*** § 2808-c. Reimbursement of general hospital inpatient services.** 1. General hospital rates and inpatient revenue cap. In determining payments from all sources for general hospital inpatient services for the rate year commencing on January first, nineteen hundred eighty-three and ending on December thirty-first, nineteen hundred eighty-three, the allowances set forth in subdivision four of this section shall be included. Effective January first, nineteen hundred eighty-four, the commissioner shall establish, in accordance with regulations adopted by the council and approved by the commissioner, the maximum amount of inpatient revenue a general hospital will be authorized to receive for services during a designated period not to exceed twelve months from all payors for the provision of inpatient services. This maximum amount will be known as the inpatient revenue cap and shall be established for each general hospital possessing a valid operating certificate issued pursuant to section twenty-eight hundred five of this article. The inpatient revenue cap shall be established by projecting to anticipated expense levels the reimbursable historical inpatient expenses and financial needs as defined in subdivision four of this section, of a general hospital approved for financing through inpatient service revenues. Expenses included in the inpatient revenue cap are those determined to be allowable and reasonable in the provision of authorized inpatient services.

The inpatient revenue caps for the rate years nineteen hundred eighty-four and nineteen hundred eighty-five shall be determined by computing an imputed revenue cap for the period beginning January first, nineteen hundred eighty-three and ending December thirty-first, nineteen hundred eighty-three, which has been based on the cost analysis pursuant to paragraphs (a) and (b) of subdivision two of this section and adjusted each year to reflect the trend factors developed and applied in accordance with paragraph (e) of subdivision two of this section, capital related expenses in accordance with paragraph (c) of subdivision two of this section, redetermination of additional financial needs or revenue requirements in accordance with paragraph (d) of subdivision two of this section, adjustments made in accordance with subdivision five of this section and adjustments to reflect audit findings.

Hospital inpatient services to patients who are not beneficiaries or subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, subchapter XVIII of the federal social security act (medicare), eligible for payments made by state governmental agencies, enrolled in organizations operating in accordance with the provisions of article forty-four of this chapter, or enrolled in a self-insured and self administered group covered under the provisions of subdivision six of this section shall be at charges established by the hospital in accordance with the provisions of subdivision six of this section with the exception that for the period from January first, nineteen hundred eighty-three through December thirty-first, nineteen hundred eighty-three rates of payment pursuant to the provisions of the workers' compensation law, the volunteer firemen's benefit law and the comprehensive automobile insurance reparations act shall be established at one hundred twelve percent of trended average per diem reimbursable cost including allowances as specified in subdivision four of this section.

Amounts prospectively established for payments for general hospital inpatient services provided in rate years subsequent to nineteen hundred eighty-three made on behalf of subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, beneficiaries of subchapter XVIII of the federal social security act (medicare), eligibles for payments made by state governmental agencies and those enrolled in organizations operating in accordance with the provisions of article forty-four of this chapter shall be based on that portion of the prospectively established inpatient revenue cap that is related to the utilization of inpatient services by the above programs, provided, however, that that share of the cost of bad debt and charity care to be paid under subchapter XVIII of the federal social security act shall be based upon the ratio of subchapter XVIII inpatient charges to total inpatient and outpatient charges, except for hospitals using an all inclusive rate, in which case the subchapter XVIII share shall be based upon the ratio of subchapter XVIII inpatient cost to total inpatient and outpatient hospital costs. After reducing the dollar amount liability of all payors by subtracting the dollar amount liability of the subchapter XVIII payor, all other payors shall pay the

remaining liability in proportion to the ratio of their hospital inpatient charges to total hospital inpatient charges less the subchapter XVIII inpatient charges. These proportions shall be computed on the basis of costs for hospitals using an all inclusive rate.

Any adjustments in the overall revenue cap in accordance with subdivision five of this section shall be reflected in an appropriate adjustment to this portion of the revenue cap and payment levels by these programs. The year end adjustment as provided for in paragraph (d) of subdivision five of this section which is based on data contained in the financial and statistical report filed for the effective year of the revenue cap may be further adjusted within the revenue cap when actual data indicates a change in payor utilization and cost apportionment between and among the above specified programs and all other payors. After such adjustments the portion of the revenue cap initially established, or as adjusted, that is related to the actual utilization of covered inpatient services of the above programs shall constitute guaranteed revenue to the general hospital. Nothing in this section shall prohibit the negotiation by health maintenance organizations operating in accordance with the provisions of article forty-three of the insurance law or article forty-four of this chapter, of agreements with general hospitals for rates of payment other than those provided herein. Such contracts shall require approval by the commissioner and must include provision for special benefit packages or arrangements for providing inpatient services to encourage patient management behavior that will minimize the length of patient stay, such as special admission arrangements, bed leasing or other inpatient capitation arrangements.

