subdivision, or have been referred to the office of the attorney general for collection, the amount of such delinquencies shall be deemed final and not subject to further revision or reconciliation by the commissioner based on any additional reports or other information submitted by the designated provider of services, provided, however, that such delinquencies shall not be referred for such recoupment or for such collection based on estimated amounts unless the hospital has received written notification of such delinquencies and has been given no less than thirty days in which to submit delinquent reports.

7. (a) (i) Every designated provider of services shall submit reports of net patient service revenues received for or on account of patient services for each month which shall be in such form as may be prescribed by the commissioner to accurately disclose information required to implement this section. For periods on and after January first, two thousand five, reports by designated providers of services shall be submitted electronically in a form as may be required by the commissioner; provided, however, any designated provider of services is not prohibited from submitting reports electronically on a voluntary basis prior to such date, and provided further, however, that all such electronic submissions submitted on and after July first, two thousand twelve shall be verified with an electronic signature as prescribed by the commissioner.

(ii) For periods on and after January first, two thousand nine, every designated provider of services shall provide the commissioner or commissioner's designee with its federal tax identification number and such identification number shall be used in connection with identifying such providers for purposes pursuant to this section, including the

posting of such identification numbers on secure websites maintained by the commissioner or the commissioner's designee in furtherance of the purposes of this section. The commissioner shall include for periods on and after January first, two thousand nine on such secure websites, the date such designated provider of services was first posted. In addition, the commissioner shall, as a part of a final resolution of an audit conducted pursuant to subdivision eight-a of this section, waive payment of interest and penalties otherwise applicable pursuant to subdivision eight of this section, when the audit findings conclusively indicate that the liability for such interest and penalties are the result of a delay in the listing of a new designated provider of services on the secure website maintained by the department.

(b) (i) Every third-party payor making an election in accordance with paragraph (a) of subdivision five of this section shall submit reports of patient service expenditures for services provided by designated providers of services for each month which shall be in such form as may be prescribed by the commissioner to accurately disclose information required to implement this section, provided, however, that for reporting periods relating to payments for services provided or dates of inpatient discharge or contracted service obligations occurring on or after January first, two thousand one, the commissioner may permit certain third-party payors which have at least one full year of pool payment experience to submit such reports on an annual basis, based on an annual demonstration by a payor through its prior year's pool payment experience that total pool obligations under this section and sections twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article are not expected to exceed ten thousand dollars for annual periods prior to January first, two thousand four, and twenty-five thousand dollars for annual periods on and after January first, two thousand four.

(ii) For periods on and after July first, two thousand four, reports submitted on a monthly basis by third-party payors in accordance with subparagraph (i) of this paragraph and reports submitted on a monthly or annual basis by payors acting in an administrative services capacity on behalf of electing third-party payors in accordance with subparagraph (i) of this paragraph shall be made electronically in a form as may be required by the commissioner; provided, however, any third-party payor,

except payors acting in an administrative services capacity on behalf of electing third-party payors, which, on or after January first, two thousand four, elects to make payments directly to the commissioner or the commissioner's designee pursuant to subdivision five of this section, shall be subject to this subparagraph only after one full year of pool payment experience which results in reports being submitted on a monthly basis, and provided further, however, that all such electronic submissions submitted on and after July first, two thousand twelve shall be verified with an electronic signature as prescribed by the commissioner. This subparagraph shall not be interpreted to prohibit any third-party payor from submitting reports electronically on a voluntary basis.

(c) If a designated provider of services or a third-party payor fails to file reports required pursuant to paragraph (a) or (b) of this subdivision and which are due on and after January first, two thousand, within sixty days of the date such reports are due and after notification of such reporting delinquency, the commissioner may assess a civil penalty of up to ten thousand dollars for each such failure, provided, however, that such civil penalty shall not be imposed if the payor or provider demonstrates good cause for the failure to timely file such reports. Such penalties shall be subject to the provisions of section twelve-a of this chapter.

8. (a) If a payment made pursuant to this section or to section twenty-eight hundred seven-s or twenty-eight hundred seven-t of this article for a month to which an allowance applies is less than ninety percent of the amount due or which the commissioner estimates, based on available financial and statistical data, is due for such month, interest shall be due and payable to the commissioner by a designated provider of services, or by a third-party payor, other than a state governmental agency, that has elected to pay an allowance directly, on the difference between the amount paid and the amount due or estimated to be due from the day of the month the payment was due until the date of payment. The rate of interest shall be twelve percent per annum or, if greater, at the rate of interest set by the commissioner of taxation and finance with respect to underpayments of tax pursuant to subsection (e) of section one thousand ninety-six of the tax law minus four

percentage points. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar. Interest due from a designated provider of services, if not paid by the due date of the following month's payment, may be collected by the commissioner pursuant to paragraph (c) of subdivision six of this section in the same manner as an allowance pursuant to subdivision two of this section.

