

§ 2807-k. General hospital indigent care pool. 1. Definitions. For purposes of this section, the following words or phrases shall have the following meanings, unless the context otherwise requires:

(a) "Major public general hospital" means all state operated general hospitals, all general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine as amended and all other public general hospitals having annual inpatient operating costs in excess of twenty-five million dollars.

(b) "Nominal payment amount" shall mean the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to a scale.

(c) "Targeted need" shall mean the relationship of uncompensated care need to reported costs expressed as a percentage. Reported costs shall mean costs allocated as prescribed by the commissioner to general hospital inpatient and ambulatory services, excluding referred ambulatory services. Targeted need shall be determined based on base year data and statistics for the calendar year two years prior to the distribution period. Base year data and statistics for the calendar year two years prior to the distribution period shall be considered final, for purposes of this section, one hundred twenty days after hospitals receive the department's initial statewide rates for the same period as the distribution period and shall include any appropriate revisions reported by hospitals during such one hundred twenty days.

(d) "Uncompensated care need" means losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient and ambulatory services, excluding referred ambulatory services. The cost of services provided as an employment benefit or as a courtesy shall not be included.

(e) "Uninsured care" means losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient and ambulatory services, excluding referred ambulatory services, which are not eligible for payment in whole or in part by a governmental agency, insurer or other third-party payor on behalf of a patient, including payments made directly to the general hospital and indemnity or similar payments made to the person who is a payor of hospital services. The

cost of services denied reimbursement, other than emergency room services, for lack of medical necessity or lack of compliance with prior authorization requirements, or provided as an employment benefit, or as a courtesy shall not be included.

(f) "Ambulatory services" of a general hospital shall mean all services delivered on an ambulatory basis, including, for periods on and after January first, two thousand four, services provided at qualified hospital-controlled diagnostic and treatment centers except as otherwise provided in subdivision thirteen of this section.

(g) "Qualified hospital-controlled diagnostic and treatment center" shall mean a voluntary, non-profit diagnostic and treatment center providing a comprehensive range of primary health care services that is controlling, controlled by, or under common control with a general hospital, and as of June thirtieth, two thousand three:

(i) qualified for an allocation of funds pursuant to section twenty-eight hundred seven-p of this article or pursuant to section seven of chapter four hundred thirty-three of the laws of nineteen hundred ninety-seven, as amended; or

(ii) the outpatient department of such general hospital had been designated a federally-qualified health center under section 330 of the Public Health Service Act (42 U.S.C. § 254b) and had directly received a grant under such section.

(h) "Underinsured" shall mean an individual with out of pocket medical costs accumulated in the past twelve months that amount to more than ten percent of such individual's gross annual income.

2. To the extent of funds appropriated therefor, funds shall be made available for distribution by or on behalf of the state in accordance with the following methodology, as payments under the state medical assistance program provided pursuant to title eleven of article five of the social services law, from a general hospital indigent care pool established by the commissioner.

3. Each major public general hospital shall be allocated for distribution from the pools established pursuant to this section for each year through December thirty-first, two thousand fourteen, an amount equal to the amount allocated to such major public general

hospital from the regional pool established pursuant to subdivision seventeen of section twenty-eight hundred seven-c of this article for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six, provided, however, that payments on and after January first, two thousand nine shall be subject to the provisions of subdivision five-a of this section.

4. (a) From funds in the pool for each year, thirty-six million dollars shall be reserved on an annual basis through December thirty-first, two thousand fourteen, for distribution as high need adjustments in accordance with subdivision six of this section, provided, however, that payments on and after January first, two thousand nine shall be subject to the provisions of subdivision five-a of this section.

(a-1) From funds in the pool for each year, twenty-seven million dollars shall be reserved on an annual basis for the periods January first, two thousand through December thirty-first, two thousand ten, for distribution in accordance with subdivision sixteen of this section, provided, however, that payments on and after January first, two thousand nine through December thirty-first, two thousand nine shall be subject to the provisions of subdivisions five-a and five-b of this section, and shall be subject to the provisions of subdivision five-b of this section for periods on and after January first, two thousand ten.

(b) The balance of funds in a pool not allocated in accordance with subdivision three of this section or reserved for distributions pursuant to subdivisions six and sixteen of this section shall be distributed to eligible general hospitals, excluding major public general hospitals, on the basis of each general hospital's targeted need share, adjusted for transition factors in accordance with subdivision seven of this section.