2. The inpatient revenue cap established shall include:

(a) allowable historical inpatient operational expenses which are comparable in nature and can reasonably be expected to be comparable in amount to other general hospitals with similar cost influencing characteristics (adjusted for comparison purposes for differences in wage and fringe benefit levels) and which are equal to or less than reasonable reimbursable operational cost ceilings developed from the average allowable cost per unadjusted (except for newborn days) appropriate unit of service of all hospitals in the comparison group.

The comparison group shall consist of general hospitals sharing similar cost influencing characteristics and classified in accordance with variables defined in regulation;

(b) allowable historical inpatient operational expenses, other than capital related expenses as defined in subdivision three of this section, and other than costs included in paragraph (a) hereof, which may be subject to reasonable reimbursable cost standards adopted by the council and approved by the commissioner;

(c) capital related expenses determined in accordance with subdivision three of this section;

(d) additional financial needs or revenue requirements in accordance with subdivision four of this section;

(e) projection of reimbursable expenses identified through the application of paragraphs (a) and (b) of this subdivision by a trend factor established by the panel of economists as set forth in subdivision eight of this section; and

(f) an amount to reflect anticipated additional revenues resulting from the implementation of the gross charge determination formula provided by the commissioner in accordance with subdivision six of this section.

The establishment of separate rates of payment for patients who require different levels or types of care shall require a reallocation of costs to insure that the total hospital inpatient revenue cap (or in the case of the period January one, nineteen hundred eighty-three to December thirty-one, nineteen hundred eighty-three the imputed revenue cap), which shall include the revenue for different levels or types of care, established under this subdivision remains unchanged except that adjustments may be made based on the cost analysis pursuant to paragraphs (a) and (b) of this subdivision.

Effective January first, nineteen hundred eighty-three through December thirty-first, nineteen hundred eighty-five, the cost limitations, utilization standards and limits on disallowances shall be computed in accordance with the methodology approved by the federal government to permit the determination of all payments for inpatient services provided by general hospitals to be made in accordance with the

amendments made to sections twenty-eight hundred seven and twenty-eight hundred seven-a of this chapter by sections three and four of a chapter of the laws of nineteen hundred eighty-two. Specialty hospitals shall not be included in any computations relating to disallowances, limitations or ceilings pursuant to this paragraph but shall receive reimbursement in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner. In order to provide for a transition period for the application of reimbursable cost limitations to payments authorized under subchapter XVIII of the federal social security act, a reasonable phase-in over a three year period is to be implemented.

3. Capital related inpatient expenses. Effective for the year beginning January first, nineteen hundred eighty-four and thereafter, capital related inpatient expenses including but not limited to depreciation, rentals and interest on capital debt (or for hospitals financed pursuant to article twenty-eight-B of this chapter, such expenses, including amortization in lieu of depreciation, as determined pursuant to the reimbursement regulations promulgated pursuant to that article and article twenty-eight of this chapter, in the case of payments on behalf of other than beneficiaries under subchapter XVIII of the federal social security act), shall be included in the revenue cap on a budget basis, and subsequently reconciled to actual expenses through appropriate audit procedures. General hospitals shall submit to the commissioner, at least one hundred twenty days prior to the commencement of each revenue cap year, a schedule of capital related inpatient expenses for the forthcoming year. Any capital related inpatient expense generated by a capital expenditure which requires or required approval pursuant to this article, must have received such approval for the capital related expense to be included in the revenue cap. The submitted budget may include the capital related inpatient expenses of all existing capital assets as well as estimates of capital related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the revenue cap year. Any capital related expense generated by a capital asset acquired or placed in use during a revenue cap year, provided all required approvals pursuant to this article have been obtained, shall be carried forward to the

subsequent revenue cap year. In instances where such approvals have been obtained, the budget may include estimates for capital related inpatient expenses. The basis for determining capital related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for the construction of the capital asset. The council shall adopt, with the approval of the commissioner, regulations to:

