NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

MARY JO BANE
Commissioner

(518) 474-9475

LOCAL COMMISSIONERS MEMORANDUM

Transmittal No: 92 LCM-76

Date: May 13, 1992

Division: Medical Assistance

TO: **Local District Commissioners**

SUBJECT: Chapter 41 of the Laws of 1992

ATTACHMENTS: Not available on-line

Attached for your information is a copy of the letter distributed by the New York State Department of Health (DOH) to all HMOs. This letter explains the impact of Chapter 41 of the Laws of 1992, which requires HMOs certified under Article 44 of the Public Health Law or Article 43 of the Insurance Law to pay hospital rates which are increased by a 9 percent differential, unless the HMO qualifies for a waiver. The letter also outlines the procedures developed by the Health Department to implement this policy.

This letter may stimulate HMO interest in contracting with your district because an HMO may receive a waiver of the 9 percent differential if it "adequately participates in the Medicaid managed care program." Additionally, an HMO may be granted an exemption from participation in a managed care program if it "has demonstrated a good faith effort to enter into contracts with the social services district in its service area."

If you have questions regarding this LCM please contact Anne Smith at the New York State Department of Social Services, Division of Medical Assistance, Managed Care Unit at 1-800-342-3715 extension 3-5600; electronic mail user #AZ1920.

Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Lorna McBarnette
Executive Deputy Commissioner

OFFICE OF HEALTH
SYSTEMS MANAGEMENT
Raymond Sweeney
Director
Brian Hendricks
Executive Deputy Director

April 14, 1992

Dear Chief Executive Officer:

Chapter 41 of the Laws of 1992 requires that HMOs certified under Article 44 of the Public Health Law or Article 43 of the Insurance Law pay hospital rates which are increased by a 9 percent differential, effective with discharges on or after July 1, 1992, unless the HMO qualifies for a waiver, as described below. Payment of this differential must be made directly into a statewide pool. A copy of the legislation is enclosed for your information.

The 9 percent differential applies to whatever inpatient rate the HMO is paying the hospital: the NYPHRM case payment (DRG) or exempt unit rate, the optional per diem adjusted DRG rate authorized in the managed care legislation and Part 86-1.51 (k) of the Commissioner's Rules and Regulations, or a negotiated rate based on a contract approved by the Commissioner of Health.

An HMO may be waived from all or part of the differential, if it meets the criteria described below by May 1, 1992 for the July 1, 1992 through December 31, 1992 rate period, and by October 1 of the year preceding each January-December rate period.

The Department of Health will notify all HMOs of their applicable factor by June 1, 1992 for the July - December 1992 rate period, and by December 1 of the year preceding each January - December rate period.

WAIVERS

Targeted Enrollment

All or part of this differential may be waived if an HMO adequately participates in the Medicaid managed care program, as determined in accordance with the criteria included in the legislation. In order to qualify for a total waiver, an HMO must enroll 90 percent of its "share" of the targeted number of non-exempt Medicaid eligibles within its service area. In order to qualify for a partial waiver (i.e., a 4.5% differential), an HMO must enroll 50 percent of its Medicaid target

enrollment for the 7/92 - 12/92 rate period, or 66% of its Medicaid target for the 1/93 - 12/93 rate period. An HMO's "share" of Medicaid eligibles is defined as its proportion of commercial enrollees compared to all HMOs' commercial enrollees within that HMO's service area. For example, if an HMO serves 20% of all HMO enrollees located within its service area, it would need to serve at least 90% of 20% of the targeted number of Medicaid eligibles in its service area for a full waiver.

The total targeted number of Medicaid Managed Care enrollees for each county is the greater of: 5% of the non-exempt Medicaid eligible population; for a designated county, the goal expected to have been attained by July 1 of the prior year, consistent with the Medicaid Managed Care legislation; or the actual number of managed care enrollees. Each HMO's target will reflect the sum of its target enrollment for each county in its service area. If an HMO meets its total service area target, and has a contract in every county, but does not meet the target for each county, it is deemed to have met the criteria.

County Exemptions

In addition to the criterion that HMOs meet their Medicaid target enrollment, each HMO is expected to have a managed care contract with each Local Social Services District falling within its service area. An HMO may appeal to the Department of Social Services for exemption from participation in managed care programs in one or more social services districts in its service area, by May 1, 1992 for an exemption in the July - December 1992 rate, and by July 1 of each year preceding each January - December rate. An exemption will apply only for the rate period for which it is issued.

