

Hospital Quality Contribution

Effective date: 2/15/12

Pursuant to the authority vested in the Commissioner of Health by section 2807-d-1 of the Public Health Law, Subpart 86-1 of Title 10 of the Official Compilation of Codes, Rules and Regulations of the State of New York, is amended, and to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subpart 86-1 of 10 NYCRR is amended by adding a new section 86-1.41, to read as follows:

86-1.41 Hospital Quality Contribution.

(a) For the period July 1, 2011 through March 31, 2012 a quality contribution shall be imposed on the inpatient revenue of each general hospital that is received for the provision of inpatient obstetrical patient care services in an amount equal to 2.4% of such revenue, as defined in § 2807-d(3)(a) of the Public Health Law.

(b) For the period on and after April 1, 2012, a quality contribution shall be imposed on the inpatient revenue of each general hospital that is received for the provision of inpatient obstetrical patient care services in an amount equal to 1.6% of such revenue, as defined in § 2807-d(3)(a) of the Public Health Law.

(c) For the purposes of computing revenue subject to this section, inpatient obstetrical patient care services shall also include services related to the care of newborns, but shall exclude neonatal intensive care services.

(d) The funds collected pursuant to this section shall be subject to and administered in accordance with the provisions of § 2807-d-1 of the Public Health Law.

Regulatory Impact Statement

Statutory Authority:

Authorization for the collection of “Hospital Quality Contributions” is set forth in section 2807-d-1 of the Public Health Law (PHL), as enacted as part of the 2011-12 state budget and effective for periods on and after July 1, 2011. That statute set the Hospital Quality Contribution at 1.6% of each hospital’s revenue for inpatient obstetrical care services, but provided that the percentage could be increased or decreased by regulation if such an increase or decrease was required to maintain total annual collections at a level of \$30 million.

Legislative Objectives:

The express provisions of PHL section 2807-d-1 requires the Department to collect thirty million dollars for the state fiscal year beginning April 1, 2011 and each state fiscal year thereafter for the Medical Indemnity Fund.

Needs and Benefits:

Since PHL section 2807-d-1 is not effective until on and after July 1, 2011 the Hospital Quality Contributions will only be collected for nine months of the 2011-12 state fiscal year. The 1.6% set forth in the statute was computed so as to generate \$30 million over a period of twelve months. To generate \$30 million over only nine months the Department of Health has determined that the percentage needs to be increased from 1.6% to 2.4%. The proposed regulation therefore effectuates this increase for the nine month period of July 1, 2011 through March 31, 2012.

Costs:

There are no additional administrative costs to the implementation of and

continuing compliance with this amendment. There are no additional costs to the Department of Health, state government, or local governments for the implementation of and continuing compliance of this amendment.

Local Government Mandates:

The proposed amendment does not impose any new programs, services, duties or responsibilities upon and county, city, town, village, school district, fire district or other special district.

Paperwork:

There is no additional paperwork required of providers as a result of the amendment.

Duplication:

These regulations do not duplicate existing state or federal regulations.

Alternatives:

No significant alternatives are available. The Department is required by the Public Health Law section 2807-d-1 to promulgate implementing regulations.

Federal Standards:

This amendment does not exceed any minimum standards of the federal government for the same or similar subject areas.

Compliance Schedule:

Section 86-1.41 requires the Department of Health to adjust the Hospital Quality Contribution rate to collections to 2.4% for the period of July 1, 2011 through March 31, 2012 and to 1.6% for the period of April 1, 2012 through March 31, 2013. No further action is required by the providers to achieve compliance with this rule.

Contact person: Katherine Ceroalo
New York State Department of Health
Bureau of House Counsel, Regulatory Affairs Unit
Corning Tower Building, Rm. 2438
Empire State Plaza
Albany, New York 12237
(518) 473-7488
(518) 473-2019 (FAX)
REGSQNA@health.state.ny.us

Regulatory Flexibility Analysis
for Small Businesses and Local Governments

Effect of Rule:

For the purpose of this regulatory flexibility analysis, small businesses were considered to be general hospitals with 100 or fewer full time equivalents. Based on recent financial and statistical data extracted from the Institutional Cost Report, seven hospitals were identified as employing fewer than 100 employees. This rule will have no effect on Local Governments.

Compliance Requirements:

There are no reporting, recordkeeping or other affirmative acts that small business or local governments will need to undertake to comply with the proposed rule. A small business guide is therefore not required.

Professional Services:

No new or additional professional services are required in order to comply with the proposed amendment.

Compliance Costs:

There are no initial capital costs required to comply with the proposed rules, and there are no annual costs for continuing compliance.

Economic and Technological Feasibility:

As the proposed rule affects only the rate applied to the Hospital Quality Contribution paid by General Hospitals, compliance by small businesses and local government is not expected to have any economic or technological implication.

Minimizing Adverse Impact:

The proposed amendment reflects statutory intent and requirements.

Small Business and Local Government Participation:

The proposed rule resulted from the 2011-12 budget and is based on the recommendation of the Medicaid Redesign Team created by Executive Order. The recommendations process allowed for input from Medicaid industry stakeholders, including large and small providers, and the general public, through statewide hearings and website outreach.

Rural Area Flexibility Analysis

Types and Estimated Numbers of Rural Areas:

Rural areas are defined as counties with a population less than 200,000 and, for counties with a population greater than 200,000, includes towns with population densities of 150 persons or less per square mile. The following 43 counties have a population less than 200,000:

Allegany	Hamilton	Schenectady
Cattaraugus	Herkimer	Schoharie
Cayuga	Jefferson	Schuyler
Chautauqua	Lewis	Seneca
Chemung	Livingston	Steuben
Chenango	Madison	Sullivan
Clinton	Montgomery	Tioga
Columbia	Ontario	Tompkins
Cortland	Orleans	Ulster
Delaware	Oswego	Warren
Essex	Otsego	Washington
Franklin	Putnam	Wayne
Fulton	Rensselaer	Wyoming
Genesee	St. Lawrence	Yates
Greene		

The following 9 counties have certain townships with population densities of 150 persons or less per square mile:

Albany	Erie	Oneida
Broome	Monroe	Onondaga
Dutchess	Niagara	Orange

Reporting, Recordkeeping and Other Compliance Requirements; and Professional Services:

No new reporting, recordkeeping, or other compliance requirements are being imposed as a result of the proposal. No additional professional services will be required for this compliance.

Costs:

There are no initial capital costs or additional annual costs which are required to comply with this proposal.

Minimizing Adverse Impact:

The proposed amendment reflects statutory intent and requirements.

Rural Area Participation:

The proposed rule resulted from the 2011-12 budget and is based on the recommendations of the Medicaid Redesign Team created by Executive Order. The recommendation process allowed for input from Medicaid stakeholders from all areas of the state, including rural areas, through regional hearings and website outreach.

Job Impact Statement

Nature of Impact:

The proposed regulation will implement statutory action to change the rate of the Hospital Quality Contribution from 1.6% to 2.4% for collections during the period of July 1, 2011 through March 31, 2012. The rate will then be reduced back to 1.6% effective April 1, 2012.

Categories and Numbers Affected:

It is apparent, from the nature and purpose of the proposed rule, that it will not have a substantial adverse impact on jobs or employment opportunities.

Regions of Adverse Impact:

The proposed regulations have no implications for job opportunities for any region.

Minimizing Adverse Impact:

No minimizing measures are required.