§ 367-b. Medical assistance information and payment system. 1. The department shall design and implement a statewide medical assistance information and payments system for the purpose of providing individual and aggregate data to social services districts to assist them in making basic management decisions, to the department and other state agencies to assist in the administration of the medical assistance program, and to the governor and the legislature as may be necessary to assist in making major administrative and policy decisions affecting such program. Such system shall be designed so as to be capable of the following:

a. receiving and processing information relating to the eligibility of each person applying for medical assistance and of issuing a medical assistance identification card to persons determined by a social services official to be eligible for such assistance;

b. receiving and processing information relating to each qualified provider of medical assistance furnishing care, services or supplies for which claims for payment are made pursuant to this title;

c. receiving and processing, in a form and manner prescribed by the department, all claims for medical care, services and supplies, and making payments for valid claims to providers of medical care, services and supplies on behalf of social services districts;

d. maintaining information necessary to allow the department, consistent with the powers and duties of the department of health, to review the appropriateness, scope and duration of medical care, services and supplies provided to any eligible person pursuant to this chapter; and

e. initiating implementation of such a system for the district comprising the city of New York, in a manner compatible with expansion of such system to districts other than the district comprising the city of New York.

2. Consistent with the capabilities of the system established pursuant to subdivision one of this section, the department shall assume payment

responsibilities on behalf of social services districts by promulgation of regulations approved by the director of the budget. Such regulations shall specify the providers of medical assistance and the medical care, services and/or supplies for the district or districts for which the department will assume payment responsibilities and the date on which such responsibilities shall be assumed. Such regulations shall be published for comment at least thirty days in advance of their promulgation and shall be filed with the secretary of state at least sixty days in advance of the date of assumption of responsibilities; provided, however, that with respect to a particular district the requirements for advance publications and/or filing may be waived, or the time limits reduced, with the written consent of the district to such waiver or reduction. Providers of medical care and services shall submit claims to the social services district for all items of care, services and supplies furnished prior to the date of state assumption of payment responsibilities and to the state for all such items furnished subsequent to such date. Such regulations shall also specify a final transition date after which any claiming submitted shall be enforceable by such provider only against the state and shall not be enforceable by such provider against the social services district; provided, however, that the department and the district may enter into a written agreement by which the department agrees on the basis of eligibility information provided by such district to pay claims submitted to such district prior to the final transition date.

3. Upon notice to a social services district in accordance with subdivision two, that the department intends to assume payment responsibilities on behalf of such district, (a) such district shall promptly submit to the department requested information regarding each person who applies for or has been determined eligible for medical assistance and each provider of medical assistance in such district; and (b) notwithstanding the provisions of paragraph (b) of subdivision three of section three hundred sixty-six-a of this chapter, the department shall provide each person found by such district to be eligible for medical assistance under this title with a medical assistance identification card.

4. Information relating to persons applying for or receiving medical assistance shall be considered confidential and shall not be disclosed to persons or agencies other than those considered entitled to such information in accordance with section one hundred thirty-six when such disclosure is necessary for the proper administration of public assistance programs.

5. By no later than forty-five days following the end of each calendar quarter after the second quarter of calendar year nineteen hundred seventy-six, the department shall, until full implementation has been achieved in all social services districts, report to the governor and the legislature regarding the current status of the medical assistance information and payment system, summarizing the progress achieved during the previous quarter and the anticipated major achievements of the succeeding two calendar quarters. The report shall include the current and anticipated overall expenditure and staffing levels for functions relating to the system, and shall specify each district affected or anticipated to be affected during the succeeding two calendar quarters and summarize the manner in which each such district is, or is anticipated to be, affected. In addition, the department shall prepare and submit to the governor and the legislature a special report demonstrating the appropriateness and relative cost-effectiveness of utilizing a fiscal intermediary.

In addition, for the purpose of insuring the compatability of the system servicing the district comprising the city of New York with the system servicing all other social services districts in the state, the department shall prepare and submit to the governor and the legislature on or before March first, nineteen hundred seventy-eight, a special report and recommendation covering the appropriateness and relative cost effectiveness of utilizing a fiscal intermediary or fiscal agent for all districts other than the district comprising the city of New York.

6. Each social services district shall be responsible for paying to the state a share of the state's expenditures for claims of providers of medical assistance attributable to such district, which shall be equal to the share of such expenditures such district would have borne after

reimbursement from state and federal funds in accordance with section three hundred sixty-eight-a of this chapter, had the expenditure been made by such district; provided, however, that no district shall be responsible for the state's expenditures for the administrative costs of developing, maintaining or operating the statewide medical assistance information and payment system; and provided, further, that no district shall be responsible for paying to the state any portion of the cost of medical assistance which the department is responsible for furnishing pursuant to section three hundred sixty-five of this chapter.

