1 of 1 DOCUMENT

*** THIS SECTION IS CURRENT THROUGH CH. 60, 05/14/2007 ***
*** WITH THE EXCEPTION OF CHS. 25-29 and 31-49 ***

PUBLIC HEALTH LAW
ARTICLE 28. HOSPITALS

GO TO CODE ARCHIVE DIRECTORY FOR THIS JURISDICTION

NY CLS Pub Health § 2807-k (2007)

§ 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 [fig 1] 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 [fig 1] January first, two thousand [fig 2] 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.

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. (a) 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 [fig 1] seven, 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.

(b) For the period January first, two thousand [fig 1] eight through [fig 2] March thirty-first, two thousand [fig 3] eight each major public general hospital shall be allocated for distribution from the pools established pursuant to this section for such period, an amount equal to [fig 4] one-quarter the amount calculated pursuant to paragraph (a) of this subdivision.

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 [fig 1] seven and [fig 2] nine million dollars shall be reserved for the period January first, two thousand [fig 3] eight through [fig 4] March thirty-first, two thousand [fig 5] eight, for distribution as high need adjustments in accordance with subdivision six 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 [fig 1] seven and [fig 2] six million [fig 3] seven hundred fifty thousand dollars shall be reserved for the period January first, two thousand [fig 4] eight through [fig 5] March thirty-first, two thousand [fig 6] eight, for distribution in accordance with subdivision sixteen of this section.

(b) The balance of funds in a pool not allocated in accordance with subdivision three of this section or reserved for distributions pursuant to [fig 1] 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%

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 [fig 1] ; 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 and must be in compliance with bad debt and charity care reporting requirements established pursuant to this article.

9-a. (a) As a condition for participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article 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 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.

(b) Such reductions from charges for uninsured patients with incomes below at least three hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for 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 at or below at least one hundred percent of the federal poverty level, the hospital shall collect no more than a nominal payment amount, consistent with guidelines established by the commissioner;

(ii) For patients with incomes between at least one hundred one percent and one hundred fifty 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 from the nominal amount described in subparagraph (i) of this paragraph in equal increments as the income of the patient increases, up to a maximum of twenty percent of the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services provided pursuant to title XIX of the federal social security act (medicaid);

(iii) For patients with incomes between at least one hundred fifty-one percent and two hundred fifty 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 twenty percent figure described in subparagraph (ii) of this paragraph in equal increments as the income of the patient increases, up to a maximum of the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services provided pursuant to title XIX of the federal social security act (medicaid); and

(iv) For patients with incomes between at least two hundred fifty-one percent and three hundred percent of the federal poverty level, the hospital shall collect no more than the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid).

(v) For the purposes of this paragraph, "highest volume payor" shall mean the insurer, corporation or organization licensed, organized or certified pursuant to article thirty-two, forty-two or forty-three of the insurance law or article forty-four of this chapter, or other third-party payor, which has a contract or agreement to pay claims for services provided by the general hospital and incurred the highest volume of claims in the previous calendar year.

(vi) A hospital may implement policies and procedures to permit, but not require, consideration on a case-by-case basis of exceptions to the requirements described in subparagraphs (i) and (ii) of this paragraph based upon the existence of significant assets owned by the patient that should be taken into account in determining the appropriate payment amount for that patient's care, provided, however, that such proposed policies and procedures shall be subject to the prior review and approval of the commissioner and, if approved, shall be included in the hospital's financial assistance policy established pursuant to this section, and provided further that, if such approval is granted, the maximum amount that may be collected shall not exceed the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid). In the event that a general hospital reviews a patient's assets in determining payment adjustments such policies and procedures shall not consider as assets a patient's primary residence, assets held in a tax deferred or comparable retirement savings account, college savings accounts, or cars used regularly by a patient or immediate family members.