(b) If a payment made for a month to which an allowance applies is less than seventy percent of the amount due or which the commissioner estimates, based on available financial and statistical data, is due for such month, a penalty shall be due and payable to the commissioner by a designated provider of services, or by a third-party payor, other than a state governmental agency, that has elected to pay an allowance directly, of five percent of the difference between the amount paid and the amount due or estimated to be due for such month when the failure to pay is for a duration of not more than one month after the due date of the payment with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding twenty-five percent in the aggregate. A penalty due from a designated provider of services may be collected by the commissioner pursuant to paragraph (c) of subdivision six of this section in the same manner as an allowance pursuant to subdivision two of this section.

(c) Overpayment by or on behalf of a designated provider of services of a payment shall be applied to any other payment due from the designated provider of services pursuant to this section, or, if no payment is due, at the election of the designated provider of services shall be applied to future payments or refunded to the designated provider of services. Interest shall be paid on overpayments from the date of overpayment to the date of crediting or refund at the rate determined in accordance with paragraph (a) of this subdivision only if the overpayment was made at the direction of the commissioner. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar.

8-a. (a) Payments and reports submitted or required to be submitted to the commissioner or to the commissioner's designee pursuant to this section and section twenty-eight hundred seven-s of this article by designated providers of services and by third-party payors which have

elected to make payments directly to the commissioner or to the commissioner's designee in accordance with subdivision five-a of this section, shall be subject to audit by the commissioner for a period of six years following the close of the calendar year in which such payments and reports are due, after which such payments shall be deemed final and not subject to further adjustment or reconciliation, including through offset adjustments or reconciliations made by designated providers of services or by third-party payors with regard to subsequent payments, provided, however, that nothing herein shall be construed as precluding the commissioner from pursuing collection of any such payments which are identified as delinquent within such six year period, or which are identified as delinquent as a result of an audit commenced within such six year period, or from conducting an audit of any adjustment or reconciliation made by a designated provider of services or by a third party payor which has elected to make such payments directly to the commissioner or the commissioner's designee, or from conducting an audit of payments made prior to such six year period which are found to be commingled with payments which are otherwise subject to timely audit pursuant to this section.

(b) Designated providers of services or third-party payors which, in the course of an audit pursuant to this section or section twenty-eight hundred seven-s of this article, fail to produce data or documentation requested in furtherance of such an audit, within thirty days of such request, may be assessed a civil penalty of up to ten thousand dollars for each such failure, provided, however, that such civil penalty shall not be imposed if the audited entity demonstrates good cause for such failure. The imposition of civil penalties pursuant to this section shall be subject to the provisions of section twelve-a of this chapter.

(c) Records required to be retained for audit verification purposes by designated providers of services and third-party payors in accordance with this section and section twenty-eight hundred seven-s of this article shall include, but not be limited to, on a monthly basis, the source records generated by supporting information systems, detailed claims information, detailed patient revenue information, capitation arrangements, financial accounting records, relevant correspondence and such other records as may be required to prove compliance with, and to support the reports submitted in accordance with, this section and

section twenty-eight hundred seven-s of this article.

(d) If a designated provider of services or a third party payor fails to produce data or documentation requested in furtherance of an audit pursuant to this section or pursuant to section twenty-eight hundred seven-s of this article, for a month to which an allowance applies, the commissioner may estimate, based on available financial and statistical data as determined by the commissioner, the amount due for such month. If the impact of the patient services revenue exemptions specified pursuant to this section, or pursuant to section twenty-eight hundred seven-s of this article, cannot be determined from such available financial and statistical data, the amount due may be calculated on the basis of the aggregate total of patient services revenue derived from such data for the year subject to audit. The commissioner shall take all necessary steps to collect amounts due as determined pursuant to this paragraph, including directing the state comptroller to offset such amounts due from any payments made by the state pursuant to this article to a designated provider of services or a third party payor. Interest and penalties shall be applied to such amounts due in accordance with the provisions of subdivision eight of this section.