(c) To be eligible for distributions from the pool, a general hospital's targeted need must exceed one-half of one percent.

(d) For the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, and January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine and on and after January first, two thousand, each eligible general

hospital's targeted need share shall mean the relationship of each general hospital's nominal payment amount of uncompensated care need determined in accordance with the scale specified in subdivision five of this section to the nominal payment amounts of uncompensated care need for all eligible general hospitals applied to funds available in the pool.

5. The scale utilized for development of each eligible general hospital's nominal payment amount shall be as follows:

Targeted Need Percentage		Percentage of Reimbursement Attributable to that Portion of Targeted Need
0	-.5%	60%
.5+	-2%	65%
2+	-3%	70%
3+	-4%	75%
4+	-5%	80%
5+	-6%	85%
6+	-7%	90%
7+	-8%	95%
8+		100%

5-a. Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law, subject to the availability of federal financial participation and within amounts appropriated, for periods on and after January first, two thousand nine, ten percent of the aggregate distributions to each general hospital made otherwise pursuant to this section and section twenty-eight hundred seven-w of this article shall be reserved and set aside and distributed in accordance with the following:

(a) Thirteen million nine hundred thirty thousand dollars of such reserved funds shall be distributed to major public hospitals and shall be allocated proportionally, based on each facility's relative uncompensated care need as determined in accordance with the provisions of paragraph (c) of this subdivision; and

(b) Seventy million seven hundred seventy thousand dollars of such

reserved funds shall be distributed to general hospitals other than major public general hospitals and shall be allocated proportionally, based on each facility's relative uncompensated care need as determined in accordance with the provisions of paragraph (c) of this subdivision; and

(c) For the purposes of distributions in accordance with paragraphs (a) and (b) of this subdivision, each facility's relative uncompensated care need amount shall be determined in accordance with the following:

(i) inpatient units of services for all uninsured patients from the calendar year two years prior to the distribution year, but excluding referred ambulatory units of services, shall be multiplied by the applicable Medicaid inpatient rates in effect for such prior year, but not including prospective rate adjustments and rate add-ons, provided, however, that for distributions on and after January first, two thousand ten, the uncompensated amount for inpatient services shall utilize the inpatient rates in effect as of July first of the prior year;

(ii) outpatient units of service for all uninsured patients from the calendar year two years prior to the distribution year, including emergency department services and ambulatory surgery services, but excluding referred ambulatory services units of service, shall be multiplied by Medicaid outpatient rates that reflect the exclusive utilization of the ambulatory patient groups (APG) rate-setting methodology as set forth in regulations promulgated pursuant to subdivision two-a of section twenty-eight hundred seven of this article, as in effect for the distribution year, provided further, however, that for those services for which APG rates are not available the applicable Medicaid outpatient rate shall be the rate in effect for the calendar year two years prior to the distribution year;

(iii) the uncompensated care need for each facility for periods on and after January first, two thousand ten shall be reduced by the sum of all payment amounts collected from such patients; and

(iv) the total uncompensated care need for each facility subject to this subdivision shall then be adjusted by application of the nominal need scale set forth in subdivision five of this section.

(d)(i) For annual periods commencing on and after January first, two thousand nine, no general hospital may receive disproportionate share payment distributions made in accordance with this section, section

twenty-eight hundred seven-w of this article or made in accordance with other provisions of law, that exceed, in aggregate, the costs incurred by such general hospital during such period in furnishing inpatient and outpatient hospital services to Medicaid eligible patients or to patients who have no health insurance or other source of third party coverage, net of all monies received from non-disproportionate share related Medicaid payments and from payments made by such uninsured patients. For purposes of this paragraph, non-Medicaid payments made to a general hospital by the state or by a unit of local government within the state for services provided to indigent patients shall not be considered to be a source of third party payment.

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

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

(B) payments made to eligible hospitals pursuant to this section and section twenty-eight hundred seven-w of this article.

(iii) Notwithstanding any contrary provision of this section or section twenty-eight hundred seven-w of this article, in the event a payment made pursuant to this section or section twenty-seven hundred seven-w of this article exceeds a hospital's applicable facility specific disproportionate share limit, then fifty percent of the amount in excess of such limit shall be paid to such facility as a grant from state funds available for distribution in accordance with this section and section twenty-eight hundred seven-w of this article, provided, however, that if payments made to an eligible rural hospital pursuant to this subdivision or section twenty-eight hundred seven-w of this article, result in payments in excess of such disproportionate share limits, then up to one hundred forty thousand dollars of such payments shall be made at one hundred percent of the amount in excess of such limits for each eligible rural hospital.