(vii) 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 upon request. 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 notification of patients during the intake and registration process, 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 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 hospital's financial assistance policy. The monthly payment under such a plan shall not exceed ten percent of the gross monthly income of the patient, provided, however, that if patient assets are considered under such a policy, then patient assets which are not excluded assets pursuant to subparagraph (vi) of paragraph (b) of this subdivision may be considered in addition to the limit on monthly payments. The rate of interest charged to the patient on the unpaid balance, if any, shall not exceed the rate for a ninety-day security issued by the United States Department of Treasury, plus .5 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 within at least ninety days of the date of discharge or date of service and provide at least twenty days for patients to submit a completed application. 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 insurance program if, in the judgment of the hospital, the patient may be eligible for medicaid or another insurance program, and upon the patient's cooperation in following the hospital's 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.

(f) Such policies and procedures shall provide that patients with incomes below three 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-l 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 not permit 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 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 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, including the amount of care provided for a nominal payment amount, 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 reimbursement received for indigent care from the pool established pursuant to this section;

(v) 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;

(vi) 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;

(vii) the hospital's financial losses resulting from services provided under medicaid; and

(viii) the number of liens placed on the primary residences of patients through the collection process used by a hospital.

(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.

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.

HISTORY: Add, L 1996, ch 639, § 54, eff Sept 12, 1996, deemed eff on and after July 1, 1996 (see 1996 note below).

Sub 1, par (c), amd, L 2000, ch 419, § 53, eff Sept 13, 2000, deemed on and after eff Jan 1, 1997 (see 2000 note below), L 2003, ch 554, § 1, eff Sept 17, 2003.

The 2003 act deleted at fig 1 "outpatient" Sub 1, par (f), add, L 2003, ch 554, § 1, eff Sept 17, 2003; amd, L 2004, ch 80, § 1, eff May 18, 2004.

The 2004 act deleted at fig 1 "July" and at fig 2 "three" Sub 1, par (g), add, L 2003, ch 554, § 1, eff Sept 17, 2003.

Sub 3, par (a), formerly entire sub 3, so designated sub 3, par (a) and amd, L 2000, ch 419, § 10, eff Sept 13, 2000, deemed eff Jan 1, 2000 (see 2000 note below); amd, L 2003, ch 62, § 7 (Part A3), eff May 15, 2003, L 2005, ch 58, § 51 (Part B), eff April 12, 2005 (see 2005 note below), L 2007, ch 58, § 56 (Part A), eff April 9, 2007, deemed eff on and after April 1, 2007 (see 2007 note below).

The 2007 act deleted at fig 1 "six" Sub 3, par (b), add, L 2000, ch 419, § 10, eff Sept 13, 2000, deemed eff on and after Jan 1, 2000 (see 2000 note below); amd, L 2003, ch 62, § 7 (Part A3), eff May 15, 2003, L 2005, ch 58, § 51 (Part B), eff April 12, 2005 (see 2005 note below), L 2007, ch 58, § 56 (Part A), eff April 9, 2007, deemed eff on and after April 1, 2007 (see 2007 note below).

The 2007 act deleted at figs 1 and 3 "seven", at fig 2 "June thirtieth" and at fig 4 "one-half" Sub 4, par (a), amd, L 2000, ch 419, § 11, eff Sept 13, 2000, deemed eff on and after Jan 1, 2000 (see 2000 note below), L 2003, ch 62, § 7 (Part A3), eff May 15, 2003, L 2005, ch 58, § 51 (Part B), eff April 12, 2005 (see 2005 note below), L 2007, ch 58, § 56 (Part A), eff April 9, 2007, deemed eff on and after April 1, 2007 (see 2007 note below).