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

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

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

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

4. Allowances. Inpatient revenue caps established, or rates for general hospital inpatient services, shall include for the three years commencing on January first, nineteen hundred eighty-three, the allowances specified below in paragraphs (a), (b), (c), (d) and (e) of this subdivision. For the period from January first, nineteen hundred eighty-three through December thirty-first, nineteen hundred eighty-three the allowances shall be computed on the basis of the general hospital's reimbursable inpatient costs after application of the trend factor. Any additional allowances for the periods January first, nineteen hundred eighty-four through December thirty-first, nineteen hundred eighty-four and from January first, nineteen hundred eighty-five through December thirty-first, nineteen hundred eighty-five shall be included in the certified inpatient revenue caps after application of the trend factor and such adjustments as may be appropriate pursuant to subdivision two of this section. For the purposes of this subdivision and subdivision nine of this section, major public general hospitals are defined as all state operated general hospitals, all general hospitals operated by the New York city health and hospitals corporation as established by chapter one thousand sixteen of the laws of nineteen hundred sixty-nine, as amended and all other public general hospitals

having annual inpatient operating costs in excess of twenty-five million dollars.

(a) For the period from January first, nineteen hundred eighty-three through December thirty-first, nineteen hundred eighty-five an allowance of one percent of the general hospital's reimbursable inpatient costs to provide funds to be used at the discretion of hospital governing boards.

(b) For public general hospitals an additional allowance of up to one percent for the second year and up to a further additional one percent in the third year of the three year period commencing January first, nineteen hundred eighty-three subject to the provisions of paragraph (d) of this subdivision.

(c) For voluntary non-profit and private proprietary general hospitals an additional allowance of up to one percent for the second year of the three year period commencing January first, nineteen hundred eighty-three and continued for the third year of the three year period subject to the provisions of paragraph (d) of this subdivision.

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

(e) A percentage to reflect the needs for the financing of losses resulting from bad debts and the costs of charity care of general hospitals within article forty-three insurance law regions, or such other regions as adopted pursuant to subdivision nine of this section, and within a statewide determination of financial resources to be committed for this purpose. Regional needs shall be equal to the total of inpatient losses from bad debts reduced to cost and the inpatient costs of charity care increased by any deficit of general hospitals from

providing ambulatory services, excluding any portion of such deficit resulting from governmental payments below average visit costs and revenues and expenses related to the provision of referred ambulatory services. The regional amount to be included in rates approved for the year commencing January first, nineteen hundred eighty-three and in the inpatient revenue caps established in subsequent years for each general hospital in the region will be equal to the result of the application of the percentage of statewide need for voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals that can be met from available resources computed without consideration of inpatient uncollectible amounts to the regional need for voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals expressed in dollars plus the dollar amount resulting from the application of the ratio of major public general hospitals inpatient reimbursable costs within the region to total statewide general inpatient reimbursable cost (as computed on the basis of nineteen hundred eighty-one financial and statistical reports) to the statewide resources committed for this purpose computed without consideration of inpatient uncollectible amounts and the ratio of these total dollars to the total regional reimbursable inpatient cost after application of the trend factor. For the three year period commencing on January first, nineteen hundred eighty-three and ending on December thirty-first, nineteen hundred eighty-five, the percentage allowances for this purpose shall not be less than an average three percent of the total statewide general hospital reimbursable inpatient cost after application of the trend factor. The allocation of resources made available under this paragraph, as specified in subdivision nine of this section, may be changed only as follows: An annual review shall be conducted pursuant to rules and regulations adopted by the council and approved by the commissioner with respect to bad debt and charity care need within each article forty-three insurance law region or such other regions as are adopted pursuant to subdivision nine of this section. If within such a region there is a definitive finding as a result of such review that there has been a change in the proportional amounts of bad debts and charity care provided by (i) major public general hospitals and (ii) voluntary non-profit, private proprietary and public general hospitals, other than

major public general hospitals, the allocation of resources made available under this paragraph shall be adjusted pursuant to the rules and regulations adopted pursuant to this paragraph so as to reflect this change.

(f) An additional allowance of one-fourth of one percent shall be included in each rate or revenue cap established for each voluntary non-profit and private proprietary general hospital to be returned to a regional pool and distributed in accordance with paragraph (c) of subdivision nine of this section.

(g) An additional allowance of one-third of one percent shall be included in each rate or revenue cap established for voluntary non-profit and private proprietary general hospitals to be returned to a regional pool and distributed in accordance with paragraph (d) of subdivision nine of this section.