(e) By no later than December first, two thousand ten, the commissioner shall issue a report evaluating the impact of the distributions made pursuant to this subdivision with regard to units of service to uninsured patients provided by each facility, and with regard to the extent of services provided by each facility to patients eligible for financial aid in accordance with each facility's financial aid

policies and procedures as mandated by subdivision nine-a of this section. Such report shall also include the use of data on services to the uninsured to model the impact of the distribution methodology set forth in this subdivision against all funding authorized pursuant to this section and section twenty-eight hundred seven-w of this article.

(f) The commissioner shall conduct outreach and educational activities to inform hospitals on matters relating to data collection and reporting requirements related to services provided to the uninsured and patients eligible for financial aid, including definitions to be utilized for identifying uninsured units of service and proper identification of out-of-pocket collections from uninsured patients.

5-b. Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law and subject to the availability of federal financial participation, for periods on and after May first, two thousand nine, funds as hereinafter described shall be reserved and set aside and distributed in accordance with the following:

(a) For the period May first, two thousand nine through December thirty-first, two thousand nine payments shall be made as follows:

(i) Ninety percent of funds available for the two thousand nine calendar year pursuant to paragraph (a-1) of subdivision four of this section shall be reserved and set aside and distributed as Medicaid disproportionate share (DSH) payments to the same hospitals and in the same proportional amounts as received pursuant to such paragraph (a-1) in two thousand eight;

(ii) Three hundred seven million dollars shall be distributed as Medicaid DSH payments to facilities designated by the department as teaching hospitals as of December thirty-first, two thousand eight in accordance with a schedule of payments to be set forth in regulations promulgated by the commissioner to compensate such facilities for Medicaid and self-pay losses reported in each facility's two thousand seven annual cost report;

(iii) Sixteen million dollars shall be proportionally distributed as Medicaid DSH payments to non-teaching hospitals based upon their proportion of uninsured losses as defined in paragraph (c) of subdivision five-a of this section to such losses of all non-teaching

hospitals on a statewide basis;

(iv) Twenty-five million dollars shall be distributed as Medicaid DSH payments to non-major public hospitals having Medicaid discharges of forty percent or greater as established by the commissioner from data reported in each hospital's two thousand seven annual cost report, in accordance with a schedule to be set forth in regulations promulgated by the commissioner, to compensate such facilities for projected Medicaid net losses, as determined by the commissioner, stemming from modifications to Medicaid payments made pursuant to a chapter of the laws of two thousand nine.

(b) For annual periods beginning January first, two thousand ten payments shall be made as follows:

(i) Two hundred sixty-nine million five hundred thousand dollars shall be distributed as Medicaid DSH payments to non-major public teaching hospitals, and such distributions shall be made on a regional basis to cover, within amounts available for each region, each eligible facility's proportional regional share of unmet need for two thousand seven, provided, however, that such regions and regional allocations and the definition of unmet need shall be set forth in regulations promulgated by the commissioner;

(ii) Twenty-five million dollars shall be distributed as Medicaid DSH payments to hospitals eligible for payments made pursuant to subparagraph (iv) of paragraph (a) of this subdivision based upon each facility's proportion of uninsured losses, as defined in paragraph (c) of subdivision five-a of this section, to such losses for all hospitals eligible for such payments;

(iii) Sixteen million dollars shall be distributed in accordance with the provisions of subparagraph (iii) of paragraph (a) of this subdivision;

(iv) Twenty-five million dollars shall be distributed in accordance with the provisions of subparagraph (iv) of paragraph (a) of this subdivision;

5-c. (a) Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for the period July first, two thousand ten through December thirty-first, two thousand ten, distributions pursuant to this section and section twenty-eight hundred

seven-w of this article, shall reflect an aggregate reduction of sixty-nine million four hundred thousand dollars, based on the proportion of each hospital's indigent care allocations to the total allocations of all hospitals' indigent care allocations prior to application of this reduction, provided, however, that such reductions shall not be applied to distributions to major public hospitals, including major public hospitals operated by public benefit corporations, and also shall not be applied to distributions made pursuant to subparagraph (ii), (iii) or (iv) of paragraph (b) of subdivision five-b of this section.