The 2007 act deleted at fig 1 "six", at fig 2 "eighteen", at figs 3 and 5 "seven" and at fig 4 "June thirtieth" Sub 4, par (a-1), add, L 1999, ch 1, § 63, eff Dec 30, 1999, deemed eff on and after Jan 1, 2000; amd, L 2000, ch 419, § 11, eff Sept 13, 2000, deemed eff on and after Jan 1, 2000 (see 2000 note below), L 2003, ch 62, § 7 (Part A3), eff May 15, 2003, L 2005, ch 58, § 51 (Part B), eff April 12, 2005 (see 2005 note below), L 2007, ch 58, § 56 (Part A), eff April 9, 2007, deemed eff on and after April 1, 2007 (see 2007 note below).

The 2007 act deleted at fig 1 "six", at fig 2 "thirteen" at fig 3 "five" at figs 4 and 6 "seven" and at fig 5 "June thirtieth" Sub 4, par (b), amd, L 1999, ch 1, § 63, eff Dec 30, 1999, deemed eff on and after Jan 1, 2000.

Sub 4, par (d), amd, L 1999, ch 1, § 60, eff Dec 30, 1999, deemed eff on and after Jan 1, 2000.

Sub 7, par (a), subpar (i), cl (A), amd, L 1999, ch 1, § 61, eff Dec 30, 1999, deemed eff on and after Jan 1, 1997, L 2000, ch 419, § 55, eff Sept 13, 2000, deemed eff on and after Jan 1, 1997 (see 2000 note below).

Sub 7, par (a), subpar (i), cl (C), amd, L 1999, ch 1, § 61, eff Dec 30, 1999, deemed eff on and after Jan 1, 2000.
The 1999 act deleted at fig 1 a period Sub 7, par (a), subpar (i), cl (D), add, L 1999, ch 1, § 61, eff Dec 30, 1999, deemed eff on and after Jan 1, 2000.
Sub 7, par (a), subpar (i), cl (E), add, L 1999, ch 1, § 61, eff Dec 30, 1999, deemed eff on and after Jan 1, 2000.
Sub 7, par (a), supbar (ii), cl (A), amd, L 2000, ch 419, § 55, eff Sept 13, 2000, demeed eff on and after Jan 1, 1997 (see 2000 note below).
Sub 7, par (a), supbar (ii), cl (B), amd, L 2000, ch 419, § 55, eff Sept 13, 2000, demeed eff on and after Jan 1, 1997 (see 2000 note below).
Sub 7, par (b), supbar (ii), amd, L 2000, ch 419, § 56, eff Sept 13, 2000, demeed eff on and after Jan 1, 1997 (see 2000 note below).
Sub 9-a, add, L 2006, ch 57, § 39-a (Part A), eff April 12, 2006, deemed eff on and after April 1, 2006 (see 2006 note below).
Sub 12, par (c), add, L 2006, ch 57, § 14 (Part D), eff April 12, 2006 (see 2006 note below).
Sub 13, formerly sub 13, par (a), previously entire sub 13, so designated sub 13, par (a), L 2003, ch 554, § 2, eff Sept 17, 2003; so designated sub 13, L 2004, ch 80, § 2, eff May 18, 2004.
Sub 13, par (a), redesignated sub 13, L 2004, ch 80, § 2, eff May 18, 2004.
Sub 13, par (b), add, L 2003, ch 554, § 2, eff Sept 17, 2003; deleted, L 2004, ch 80, § 2, eff May 18, 2004.
Sub 16, add, L 1999, ch 1, § 63, eff Dec 30, 1999, deemed eff on and after Jan 1, 2000; amd, L 2000, ch 419, § 12, eff Sept 13, 2000, deemed eff on and after Jan 1, 2000 (see 2000 note below).

NOTES:

Editor's Notes

Laws 1996, ch 639, §§ 2, 168, subs 6-10, eff Sept 12, 1996, deemed eff on and after July 1, 1996, provide as follows:
§ 2. This act shall be known and may be cited as the "New York Health Care Reform Act of 1996".
§ 168. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 1996; provided that:
6. this act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act;
7. the commissioner of health and the superintendent of insurance and any appropriate council may take any steps necessary to implement this act prior to its effective date;
8. notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, the commissioner of health and the superintendent of insurance and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date;
9. the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act; and.
10. nothing contained herein shall be deemed to affect the application, qualification, expiration, reversion or repeal of any provision of law amended by any section of this act and the provisions of this act shall be applied or qualified or shall expire or revert or be deemed repealed in the same manner, to the same extent and on the same date as the case may be as otherwise provided by law.

