§ 2807-f. Health maintenance organization payment factor. 1. For purposes of this section, the following terms shall have the following meaning:

(a) "HMO" shall mean a health maintenance organization operating in accordance with the provisions of article forty-four of this chapter or article forty-three of the insurance law.

(b) "Medicaid" shall mean the medical assistance program established pursuant to title eleven of article five of the social services law.

2. For periods commencing on or after July first, nineteen hundred ninety-eight, an HMO payment factor shall be determined in accordance with subdivision three of this section. Such subdivision shall apply during the period July first, nineteen hundred ninety-eight through June thirtieth, nineteen hundred ninety-nine; provided, however, that this section shall expire and be deemed repealed on and after the date on which New York state is granted the authority, by federal waiver, agreed upon by the state and the secretary of the federal department of health and human services, or federal statute, to operate a mandatory medicaid managed care program.

3. (a) In recognition of the public benefits resulting from enrolling medicaid enrollees into managed care plans, HMOs are required to make a good faith effort to enroll medicaid recipients. A good faith effort shall be defined as:

(i) submitting a reasonable bid in response to a state or county procurement process;

(ii) willingness to enter into reasonable managed care contracts with counties in its approved service area;

(iii) demonstrating a willingness to enroll medicaid recipients including accepting referrals from counties, brokers and auto-assignments; and

(iv) such other factors as may be established by the commissioner.

(b) In the event that an HMO has not made a good faith effort to enroll medicaid recipients, the commissioner shall impose a payment factor of nine percent on payments to general hospitals for the calendar year by such HMO. The commissioner shall notify HMOs of any failure to make a good faith effort and the application of the payment factor by

November first preceding the applicable calendar year.

4. (a) Each HMO on behalf of general hospitals shall pay into a statewide health maintenance organization pool created by the commissioner the factor established pursuant to subdivision two or three and this subdivision for each patient discharged in the previous calendar month commencing with July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-nine or contracted hospital inpatient service obligations for periods on or after July first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-nine. Funds accumulated in the pool, including income from invested funds, shall be deposited by the commissioner and credited to the general fund.

(b) Payments by HMOs to the pool shall be due on or before the fifteenth day following the end of each month.

(c) (i) If a payment made for a month to which a payment factor applies is less than ninety percent of the actual amount due for such month, interest shall be due and payable to the commissioner by a health maintenance organization on the difference between the amount paid and the amount due from the day of the month the payment was due until the date of payment. The rate of interest shall be twelve percent per annum or, if greater, at the rate of interest set by the commissioner of taxation and finance with respect to underpayments of tax pursuant to subsection (e) of section one thousand ninety-six of the tax law minus four percentage points. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar.

(ii) If a payment made for a month to which a payment factor applies is less than seventy percent of the actual amount due for such month, a penalty shall be due and payable to the commissioner by a health maintenance organization of five percent of the difference between the amount paid and the amount due for such month when the failure to pay is for a duration of not more than one month after the due date of the payment with an additional five percent for each additional month or fraction thereof during which such failure continues, not exceeding twenty-five percent in the aggregate.

(iii) Overpayment by a health maintenance organization of a payment shall be applied to any other payment due pursuant to this section, or,

if no payment is due, at the election of the health maintenance organization shall be applied to future payments or refunded to the health maintenance organization. Interest shall be paid on overpayments from the date of overpayment to the date of crediting or refund at the rate determined in accordance with paragraph (a) of this subdivision only if the overpayment was made at the direction of the commissioner. Interest under this paragraph shall not be paid if the amount thereof is less than one dollar.

(d) The commissioner is authorized to contract with a pool administrator designated for purposes of administering pools pursuant to subdivision two-a of section twenty-eight hundred seven-c of this article as in effect on June thirtieth, nineteen hundred ninety-six, 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.

5. Payment factors established pursuant to this section shall not apply to payments for subscribers who are eligible for medical assistance pursuant to the social services law, participants in regional pilot projects established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight or successor insurance programs, and enrollees in the child health insurance program pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this title.

6. Notwithstanding any inconsistent provisions of the state administrative procedure act or any other provision of law, the commissioner is authorized to adopt or amend on an emergency basis any regulation he or she determines necessary to implement this section.

7. HMOs shall provide to the commissioner such information as the commissioner may require to effectuate the provisions of this section.