5. Adjustments. (a) The commissioner shall, on his own initiative, or on the basis of a request from a general hospital, adjust an established inpatient revenue cap to reflect:

(i) the reduction of costs related to the elimination of a general hospital inpatient service in instances where the costs of such service were included in the basis of the inpatient revenue cap established; and

(ii) the correction of errors or omissions of data or in computations.

(b) General hospitals may request and the commissioner shall consider an adjustment to an established revenue cap to reflect increased expenses or reconsideration of disallowed expenses based on:

(i) justification of all or a portion of expenses not included in the inpatient revenue cap resulting from the cost analysis process contained in subparagraph (i) of paragraph (a) of this subdivision;

(ii) additional operational expenses related to construction or service changes. These changes if applicable must be approved under section twenty-eight hundred two of this article;

(iii) the addition of costs related to a state requirement for additional services to be provided or additional costs to be incurred in meeting state or federal requirements;

(iv) additional expenses to permit a more efficient and economical method of delivering a service; and

(v) increased costs for compensation of employees.

(c) In determining the reasonableness or justification of an adjustment to an established inpatient revenue cap based on a request related to subparagraph (v) of paragraph (b) of this subdivision the commissioner shall consider:

(i) the fiscal capability of the general hospital to finance such increases from its own resources;

(ii) the past history of the general hospital with respect to compensation increases and allowed compensation trend factors; and

(iii) the economy in the area in which the general hospital is located.

(d) The commissioner shall adjust a prospectively established inpatient revenue cap on the basis of subsequent data that demonstrates a significant cost influencing change in patient mix or volume of service. Such adjustment will be made in conformity with regulations adopted by the council as approved by the commissioner.

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

(f) The commissioner shall act upon all properly documented appeals for adjustments concerning base year costs by November first of the calendar year for which the revenue cap is effective provided that all information necessary to determine whether an adjustment is justified is submitted by the facility prior to May first of such year. In the event such an appeal is filed by May first, but information necessary to determine whether an adjustment is justified is submitted after such date, the commissioner shall act on the appeal within six months after receiving the necessary information.

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

6. Hospital charge schedules. Effective for the year beginning January first, nineteen hundred eighty-four and thereafter, each general

hospital shall establish a charge schedule for available and authorized services in accordance with a gross charge determination formula provided by the commissioner which shall:

(a) Establish gross charges sufficient to generate the inpatient revenue authorized by the revenue cap; and

(b) Establish gross charges such that (i) the payment rate to be made on behalf of subscribers of corporations organized and operating in accordance with article forty-three of the insurance law, adjusted for uncovered services, shall be at a specified discount from the gross charge rate billed to or on behalf of charge paying patients; (ii) permit the continuation of negotiated payment rate determination systems between self-insured and self-administered groups and hospitals which were in effect on May first, nineteen hundred eighty-two; and (iii) for general hospitals subject to the provisions of paragraph (a) or (b) of subdivision twelve of this section, the costs (including all allowances specified in subdivision four of this section) of services provided to charge paying patients shall be at a specified discount from the gross charge rate billed to or on behalf of charge paying patients.

During the period January first, nineteen hundred eighty-four through December thirty-first, nineteen hundred eighty-five, the discount referred to in subparagraphs (i) and (iii) of paragraph (b) of this subdivision shall not exceed twelve percent for those hospitals which had a discount of less than twelve percent during the previous year, shall be no greater than the discount in effect during the previous year for those hospitals whose previous year's discount was between twelve and fifteen percent and shall not exceed fifteen percent for all others. Self-insured and self-administered negotiated systems as described in subparagraph (ii) of paragraph (b) of this subdivision may remain in effect for the period commencing January first, nineteen hundred eighty-three and ending on December thirty-first, nineteen hundred eighty-five and shall be incorporated in the formula methodology provided by the commissioner.

The commissioner shall effectuate direct repayment or adjustment of a subsequent inpatient revenue cap to reflect actual inpatient revenues received for inpatient services provided by a general hospital that

exceed the inpatient revenue cap initially established or adjusted in accordance with provisions of this section. Revenue received in excess of the revenue cap established as the result of the provisions of subchapter XVIII of the federal social security act (medicare) phase-in policies or from charges authorized under subdivision seven of this section shall not be included in the adjustment.

7. Working capital. General hospitals may include as a financing or working capital charge an addition of two percent of any valid claim not paid within thirty days of submission or determination of payor liability, whichever is later, and one percent per month thereafter. Revenues received from such financing or working capital charges shall not be included in a revenue cap established or considered as a cost offset. Financing or working capital charges shall not be applied to hospital billings to third party payors participating in a periodic interim payment system.