An HMO may receive an exemption if it has demonstrated a good faith effort to enter into contracts with the social services districts in its service area. Examples of a good faith effort include:

1. The HMO has, by the designated dates, submitted to the local social services district in question, an implementation plan which has been approved by the Departments of Social Services and Health, and would have begun enrolling Medicaid eligibles in the district but for refusal of the district to sign a contract; or

of the Bad Debt and Charity Care Pool percent add-on. Payments made should reflect the HMO's best estimate of incurred but not reported discharges for that period, consistent with the IBNR methodology used in the HMO's financial statements. A reconciliation will be made subsequent to year-end to assure that proper payments were made by the HMO. The legislation stipulates that interest and penalties on arrearages be applied for non-compliance.

Any questions regarding payments to the pool by HMOs should be directed to:

Mr. Richard Pellegrini
Director
Bureau of Financial Management
and Information Support
Empire State Plaza
Corning Tower - Room 984
Albany, New York 12237-0719
(518) 474-1673

DATA SUBMISSION

As noted, an HMO's "share" of the Medicaid Managed Care target reflects, in part, its proportion of HMO enrollees in its service area. Attached is a form to be completed by each HMO, to be received by the Department of Health no later than May 1, 1992. The form should list in the first column each county in the HMO's approved service area. The second column should state the number of HMO commercial enrollees whose home address is located within that county. If enrollees reside outside of an HMO's approved service area but are enrolled based on their employer location, include such enrollees within the employer's county. The third column should reflect the number of Medicare enrollees, the fourth Medicaid enrollees, the fifth regional pilot project enrollees, and the sixth column total enrollment for each county.

The legislation requires that HMOs provide the most recent subscriber statistics available, in no event less recent than the prior year. In order to ensure comparability across HMOs, it is strongly urged that enrollment numbers should be reported as of March 31, 1992. The enrollment statistics should correspond to the enrollment reported in the HMO's quarterly statements. Any discrepancies should be explained. Failure to provide these data in a timely manner will result in automatic application of the 9 percent differential for the applicable rate period. In addition, such failure may result in imposition of financial penalties as authorized under Article 44 of the Public Health Law.

2. The HMO has submitted a letter of intent to contract with each of the counties in its service area, has executed contracts with 50% of the counties in its service area for the rate period beginning July 1, 1992, and with 66% of the counties in its service area for the rate period beginning January 1, 1993, and would have been able to execute contracts in the remaining districts but for a request by or agreement with the Department of Social Services to delay implementation; or

3. The HMO has submitted a letter of intent to contract with each of the counties in its service area, has executed contracts with counties in which at least 50% of the Medicaid eligible population of the HMO's service area reside for the rate period beginning July 1, 1992, and with counties in which 66% of the Medicaid eligible population reside for the rate period beginning January 1, 1993, and would have been able to execute contracts in the remaining districts but for a request by or agreement with the Department of Social Services to delay implementation.

The HMO must apply for county exemptions in writing, to:

Mr. Stuart Lefkowich
Assistant Commissioner
Bureau of Primary Care
Division of Medical Assistance
New York State Department
of Social Services
40 North Pearl Street
Albany, New York 12243
(518) 473-5875

PAYMENTS

The Department of Health will select a designated pool administrator to collect the payments to be made by HMOs. You will be notified of the selected administrator and will be provided detailed instructions regarding payments into the statewide health maintenance organization pool. HMOs are required to make estimated payments of amounts due for patients discharged in a calendar month no later than fifteen days following the month of discharge. This means that the first payment will be due, on August 15 for discharges occurring in July, 1992. The 9 or 4.5 percent differential should be multiplied by the hospital rate after application

Please return the completed enrollment data form and direct any questions regarding this data to:

Mr. Paul M. Tenan
Director
Bureau of Community Health
Insurance and Finance Systems
Empire State Plaza
Corning Tower - Room 1168
Albany, New York 12237-0721
(518) 474-5050

Sincerely,

Raymond Sweeney
Director
Office of Health Systems Management

Jo-Ann Costantino
Deputy Commissioner
Division of Medical Assistance
New York State Department
of Social Services