(e) The commissioner may, as part of a final resolution of an audit conducted pursuant to this subdivision, waive payment of interest and penalties otherwise applicable pursuant to subdivision eight of this section when amounts due as a result of such audit, other than such waived penalties and interest, are paid in full to the commissioner or the commissioner's designee within sixty days of the issuance of a final audit report that is mutually agreed to by the commissioner and auditee, provided, however, that if such final audit report is not so mutually agreed upon, then neither the commissioner nor the auditee shall have any obligations pursuant to this paragraph.

(f) The commissioner may enter into agreements with designated providers of services, and with third-party payors, in regard to which audit findings or prior settlements have been made pursuant to this section or section twenty-eight hundred seven-s of this article, extending and applying such audit findings or prior settlements, or a portion thereof, in settlement and satisfaction of potential audit liabilities for subsequent un-audited periods. The commissioner may reduce or waive payment of interest and penalties otherwise applicable

to such subsequent unaudited periods when such amounts due as a result of such agreement, other than reduced or waived penalties and interest, are paid in full to the commissioner or the commissioner's designee within sixty days of execution of such agreement by all parties to the agreement. Any payments made pursuant to agreements entered into in accordance with this paragraph shall be deemed to be in full satisfaction of any liability arising under this section and section twenty-eight hundred seven-s of this article, as referenced in such agreements and for the time periods covered by such agreements, provided, however, that the commissioner may audit future retroactive adjustments to payments made for such periods based on reports filed by providers and payors subsequent to such agreements.

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

(a) funds shall be deposited and credited to a special revenue-other fund to be established by the comptroller or to the health care reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable. To the extent of funds appropriated therefore, the commissioner shall make payments to general hospitals related to bad debt and charity care pursuant to section twenty-eight hundred seven-k of this article. Funds shall be deposited in the following amounts:

(i) fifty-seven and thirty-three-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven,

(ii) fifty-seven and one-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight,

(iii) fifty-five and thirty-two-hundredths percent of the funds

accumulated for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, and

(iv) seven hundred sixty-five million dollars annually of the funds accumulated for the periods January first, two thousand through December thirty-first, two thousand twenty-eight, and

(v) one hundred ninety-one million two hundred fifty thousand dollars of the funds accumulated for the period January first, two thousand twenty-nine through March thirty-first, two thousand twenty-nine.

(b) funds shall be accumulated in a health care initiatives pool established by the commissioner, for distribution in accordance with section twenty-eight hundred seven-l of this article, in the following amounts:

(i) forty-two and sixty-seven-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven,

(ii) forty-two and ninety-nine-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight,

(iii) forty-four and sixty-eight-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, and

(iv) the remaining balance of the funds accumulated for each period on and after January first, two thousand.

10. Notwithstanding any inconsistent provision of law or regulation to the contrary, the allowances applicable to payments by state governmental agencies pursuant to subdivision two of this section shall be reflected in the determination of reimbursement rates pursuant to sections twenty-eight hundred seven and twenty-eight hundred seven-c of this article and fees for clinical laboratory services under the medical assistance program.

11. Each exclusion from the allowances effective on or after January first, nineteen hundred ninety-seven established pursuant to this section shall be contingent upon either: (a) qualification of the allowances for waiver pursuant to federal law and regulation; or (b) consistent with federal law and regulation, not requiring a waiver by

the secretary of the department of health and human services related to such exclusion; in order for the allowances under this section to be qualified as a broad-based health care related tax for purposes of the revenues received by the state pursuant to the allowances not reducing the amount expended by the state as medical assistance for purposes of federal financial participation. The commissioner shall collect the allowances relying on such exclusions, pending any contrary action by the secretary of the department of health and human services. In the event the secretary of the department of health and human services determines that the allowances do not so qualify based on any such exclusion, then the exclusion shall be deemed to have been null and void as of January first, nineteen hundred ninety-seven, and the commissioner shall collect any retroactive amount due as a result, without interest or penalty provided the designated provider of services or third-party payor that has elected to pay directly pays the retroactive amount due within ninety days of notice from the commissioner to the designated provider of services or third-party payor that has elected to pay directly that an exclusion is null and void. Interest and penalties shall be measured from the due date of ninety days following notice from the commissioner or the commissioner's designee to the designated provider of services or third-party payor that has elected to pay directly.

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 of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision eighteen 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.

* NB Expires December 31, 2029