8. Trend factor. (a) The commissioner in accordance with the methodology developed by the consultants pursuant to paragraph (b) of this subdivision shall establish trend factors to project for the effects of inflation. The factors shall be applied to the appropriate portion of charge levels and reimbursement rates in effect until December thirty-first, nineteen hundred eighty-three and the appropriate portion of the inpatient revenue cap in subsequent years. The methodology for developing the trend factor shall include the appropriate external price indicators and shall also include the data from major collective bargaining agreements as reported quarterly by the federal department of labor, bureau of labor statistics, for non-supervisory employees.

(b) The methodology shall be developed by four independent consultants with expertise in health economics appointed by the commissioner. Not later than September first of each year, the consultants shall provide to the commissioner and the council, the methodology to be used to determine the trend factors for the subsequent twelve month period commencing January first. The commissioner shall monitor the actual price movement during this twelve month period of the external price indicators used in the methodology, shall report the results of the monitoring to the consultants, and shall implement, semi-annually, the

recommendations of the consultants for adjustments to the trend factor provided, however, that adjustments, except for the final adjustment in the trend factor shall not be required unless such adjustment would result in the weighted average of the operating cost component of the rates or charge limits differing by more than one-half of one percent from that which was previously determined.

9. Bad debt, charity care and transition pool. Regional pools consisting of funds made available within each region through the allowances specified in paragraphs (e), (f) and (g) of subdivision four of this section shall be created. The regions are established as the article forty-three insurance law plan regions, with the exception that the southern sixteen counties will be divided into three regions for the purposes of this subdivision and subdivision four of this section with separate regions consisting of Richmond, Manhattan, Bronx, Queens and Kings counties; Nassau and Suffolk counties; and Delaware, Columbia, Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland and Westchester counties. The council with the approval of the commissioner may combine regions, with the exception of the above specified regions for the southern sixteen counties, upon application of the article forty-three insurance law plans involved and a demonstration that significant inequities would not occur. The commissioner is authorized to contract with the article forty-three insurance law plans to receive funds for the pools and distribute such funds. In the event contracts with the article forty-three insurance law plans are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of pooled funds and issue an annual report on the receipt and distribution of the pooled funds. In order for general hospitals to participate in the distribution of funds from the pool the general hospital must implement collection policies and procedures approved by the commissioner. Funds available in each regional pool shall be distributed or retained in the following sequence:

(a) Each eligible major public general hospital as defined in subdivision four of this section shall receive from its regional pool created by the allowance in paragraph (e) of subdivision four of this section a portion of its bad debt and charity care need equal to the result of the application of its percentage of statewide inpatient

reimbursable costs developed on the basis of nineteen hundred eighty-one financial and statistical reports to the total of all regional pools.

(b) Funds remaining in the regional pool created by the allowance in paragraph (e) of subdivision four of this section, after distribution in accordance with paragraph (a) of this subdivision, shall be distributed proportionately to voluntary non-profit, private proprietary and public general hospitals, other than major public general hospitals on the basis of need within the region as determined in accordance with paragraph (e) of subdivision four, with the exception that any funds in a regional pool that were allocated to major public general hospitals and not distributed shall be distributed to each major third party payor on the basis of its percentage of major third party payor liability for bad debt and charity care as described in subdivision one of this section, in the specific major public general hospital to which distribution was not made.

(c) Funds in regional pools created by the allowance in paragraph (f) of subdivision four of this section shall not be available for immediate distribution from the regional pool but shall be retained in the pool for distribution by the commissioner in accordance with rules adopted by the state hospital review and planning council to assist in offsetting losses from bad debts and the costs of charity care of voluntary non-profit and private proprietary general hospitals experiencing severe fiscal hardship because of insufficient resources to finance such losses or costs.

(d) Funds in regional pools created by the allowance in paragraph (g) of subdivision four of this section shall be distributed by including one-fourth of such funds with the funds to be distributed in accordance with paragraph (c) of this subdivision and three-quarters of such funds to be distributed to voluntary non-profit and private proprietary general hospitals within the region that are severely negatively impacted by the inclusion of title XVIII (medicare) patients, or changes in the determination of payor liability, resulting from the implementation of the reimbursement provisions in this section. Rules for such distribution will be those adopted by the state hospital review and planning council and approved by the commissioner.