(b) Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for the period January first, two thousand eleven through December thirty-first, two thousand eleven and each calendar year thereafter, distributions pursuant to this section and section twenty-eight hundred seven-w of this article shall reflect an aggregate reduction of seventy-three million two hundred thousand dollars, based on the proportion of each hospital's indigent care allocation to the total allocations of all hospitals' indigent care allocations prior to application of this reduction, provided, however, that such reductions shall not be applied to distributions to major public hospitals, including major public hospitals operated by public benefit corporations, and shall also not be applied to distributions made pursuant to subparagraph (ii), (iii) or (iv) of paragraph (b) of subdivision five-b of this section.

5-d. (a) Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law, and subject to the availability of federal financial participation, for periods on and after January first, two thousand twenty, through December thirty-first, two thousand twenty-nine, all funds available for distribution pursuant to this section, except for funds distributed pursuant to paragraph (b) of subdivision five-b of this section, and all funds available for distribution pursuant to section twenty-eight hundred seven-w of this article, shall be reserved and set aside and distributed in accordance with the provisions of this subdivision.

(b) The commissioner shall promulgate regulations, and may promulgate

emergency regulations, establishing methodologies for the distribution of funds as described in paragraph (a) of this subdivision and such regulations shall include, but not be limited to, the following:

(i) Such regulations shall establish methodologies for determining each facility's relative uncompensated care need amount based on uninsured inpatient and outpatient units of service from the cost reporting year two years prior to the distribution year, multiplied by the applicable medicaid rates in effect January first of the distribution year, as summed and adjusted by a statewide cost adjustment factor and reduced by the sum of all payment amounts collected from such uninsured patients, and as further adjusted by application of a nominal need computation that shall take into account each facility's medicaid inpatient share.

(ii) Annual distributions pursuant to such regulations for the two thousand twenty through two thousand twenty-nine calendar years shall be in accord with the following:

(A) (1) one hundred thirty-nine million four hundred thousand dollars shall be distributed as Medicaid Disproportionate Share Hospital ("DSH") payments to major public general hospitals;

(2) for the calendar years two thousand twenty-five and thereafter, the total distributions to major public general hospitals shall be subject to an aggregate reduction of one hundred thirteen million four hundred thousand dollars annually, provided that 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 not receive distributions pursuant to this subdivision; and

(B) nine hundred sixty-nine million nine hundred thousand dollars as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals.

For the calendar years two thousand twenty through two thousand twenty-two, the total distributions to eligible general hospitals, other than major public general hospitals, shall be subject to an aggregate reduction of one hundred fifty million dollars annually, provided that eligible general hospitals, other than major public general hospitals, that qualify as enhanced safety net hospitals under section two thousand

eight hundred seven-c of this article shall not be subject to such reduction.

For the calendar years two thousand twenty-three through two thousand twenty-nine, the total distributions to eligible general hospitals, other than major public general hospitals, shall be subject to an aggregate reduction of two hundred thirty-five million four hundred thousand dollars annually, provided that eligible general hospitals, other than major public general hospitals that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of this article as of April first, two thousand twenty, shall not be subject to such reduction.

Such reductions shall be determined by a methodology to be established by the commissioner. Such methodologies may take into account the payor mix of each non-public general hospital, including the percentage of inpatient days paid by Medicaid.

(iii) For calendar years two thousand twenty through two thousand twenty-nine, sixty-four million six hundred thousand dollars shall be distributed to eligible general hospitals, other than major public general hospitals, that experience a reduction in indigent care pool payments pursuant to this subdivision, and that qualify as enhanced safety net hospitals under section two thousand eight hundred seven-c of this article as of April first, two thousand twenty. Such distribution shall be established pursuant to regulations promulgated by the commissioner and shall be proportional to the reduction experienced by the facility.

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

(c) The commissioner shall annually report to the governor and the legislature on the distribution of funds under this subdivision including, but not limited to:

(i) the impact on safety net providers, including community providers, rural general hospitals and major public general hospitals;

(ii) the provision of indigent care by units of services and funds distributed by general hospitals; and

(iii) the extent to which access to care has been enhanced.