ENCLOSURE

CHAPTER 41 OF THE LAWS OF 1992

under section 1927 of the federal social security act, the department shall reimburse for covered outpatient drugs which are dispensed under the medical assistance program to all persons in receipt of medical assistance benefits as a result of their being eligible for or in receipt of home relief, only pursuant to the terms of the rebate agreement between the department and such manufacturer; provided, however, that any agreement between the department and a manufacturer entered into before August first, nineteen hundred ninety-one, shall be deemed to have been entered into on April first, nineteen hundred ninety-one; and provided further, that if a manufacturer has not entered into an agreement with the department before August first, nineteen hundred ninety-one, such agreement shall not be effective until April first, nineteen hundred ninety-two, unless such agreement provides that rebates will be retroactively calculated as if the agreement had been in effect on April first, nineteen hundred ninety-one. The rebate agreement between such manufacturer and the department shall utilize for [covered outpatient] single source drugs and innovator multiple source drugs the identical formula used to determine the basic rebate for federal financial participation single source drugs and innovator multiple source drugs, pursuant to paragraph one of subdivision (c) of section 1927 of the federal social security act, to determine the amount of the rebate pursuant to this paragraph. The rebate agreement between such manufacturer and the department shall utilize for non-innovator multiple source drugs the identical formula used to determine the basic rebate for federal financial participation non-innovator multiple source drugs, pursuant to paragraphs three and four of subdivision (c) of section 1927 of the federal social security act, to determine the amount of the rebate pursuant to this paragraph. The terms and conditions of such rebate agreement with respect to periodic payment of the rebate, provision of information by the department, audits, manufacturer provision of information verification of surveys, penalties, confidentiality of information, and length of the agreement shall apply to drugs of the manufacturer dispensed under the medical assistance program to all persons in receipt of medical assistance benefits as a result of their being eligible for or in receipt of home relief. The department in providing utilization data to a manufacturer (as provided for under section 1927.4 (b)(1)(A) of the federal social security act) shall provide such data by zip code, if requested, for drugs covered under a rebate agreement.

§ 93. (Intentionally omitted)

§ 94. (Intentionally omitted)

§ 95. Section 2807-c of the public health law is amended by adding a new subdivision 2-a to read as follows:

2-a. (a) Notwithstanding any inconsistent provision of this section or any other provision to the contrary, rates of payment to general hospitals for reimbursement of inpatient hospital services provided to subscribers of health maintenance organizations operating in accordance with the provisions of article forty-four of this chapter or article forty-three of the insurance law for patients discharged on or after July first, nineteen hundred ninety-two, excluding subscribers who are eligible for medical assistance pursuant to the social services law and participants in regional pilot projects established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight, shall be the case based payments per discharge as determined in accordance with subdivision one of this section or the per diem rates of payment determined in accordance with subdivision four of this section or the rate negotiated and approved pursuant to paragraph (b) of subdivision two of this sec-

tion, whichever is applicable, increased by a factor of nine percent, subject to an elimination of or a reduction in such factor pursuant to paragraph (b) of this subdivision. The commissioner shall advise each health maintenance organization on or before June first for the nineteen hundred ninety-two rate period and on or before December first for each annual period thereafter commencing on January first whether it qualifies for an elimination of or a reduction in the factor; provided, however, that a health maintenance organization may appeal on or before May first for an elimination of or a reduction in pursuant to paragraph (b) of this subdivision, to be effective July first, the factor established for the rate year.

(b) (i) The nine percent increase shall be eliminated for a health maintenance organization if on or before May first for the nineteen hundred ninety-two rate period and on or before October first preceding the nineteen hundred ninety-three rate year and April first, if the health maintenance organization has appealed therefor, for the six month period thereafter commencing on July first the health maintenance organization is determined by the commissioner of social services to be a managed care provider under section three hundred sixty-four-j of the social services law in each social services district within its service area, and to have enrolled at least ninety percent of the sum of its target numbers of medical assistance eligibles who are not exempt from participating in the managed care program and are residing in social services districts in its service area.

(ii) The nine percent increase shall be reduced by four and one-half percentage points if on or before May first for the nineteen hundred ninety-two rate period and on or before October first preceding the nineteen hundred ninety-three rate year and April first, if the health maintenance organization has appealed therefor, for the six month period thereafter commencing on July first the health maintenance organization is determined by the commissioner of social services to be a managed care provider under section three hundred sixty-four-j of the social services law in each social services district within its service area, and to have enrolled for the nineteen hundred ninety-two rate period at least fifty percent and for the nineteen hundred ninety-three rate year at least sixty-six percent of the sum of its target number of medical assistance eligibles who are not exempt from participating in the managed care program and are residing in social services districts in its service area.