(e) Any balance in the portion of regional pools created by the allowance in paragraph (e) of subdivision four of this section, after

distribution in accordance with paragraph (b) of this subdivision, including income from invested funds, shall be distributed to voluntary non-profit, private proprietary and public general hospitals other than major public general hospitals within the region on a basis related to specific hospital need as defined for regional purposes in paragraph (e) of subdivision four of this section. Any balance in the portion of regional pools created by the allowance in paragraph (f) of subdivision four of this section and the distribution specified in paragraph (d) of this subdivision after distribution in accordance with paragraph (c) of this subdivision, including income from invested funds, shall be distributed to voluntary non-profit and private proprietary general hospitals within the region on a basis related to specific hospital need as defined for regional purposes in paragraph (e) of subdivision four of this section. Any balance in the portion of regional pools created by the allowance in paragraph (g) of subdivision four of this section after distribution in accordance with this paragraph and paragraph (d) of this subdivision, including income from invested funds, shall be returned to voluntary non-profit and private proprietary general hospitals on the basis of the reimbursable costs of those hospitals within the region.

10. Unit of service. The unit of general hospital inpatient service on which payment shall be based should be uniform for all payors and shall best identify the cost of services provided.

11. The commissioner shall provide to fiscal intermediaries for subchapter XVIII of the federal social security act (medicare) and article forty-three of the insurance law plans, the information required to effectuate the provisions of this section, exclusive of adjustments for uncovered services.

12. Provisions for article forty-three insurance law corporations and article forty-four of this chapter organizations. Except as provided in paragraphs (a) and (b) of this subdivision, general hospital charges for inpatient and outpatient services to subscribers or beneficiaries of contracts entered into pursuant to the provisions of article forty-three of the insurance law or to members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this

chapter for patient services rendered shall not exceed the rates of payment approved by the superintendent of financial services or approved or certified by the commissioner, whichever is applicable and required by this section, for payments by such article forty-three insurance law corporations or article forty-four organizations. No general hospital may demand or request any charge for such covered services in addition to the charges or rates authorized by this article.

(a) Any general hospital which terminated its contract with an article forty-three insurance law corporation or a comprehensive health services plan after October first, nineteen hundred seventy-six and prior to May first, nineteen hundred seventy-eight, may not charge subscribers or beneficiaries of contracts entered into pursuant to the provisions of article forty-three of the insurance law, or members of a comprehensive health services plan operating pursuant to the provisions of article forty-four of this chapter, amounts in excess of the schedule of charges established by such hospital for patient services in effect on May first, nineteen hundred seventy-eight, adjusted for the rate year nineteen hundred eighty-three in accordance with the provisions of subdivision thirteen of this section, and adjusted for the rate years thereafter in accordance with the provisions of subdivision six of this section.

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

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

13. Charge control. For the period January first, nineteen hundred eighty-three, and until January first, nineteen hundred eighty-four:

(a) No general hospital shall establish charges for inpatient services in excess of those permitted by law immediately prior to the effective date of this section adjusted by the applicable trend factor.

(b) The commissioner shall establish an appeals board within the department to consider and recommend action in writing on an appeal by a general hospital of the inpatient charge limits established pursuant to this subdivision. The board and the commissioner may only consider, and appeals shall be limited to, changes in the base charge or the allowable limits because of the (i) establishment of an approved new hospital service, (ii) substantial changes in the volume of services provided, or (iii) substantial and adverse changes in the relationship between total accrued inpatient revenues and total inpatient costs due to such factors as significant increases in cost from labor settlements or increases in bad debts. Expenditures resulting from such changes must be essential to assure the continuance of quality medical care. In the event a determination on such appeal is not made by the commissioner within ninety days of receipt of a complete request as determined by the commissioner, the hospital may increase its inpatient charges in conformance with such request. If the commissioner shall determine thereafter that all or a portion of such increase is not warranted hereunder, the hospital on notice of such determination shall promptly reduce its inpatient charges in conformance therewith. In no event shall the hospital bear any liability to any payor for such interim increase.

(c) In any proceeding under this subdivision the recognized collective bargaining agent shall be entitled to submit any relevant data. All data submitted hereunder shall be agency records under the freedom of information law. All proceedings and appeals hereunder shall be meetings of public bodies under the open meetings law.

(d) No provision of this subdivision or subdivision twelve of this section shall be construed to prohibit a general hospital from continuing the amount of inpatient charges in effect on May first,

nineteen hundred seventy-eight.

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

* NB Expired January 1, 1986