6. Funds reserved for high need adjustments shall be distributed to general hospitals, excluding major public general hospitals, with nominal need in excess of four percent as follows: each general hospital's share of the reserved amount shall be based on such hospital's aggregate share of nominal need above four percent compared to the total aggregate nominal need above four percent of all eligible hospitals.

7. (a) Hospital specific transition adjustment. Notwithstanding any inconsistent provision of this section, distributions to general hospitals determined in accordance with subdivision four of this section shall be adjusted as follows:

(i) For general hospitals which qualified for distributions pursuant to paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article as of December thirty-first, nineteen hundred ninety-five:

(A) for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, each such general hospital shall receive as an allocation one hundred percent of the projected distribution, as of June first, nineteen hundred ninety-seven, to such general hospital pursuant to subdivisions fourteen-c and seventeen and paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six; and

(B) for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, each such general hospital shall receive as an allocation seventy-five percent of the amount determined in accordance with clause (A) of this subparagraph

and twenty-five percent of the amount determined in accordance with subdivision four of this section; and

(C) for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, each such general hospital shall receive as an allocation fifty percent of the amount determined in accordance with clause (A) of this subparagraph and fifty percent of the amount determined in accordance with subdivision four of this section; and

(D) for the period January first, two thousand through December thirty-first, two thousand, each such general hospital shall receive as an allocation twenty-five percent of the amount determined in accordance with clause (A) of this subparagraph and seventy-five percent of the amount determined in accordance with subdivision four of this section provided, however, that for any general hospital whose distribution is greater when determined solely in accordance with subdivisions four and six of this section than when determined according to this clause, such general hospital's distribution shall not be adjusted pursuant to this clause; and

(E) for periods on and after January first, two thousand one, each such general hospital shall receive as an allocation one hundred percent of the amount determined in accordance with subdivision four of this section.

(ii) For all other general hospitals, excluding major public general hospitals, general hospitals qualifying for an adjustment pursuant to subparagraph (i) of this paragraph, general hospitals which qualified for an adjustment pursuant to subdivision fourteen-d of section twenty-eight hundred seven-c of this article and rural general hospitals that met the qualifications as a rural general hospital pursuant to paragraph (f) of subdivision four of section twenty-eight hundred seven-c of this article in nineteen hundred ninety-six:

(A) for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, each such general hospital shall receive as an allocation fifty percent of the projected distribution, as of June first, nineteen hundred ninety-seven, to such general hospital pursuant to subdivision seventeen of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six and fifty percent of the amount determined in accordance with

subdivision four of this section; and

(B) for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, each such general hospital shall receive as an allocation twenty-five percent of the projected distribution, as of June first, nineteen hundred ninety-seven, to such general hospital pursuant to subdivision seventeen of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six and seventy-five percent of the amount determined in accordance with subdivision four of this section.

(b) Hospital category adjustment. Notwithstanding any inconsistent provision of this section, distributions to each general hospital, excluding major public general hospitals, for nineteen hundred ninety-seven determined in accordance with subdivision four of this section and paragraph (a) of this subdivision within the categories specified in subparagraph (i) of this paragraph shall be adjusted in accordance with subparagraph (ii) of this paragraph.

(i)(A) General hospitals that qualified for distributions in accordance with subdivision fourteen-d of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six.

(B) Rural general hospitals that met the qualifications as a rural general hospital pursuant to paragraph (f) of subdivision four of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six.

(C) All other general hospitals, excluding general hospitals that qualified for distributions pursuant to paragraph (c) of subdivision nineteen of section twenty-eight hundred seven-c of this article.

(ii) For each category specified in subparagraph (i) of this paragraph, fifty percent of the amount by which the allocation pursuant to subdivision four of this section and paragraph (a) of this subdivision to a general hospital within such category exceeds the projected distribution, as of June first, nineteen hundred ninety-seven, pursuant to subdivision seventeen and, if applicable, subdivision fourteen-d of section twenty-eight hundred seven-c of this article for nineteen hundred ninety-six to such general hospital shall be reserved by the commissioner for allocation to general hospitals within such category that would experience a loss based on such comparison based on each such general hospital's proportionate share of the aggregate losses

for all general hospitals within such category; provided however, that the amount reserved within a category shall not exceed the aggregate amount of losses within such category.

8. Notwithstanding any inconsistent provision of this section, up to five percent of the amount allocated for each of the periods for distributions pursuant to this section may be transferred by the commissioner, to the extent of funds appropriated therefor, and allocated for distributions pursuant to the child health insurance plan established pursuant to title one-A of article twenty-five of this chapter.