Laws 1999, ch 1, §§ 1, 2 and 138, subs 16-21, eff Dec 30, 1999, deemed eff on and after Jan 1, 2000, provide as follows:
Section 1. Statement of legislative intent. The legislature finds that New York, like the rest of the nation, continues to

experience dramatic changes in the organization and delivery of health care services. These changes are occurring as a result of market forces such as the growth of managed care, the integration of providers across the continuum of health care, and the significant shift in the locus of care from inpatient to outpatient settings. In light of these changes in the market, the legislature finds that the hospital inpatient reimbursement methodology established pursuant to the New York health care reform act of 1996 should be continued and refined. The legislature finds that New York should continue its system of negotiated rates for all non-medicare and non-medicaid payors; the state should maintain a significant role in assuring quality and access to care; and the state should continue to provide for the financing of public policy objectives unlikely to be addressed through market forces.

The legislature further finds that containing health care costs, improving quality, expanding access to services, enhancing public health, and improvements and reforms to the health care system are required to meet the needs of the state's citizens. The legislature further finds that New York should provide comprehensive health insurance for those citizens who need it most and insure the availability of affordable insurance for those persons in the direct pay market.

The legislature finds that this legislation will promote competition in the health care marketplace by increasing reliance on market incentives while reducing the role of regulation; provide an equitable approach to financing health care services; promote access to quality health care through increased availability of insurance coverage for individuals and families; maintain or enhance health care access, quality and availability for populations and areas where market forces are not effective; promote access to primary care; maintain, but rightsize the graduate medical education system; address issues related to access to capital; constrain the growth of health care expenditures; promote healthy outcomes; and ensure accountability in the health care system.

The legislature finds that these actions will also improve the quality of health care for New Yorkers. The legislature therefore concludes that implementation of this New York Health Care Reform Act of 2000 be among the highest priorities of the state's actions.

§ 2. This act shall be known and may be cited as the "New York Health Care Reform Act of 2000".

§ 138. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after January 1, 2000; provided that:

16. this act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act;

17. the commissioner of health and the superintendent of insurance and any appropriate council may take any steps necessary to implement this act prior to its effective date;

18. notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of insurance and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date;

19. the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act;

20. nothing contained herein shall be deemed to affect the application, qualification, expiration, reversion or repeal of any provision of law amended by any section of this act and the provisions of this act shall be applied or qualified or shall expire or revert or be deemed repealed in the same manner, to the same extent and on the same date as the case may be as otherwise provided by law; and.

21. notwithstanding any other provision of law to the contrary, the appropriate chief administrative officer, or his or her designee, charged with the responsibility of administering any provision of this act, the effectiveness of which is contingent upon the following including, but not limited to, the compliance of any party with the provisions of this act, the promulgation of any rule or regulation, the adoption of any rule or regulation, or the availability of federal financial participation in the cost of medical assistance, shall notify the Legislative Bill Drafting Commission of the performance of such contingency. This notification is necessary in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effecting the provisions of *section 44 of the legislative law* and *section 70-b of the public officers law*.

Laws 2000, ch 419, §§ 68 and 70, subs 8-12, eff Sept 13, 2000, deemed eff on and after Jan 1, 2000, provide as follows:

§ 68. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of title 1-A of article 25 and article 28 of the public health law, references to titles XIX and XXI of the federal social security act in title 1-A of article 25 and article 28 of the public health law shall be deemed to include and also mean any successor titles thereto under the federal social security act.