(iii) A health maintenance organization may apply to the state commissioner of social services on or before May first for the nineteen hundred ninety-two rate period and on or before July first preceding the nineteen hundred ninety-three rate year for an exemption from participation in managed care programs in a social services district on such bases as demonstration of a good faith effort to enter into a managed care contract with the social services district, or such other criteria as the commissioner of social services may establish. For purposes of this paragraph, the health maintenance organization's service area shall be deemed not to include a social services district in which the health maintenance organization is exempted by the state commissioner of social services from participating in managed care programs. The target number for a social services district shall be determined by calculating the

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [ ] is old law to be omitted.

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ratio of the health maintenance organization's subscribers in the social services district, excluding subscribers who are eligible for medical assistance pursuant to the social services law, subscribers who are beneficiaries of title XVIII of the federal social security act (medicare) and participants in regional pilot projects established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight, to the number of all health maintenance organization subscribers residing in the social services district, excluding subscribers who are eligible for medical assistance pursuant to the social services law, subscribers who are beneficiaries of title XVIII of the federal social security act (medicare) and participants in regional pilot projects established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight, and applying that ratio to the medicaid managed care enrollment objective. The medicaid managed care enrollment objective for each social services district shall be the greater of: the number of medical assistance eligibles residing in the social services district who are not exempt from participating in managed care programs determined by the commissioner of social services to be the enrollment goal under approved medicaid managed care plans as of July first in the year preceding the rate year as required by paragraph seven of section three hundred sixty-four-j of the social services law; or five percent of the medical assistance eligibles who are not exempt from participating in managed care programs who reside in social services districts in which the first full year of an approved medicaid managed care plan has not been completed; or the actual number of medical assistance eligibles residing in the social services district who are not exempt from participating in managed care programs who are in fact enrolled in managed care programs as of July first of the year preceding the rate year (except as of May first, nineteen hundred ninety-two for the rate period commencing July first, nineteen hundred ninety-two). The data used to determine the subscriber ratio shall be based on the most recent subscriber statistics available. For purposes of this paragraph, managed care program enrollees in a health maintenance organization shall be deemed to include persons eligible for medical assistance pursuant to the social services law enrolled by the health maintenance organization through an affiliation contract, approved by the commissioner in consultation with the commissioner of social services, with a prepaid health services plan.

(c) (i) Each health maintenance organization shall pay into a statewide health maintenance organization pool created by the commissioner the factor established pursuant to paragraph (a) of this subdivision, as adjusted in accordance with paragraph (b) of this subdivision, for each patient discharged in the previous calendar month commencing with patients discharged on or after July first, nineteen hundred ninety-two. Funds accumulated in the pool, including income from invested funds, shall be deposited by the commissioner and credited to the general fund.

(ii) Payments by health maintenance organizations to the pool shall be made on a time schedule established by the council, subject to the approval of the commissioner, by regulation; provided, however, that estimated payments shall be due on or before the fifteenth day following the end of each month unless payments of actual amounts due for such calendar months have been made within such fifteen day time period. Interest and penalties on arrearages shall be determined in accordance with subdivision twenty of this section in the same manner as interest and

penalties on arrearages on payments to bad debt and charity care regional pools.

(iii) The commissioner is authorized to contract with a pool administrator designated in accordance with paragraph (c) of subdivision sixteen of this section, or if not available such other administrators as the commissioner shall designate, to receive and distribute health maintenance organization pool funds. In the event contracts are effectuated, the commissioner shall conduct or cause to be conducted annual audits of the receipt and distribution of the pool funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis two hundred thousand dollars, shall be paid from the pooled funds.

(d) (i) Notwithstanding any inconsistent provision of this section or any other law to the contrary, for a corporation organized and operating in accordance with article forty-three of the insurance law that offers a point of service type benefit and in addition is certified on April first, nineteen hundred ninety-two to operate as a health maintenance organization for which the number of enrollees in the health maintenance organization is reduced on or after April first, nineteen hundred ninety-two by more than twenty percent based on transfers to point of service indemnity type benefits offered by such corporations, the subscriber ratio for purposes of determining the target number of medical assistance recipients calculated pursuant to paragraph (b) of this subdivision shall be based on subscriber ratio data for the period prior to April first, nineteen hundred ninety-two and the factor of nine percent established pursuant to paragraph (a) of this subdivision, as adjusted in accordance with paragraph (b) of this subdivision, shall be applied further to rates of payment to general hospitals for reimbursement of inpatient hospital services provided to enrollees in the point of service indemnity type benefit. If a corporation can provide the commissioner with satisfactory evidence that the transfers from the health maintenance organization to the point of service contracts were due to reasons or circumstances beyond the control of the corporation, this paragraph will not apply.