9. In order for a general hospital to participate in the distribution of funds from the pool, the general hospital must implement minimum collection policies and procedures approved by the commissioner, utilizing only a uniform financial assistance form developed and provided by the department. All general hospitals that do not participate in the indigent care pool shall also utilize only the uniform financial assistance form and otherwise comply with subdivision nine-a of this section governing the provision of financial assistance and hospital collection procedures.

9-a. (a) For periods on and after January first, two thousand nine, general hospitals shall, effective for periods on and after January first, two thousand seven, establish financial aid policies and procedures, in accordance with the provisions of this subdivision, for reducing charges otherwise applicable to low-income individuals without health insurance or underinsured individuals, or who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges, and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts. Immigration status shall not be an eligibility criterion for the purpose of determining financial assistance under this section.

(b) Such reductions from charges for patients with incomes below at least four hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed the amount that would

have been paid for the same services provided pursuant to title XIX of the federal social security act (medicaid), and provided further that such amounts shall be adjusted according to income level as follows:

(i) For patients with incomes below at least two hundred percent of the federal poverty level, the hospital shall waive all charges. No nominal payment shall be collected;

(ii) For patients with incomes between at least two hundred percent and up to three hundred percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower incomes shall pay the lowest amount. Such schedule shall provide that the amount the hospital may collect for such patients increases in equal increments as the income of the patient increases, up to a maximum of ten percent of the amount that would have been paid for the same services provided pursuant to title XIX of the federal social security act (medicaid), or for underinsured patients, up to a maximum of ten percent of the amount that would have been paid pursuant to such patient's insurance cost sharing;

(iii) For patients with incomes between at least three hundred one percent and four hundred percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower income shall pay the lowest amounts. Such schedule shall provide that the amount the hospital may collect for such patients increases from the ten percent figure described in subparagraph (ii) of this paragraph in equal increments as the income of the patient increases, up to a maximum of twenty percent of the amount that would have been paid for the same services provided pursuant to title XIX of the federal social security act (medicaid), or for underinsured patients, up to a maximum of twenty percent of the amount that would have been paid pursuant to such patient's insurance cost sharing;

(iv) Nothing in this paragraph shall be construed to limit a hospital's ability to establish patient eligibility for payment discounts at income levels higher than those specified herein and/or to provide greater payment discounts for eligible patients than those required by this paragraph.

(c) Such policies and procedures shall be clear, understandable, in

writing and publicly available in summary form and each general hospital participating in the pool shall ensure that every patient is made aware of the existence of such policies and procedures and is provided, in a timely manner, with a summary of such policies and procedures. Any summary provided to patients shall, at a minimum, include specific information as to income levels used to determine eligibility for assistance, a description of the primary service area of the hospital and the means of applying for assistance. For general hospitals with twenty-four hour emergency departments, such policies and procedures shall require the written notification of patients during the intake and registration process, and during discharge of the patient, and through the conspicuous posting of language-appropriate information in the general hospital, and information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. For specialty hospitals without twenty-four hour emergency departments, such notification shall take place through written materials provided to patients during the intake and registration process prior to the provision of any health care services or procedures, and during discharge of the patient, and through information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. Application materials shall include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility pursuant to the hospital's financial assistance policy, the patient may disregard any bills until the hospital has rendered a decision on the application in accordance with this paragraph.

(d) Such policies and procedures shall include clear, objective criteria for determining a patient's ability to pay and for providing such adjustments to payment requirements as are necessary. In addition to adjustment mechanisms such as sliding fee schedules and discounts to fixed standards, such policies and procedures shall also provide for the use of installment plans for the payment of outstanding balances by patients pursuant to the provisions of the financial assistance policy. The monthly payment under such a plan shall not exceed five percent of the gross monthly income of the patient. The rate of interest charged to the patient on the unpaid balance, if any, shall not exceed two percent

and no plan shall include an accelerator or similar clause under which a higher rate of interest is triggered upon a missed payment. If such policies and procedures include a requirement of a deposit prior to non-emergent, medically-necessary care, such deposit must be included as part of any financial aid consideration. Such policies and procedures shall be applied consistently to all eligible patients.