§ 70. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after January 1, 2000; provided that:

8. this act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act;

9. the commissioner of health and the superintendent of insurance and any appropriate council may take any steps necessary to implement this act prior to its effective date;

10. notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of insurance and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date;

11. the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act; and.

12. nothing contained herein shall be deemed to affect the application, qualification, expiration, reversion or repeal of any provision of law amended by any section of this act and the provisions of this act shall be applied or qualified or shall expire or revert or be deemed repealed in the same manner, to the same extent and on the same date as the case may be as otherwise provided by law.

§ 42. This act shall take effect immediately, provided, however, that:

4. Provided, however, that any rules or regulations necessary to implement the provisions of this act may be promulgated and any procedures, forms, or instructions necessary for such implementation may be adopted and issued on or after the date this act shall have become a law;

5. This act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act;

6. The commissioner of health and the superintendent of insurance and any appropriate council may take any steps necessary to implement this act prior to its effective date;

7. Notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of insurance and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date; and.

8. The provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act (Amd, L 2003, ch 686, § 25 (Part H), eff Oct 21, 2003, deemed eff on and after May 15, 2003.).

Laws 2005, ch 58, § 105, subs 4-8 (Part B), eff April 12, 2005, provides as follows:

§ 105. This act shall take effect immediately provided, however, that:

4. Any rules or regulations necessary to implement the provisions of this act may be promulgated and any procedures, forms, or instructions necessary for such implementation may be adopted and issued on or after the date this act shall have become a law;

5. This act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act;

6. The commissioner of health and the superintendent of insurance and any appropriate council may take any steps necessary to implement provisions of this act prior to its effective date;

7. Notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of insurance and any appropriate council is

authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date;

8. The provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act;

Laws 2006, ch 57, §§ 99 and 101, sub 9 (Part A), eff April 12, 2006, deemed on and after eff April 1, 2006, provide as follows:

§ 99. The commissioner of health is authorized to promulgate or adopt any rules or regulations necessary to implement the provisions of this act and any procedures, forms, or instructions necessary for such implementation may be adopted and issued on or after the effective date of this act. Notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation the commissioner of health and the superintendent of insurance and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date.

§ 101. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2006; provided however, that:

9. No section of this act shall be required to be implemented sooner than sixty days following receipt of all waivers and approvals necessary under federal law and regulation to implement the provisions of this act with federal financial participation; the commissioner of health shall submit such waiver applications and/or state plan amendments as may be necessary to obtain such approvals and to ensure continued federal financial participation;

Laws 2006, ch 57, § 34 subs 6-9 (Part D), eff April 12, 2006, provides as follows:

§ 34. This act shall take effect immediately provided, however, that:

6. This act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interest accrued, incurred or conferred prior to the enactment of this act;

7. The commissioner of health and superintendent of insurance and any appropriate council may take any steps necessary to implement provisions of this act prior to its effective date;

8. Notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of insurance and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date; and.

9. The provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act.

Laws 2007, ch 58, § 69, subs 1-5, eff April 9, 2007, deemed eff on and after April 1, 2007, provides as follows:

§ 69. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2007; provided, however, that:

1. Any rules or regulations necessary to implement the provisions of this act may be promulgated and any procedures, forms, or instructions necessary for such implementation may be adopted and issued on or after the date this act shall have become a law;

2. This act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act;

3. The commissioner of health and the superintendent of insurance and any appropriate council may take any steps necessary to implement this act prior to its effective date;

4. Notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law,

rule or regulation, the commissioner of health and the superintendent of insurance and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date;

5. The provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act;

Federal References:

Title XVIII of the federal Social Security Act, cited in statutory text, appears as *42 USCS §§ 1395* et seq

Title XIX of the federal social security act, cited in statutory text, appears as *42 USCS §§ 1396* et seq

Research References & Practice Aids:

Law Reviews:

Butler, Cassady, Patil, 1999-2000 survey of New York law: health law. *51 Syracuse LR 545*