(ii) Each article forty-three insurance law corporation shall pay into the statewide health maintenance organization pool created pursuant to paragraph (c) of this subdivision the factor as applied to point of service indemnity type benefit reimbursement pursuant to subparagraph (i) of this paragraph in such time and manner as established pursuant to paragraph (c) of this subdivision for purposes of payments by health maintenance organizations.

(e) Health maintenance organizations operating in accordance with article forty-four of this chapter or article forty-three of the insurance law and corporations organized and operating in accordance with article forty-three of the insurance law shall provide to the commissioner such information as the commissioner may require to effectuate the provisions of this subdivision, including by May first of each year data by county of total enrollment and separately identifying subscribers who are eligible for medical assistance pursuant to the social services law, subscribers who are beneficiaries of title XVIII of the federal social security act (medicare) and participants in regional pilot projects established pursuant to chapter seven hundred three of the laws of

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nineteen hundred eighty-eight, reflecting enrollment no earlier than the prior year.

§ 96. (Intentionally omitted)

§ 97. (Intentionally omitted)

§ 98. (Intentionally omitted)

§ 99. (a) Notwithstanding any inconsistent provision of law to the contrary, the sum of twenty-nine million dollars shall be reallocated from funds otherwise to be distributed in accordance with subparagraphs (i) and (ii) of paragraph (f) of subdivision 19 of section 2807-c of the public health law and credited to the department of social services medical assistance program general fund - local assistance account; provided, however, solely for the purposes of the calculations pursuant to subdivisions (a), (b) and (c) of section 11 of chapter 703 of the laws of 1988, such reallocated funds shall be deemed distributed in accordance with subparagraphs (i) and (ii) of paragraph (f) of subdivision 19 of section 2807-c of the public health law.

(b) Notwithstanding any inconsistent provision of law an amount of up to eight million dollars from funds accumulated in the bad debt and charity care regional pools created pursuant to subdivision nine of section twenty-eight hundred eight-c, subdivision fifteen of section twenty-eight hundred seven-a or paragraph (a) of subdivision sixteen of section twenty-eight hundred seven-c of the public health law shall be transferred and credited to the department of social services medical assistance program general fund - local assistance account.

§ 100. Notwithstanding any inconsistent provision of law or regulation to the contrary, the sum of fourteen million one hundred thousand dollars shall be reallocated from funds otherwise to be distributed in accordance with paragraph (b-1) of subdivision 19 of section 2807-c of the public health law and credited to the department of social services medical assistance program general fund - local assistance account; provided, however, such reallocated funds shall be deemed distributed in accordance with paragraph (b-1) of subdivision 19 of section 2807-c of the public health law. The commissioner may borrow from the regional or statewide pool reserves established pursuant to section 2807-c of the public health law such funds as shall be necessary to meet 1992 and 1993 premium requirements pursuant to paragraph (b-1) of subdivision 19 of section 2807-c of the public health law and shall refund such monies when 1992 and 1993 pool funds for purposes of paragraph (b-1) of subdivision 19 of section 2807-c of the public health law become available.

§ 101. Subparagraphs (iv) and (v) of paragraph (f) of subdivision 11 of section 2807-c of the public health law, as amended by chapter 938 of the laws of 1990, are amended to read as follows:

(iv) [redacted] of payment of a general hospital shall be adjusted in accordance [redacted] paragraph (c) of this subdivision to reflect the difference [redacted] an individual general hospital's case payment rates adjusted in accordance with subparagraph (i) of this paragraph for a rate period and such rates determined in accordance with paragraphs (a) and (b) of subdivision one of this section, taking into consideration any adjustment to case payment rates applicable for such rate period made in accordance with subparagraphs (ii) and (iii) and for the periods beginning on or after July first, nineteen hundred ninety and ending on [March] December thirty-first, nineteen hundred [ninety-two] ninety-three, subparagraph (v) of this paragraph.

(v) Notwithstanding any inconsistent provision of law, for the periods beginning on or after July first, nineteen hundred ninety and ending on [March] December thirty-first, nineteen hundred [ninety-two] ninety-