(e) Such policies and procedures shall permit patients to apply for assistance at any time during the collection process. Such policies and procedures may require that patients seeking payment adjustments provide appropriate financial information and documentation in support of their application, provided, however, that such application process shall not be unduly burdensome or complex. General hospitals shall, upon request, assist patients in understanding the hospital's policies and procedures and in applying for payment adjustments. Application forms shall be printed in the "primary languages" of patients served by the general hospital. For the purposes of this paragraph, "primary languages" shall include any language that is either (i) used to communicate, during at least five percent of patient visits in a year, by patients who cannot speak, read, write or understand the English language at the level of proficiency necessary for effective communication with health care providers, or (ii) spoken by non-English speaking individuals comprising more than one percent of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems. Decisions regarding such applications shall be made within thirty days of receipt of a completed application. Such policies and procedures shall require that the hospital issue any denial/approval of such application in writing with information on how to appeal the denial and shall require the hospital to establish an appeals process under which it will evaluate the denial of an application. Nothing in this subdivision shall be interpreted as prohibiting a hospital from making the availability of financial assistance contingent upon the patient first applying for coverage under title XIX of the social security act (medicaid) or another publicly subsidized insurance program if, in the judgment of the hospital, the patient may be eligible for medicaid or another publicly subsidized insurance program, and upon the patient's cooperation in following the financial assistance application

requirements, including the provision of information needed to make a determination on the patient's application in accordance with the hospital's financial assistance policy, provided, however, that this requirement shall not apply to any patient that would otherwise not qualify for coverage based on their immigration status.

(f) Such policies and procedures shall provide that patients with incomes below four hundred percent of the federal poverty level are deemed presumptively eligible for payment adjustments and shall conform to the requirements set forth in paragraph (b) of this subdivision, provided, however, that nothing in this subdivision shall be interpreted as precluding hospitals from extending such payment adjustments to other patients, either generally or on a case-by-case basis. Such policies and procedures shall provide financial aid for emergency hospital services, including emergency transfers pursuant to the federal emergency medical treatment and active labor act (42 USC 1395dd), to patients who reside in New York state and for medically necessary hospital services for patients who reside in the hospital's primary service area as determined according to criteria established by the commissioner. In developing such criteria, the commissioner shall consult with representatives of the hospital industry, health care consumer advocates and local public health officials. Such criteria shall be made available to the public no less than thirty days prior to the date of implementation and shall, at a minimum:

(i) prohibit a hospital from developing or altering its primary service area in a manner designed to avoid medically underserved communities or communities with high percentages of uninsured residents;

(ii) ensure that every geographic area of the state is included in at least one general hospital's primary service area so that eligible patients may access care and financial assistance; and

(iii) require the hospital to notify the commissioner upon making any change to its primary service area, and to include a description of its primary service area in the hospital's annual implementation report filed pursuant to subdivision three of section twenty-eight hundred three-1 of this article.

(g) Nothing in this subdivision shall be interpreted as precluding hospitals from extending payment adjustments for medically necessary non-emergency hospital services to patients outside of the hospital's

primary service area. For patients determined to be eligible for financial aid under the terms of a hospital's financial aid policy, such policies and procedures shall prohibit any limitations on financial aid for services based on the medical condition of the applicant, other than typical limitations or exclusions based on medical necessity or the clinical or therapeutic benefit of a procedure or treatment.

(h) Such policies and procedures shall prohibit the denial of admission or denial of treatment for services that are reasonably anticipated to be medically necessary because the patient has an unpaid medical bill. Such policies and procedures shall prohibit the forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill and shall require the hospital to refrain from sending an account to collection if the patient has submitted a completed application for financial aid, including any required supporting documentation, while the hospital determines the patient's eligibility for such aid. Such policies and procedures shall prohibit the sale of medical debt accumulated pursuant to this section to a third party, unless the third party explicitly purchases such medical debt in order to relieve the debt of the patient. Such policies and procedures shall provide for written notification, which shall include notification on a patient bill, to a patient not less than thirty days prior to the referral of debts for collection and shall require that the collection agency obtain the hospital's written consent prior to commencing a legal action. Such policies and procedures shall prohibit a hospital from commencing a legal action related to the recovery of medical debt or unpaid bills against patients with incomes below four hundred percent of the federal poverty level. In any legal action related to the recovery of medical debt or unpaid bills by or on behalf of a hospital, the complaint shall be accompanied by an affidavit by the hospital's chief financial officer stating that based upon the hospital's reasonable effort to determine the patient's income, the patient whom they are taking legal action against does not have an income below four hundred percent of the federal poverty level. Such policies and procedures shall require all general hospital staff who interact with patients or have responsibility for billing and collections to be trained in such policies and procedures, and require the implementation of a mechanism for the general hospital to measure its compliance with such policies

and procedures. Such policies and procedures shall require that any collection agency under contract with a general hospital for the collection of debts follow the hospital's financial assistance policy, including providing information to patients on how to apply for financial assistance where appropriate. Such policies and procedures shall prohibit collections from a patient who is determined to be eligible for medical assistance pursuant to title XIX of the federal social security act at the time services were rendered and for which services medicaid payment is available.

(i) Reports required to be submitted to the department by each general hospital as a condition for participation in the pools, and which contain, in accordance with applicable regulations, a certification from an independent certified public accountant or independent licensed public accountant or an attestation from a senior official of the hospital that the hospital is in compliance with conditions of participation in the pools, shall also contain, for reporting periods on and after January first, two thousand seven:

(i) a report on hospital costs incurred and uncollected amounts in providing services to eligible patients without insurance during the period covered by the report;

(ii) hospital costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other third-party payor coverage;

(iii) the number of patients, organized according to United States postal service zip code, who applied for financial assistance pursuant to the hospital's financial assistance policy, and the number, organized according to United States postal service zip code, whose applications were approved and whose applications were denied;

(iv) the number of patients, including their age, race, ethnicity, gender and insurance status, who applied for financial assistance under the hospital's financial assistance policy, and the number of patients, including their age, race, ethnicity, gender and insurance status, whose applications were approved and denied;

(v) the reimbursement received for indigent care from the pool established pursuant to this section;

(vi) the amount of funds that have been expended on charity care from charitable bequests made or trusts established for the purpose of

providing financial assistance to patients who are eligible in accordance with the terms of such bequests or trusts;

(vii) for hospitals located in social services districts in which the district allows hospitals to assist patients with such applications, the number of applications for eligibility under title XIX of the social security act (medicaid) that the hospital assisted patients in completing and the number denied and approved; and

(viii) the hospital's financial losses resulting from services provided under medicaid.

(j) Within ninety days of the effective date of this subdivision each hospital shall submit to the commissioner a written report on its policies and procedures for financial assistance to patients which are used by the hospital on the effective date of this subdivision. Such report shall include copies of its policies and procedures, including material which is distributed to patients, and a description of the hospital's financial aid policies and procedures. Such description shall include the income levels of patients on which eligibility is based, the financial aid eligible patients receive and the means of calculating such aid, and the service area, if any, used by the hospital to determine eligibility.

(k) Notwithstanding section twelve of this chapter, failure to comply with the provisions of this subdivision by a hospital on and after the date of such determination shall make such hospital liable for a civil penalty not to exceed ten thousand dollars for each such violation. The imposition of such civil penalties shall be subject to the provisions of section twelve-a of this chapter.

(l) A hospital or its collection agent shall not commence a civil action against a patient or delegate a collection activity to a debt collector for nonpayment for at least one hundred eighty days after the first post-service bill is issued and until a hospital has made reasonable efforts to determine whether a patient qualifies for financial assistance.

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

this article.

11. Minimum hospital procedures to determine the availability of insurance or other third-party coverage for hospital services shall be specified by the commissioner.

12. Each general hospital shall submit reports to the department at such time and in such form as the commissioner shall require of:

(a) hospital costs incurred and uncollected amounts in providing services to the uninsured during the period covered by the report; and

(b) hospital costs incurred and uncollected amounts for deductibles and coinsurance for patients with insurance or other third-party payor coverage.

(c) Such reports shall comply with the reporting requirements established for receipt of bad debt and charity care pool payments as provided in accordance with section twenty-eight hundred seven-c of this article and regulations promulgated thereunder for periods prior to January first, nineteen hundred ninety-seven.

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

14. Notwithstanding any inconsistent provision of law to the contrary, the availability or payment of funds to a general hospital pursuant to this section shall not be admissible as a defense, offset or reduction in any action or proceeding relating to any bill or claim for amounts due for hospital services provided.

15. Revenue from distributions pursuant to this section and adjustments pursuant to subdivision fourteen-f of section twenty-eight

hundred seven-c of this article shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen 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.

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

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