7. In any case in which the department has made payments for medical assistance on behalf of a social services district pursuant to this section, the commissioner on behalf of the social services official shall be empowered to bring actions to recover the cost of such assistance, pursuant to this subdivision and the provisions of title six of article three of this chapter.

8. (a) For the purpose of orderly and timely implementation of the medical assistance information and payment system, the department is hereby authorized to enter into agreements with fiscal intermediaries or fiscal agents for the design, development, implementation, operation, processing, auditing and making of payments, subject to audits being conducted by the state in accordance with the terms of such agreements, for medical assistance claims under the system described by this section in any social services district. Such agreements shall specifically provide that the state shall have complete oversight responsibility for the fiscal intermediaries' or fiscal agents' performance and shall be solely responsible for establishing eligibility requirements for recipients, provider qualifications, rates of payment, investigation of suspected fraud and abuse, issuance of identification cards, establishing and maintaining recipient eligibility files, provider profiles, and conducting state audits of the fiscal intermediaries' or agents' at least once annually. The system described in this subdivision shall be operated by one or more fiscal intermediaries or fiscal agents in accordance with this subdivision unless the department is otherwise authorized by a law enacted subsequent to the effective date of this subdivision to operate the system in another manner. In no event shall

such intermediary or agent be a political subdivision of the state or any other governmental agency or entity. Notwithstanding the foregoing, the department may make payments to a provider upon the commissioner's determination that the provider is temporarily unable to comply with billing requirements. The department shall consult with the office of Medicaid inspector general regarding any activities undertaken by the fiscal intermediaries or fiscal agents regarding investigation of suspected fraud and abuse.

(b) The department of health, in consultation with the office of Medicaid inspector general, shall develop, test and implement new methods to strengthen the capability of the medical assistance information and payment system to detect and control fraud and improve expenditure accountability, and is hereby authorized to enter into further agreements with fiscal and/or information technology agents for the development, testing and implementation of such new methods. Any such agreements shall be with agents which have demonstrated expertise in the areas addressed by the agreement. Such methods shall, at a minimum, address the following areas:

(1) Prepayment claims review. Develop, test and implement an automated claims review process which, prior to payment, shall subject medical assistance program services claims to review for proper coding and such other review as may be deemed necessary. Services subject to review shall be based on: the expected cost-effectiveness of reviewing such service; the capabilities of the automated system for conducting such a review; and the potential to implement such review with negligible effect on the turnaround of claims for provider payment or on recipient access to necessary services. Such initiative shall be designed to provide for the efficient and effective operation of the medical assistance program claims payment system by performing functions including, but not limited to, capturing coding errors, misjudgments, incorrect or multiple billing for the same service and possible excesses in billing or service use, whether intentional or unintentional.

(2) Coordination of benefits. Develop, test and implement an automated process to improve the coordination of benefits between the medical assistance program and other sources of coverage for medical assistance recipients. Such initiative shall initially examine the savings potential to the medical assistance program through retrospective review

of claims paid which shall be completed not later than January thirty-first, two thousand seven. If, based upon such initial experience, the Medicaid inspector general deems the automated process to be capable of including or moving to a prospective review, with negligible effect on the turnaround of claims for provider payment or on recipient access to services, then the Medicaid inspector general in subsequent tests shall examine the savings potential through prospective, pre-claims payment review.

(3) Comprehensive review of paid claims. Take all reasonable and necessary actions to intensify the state's current level of monitoring, analyzing, reporting and responding to medical assistance program claims data maintained by the state's medical assistance information and payment system contract agents. Pursuant to this initiative, the department of health, in collaboration with the office of Medicaid inspector general, shall make efforts to improve the utilization of such data in order to better identify fraud and abuse within the medical assistance program and to identify and implement further program and patient care reforms for the improvement of such program. In addition, the department of health, in consultation with such contract agents and the office of Medicaid inspector general, shall identify additional data elements that are maintained and otherwise accessible by the state, directly or through any of its contractors, that would, if coordinated with medical assistance data, further increase the effectiveness of data analysis for the management of the medical assistance program. To further the objectives of this subparagraph, the department of health, in collaboration with the office of Medicaid inspector general, shall provide or arrange in-service training for state and county medical assistance personnel to increase the capability for state and local data analysis, leading to a more cost-effective operation of the medical assistance program.

(4) Targeted claims and utilization review. Develop, test and implement an automated process for the targeted review of claims, services and/or populations not later than January thirty-first, two thousand seven. Such review shall be for the purposes of identifying statistical aberrations in the use or billing of such services and for assisting in the development and implementation of measures to ensure that service use and billing are appropriate to recipients' needs.

(c) The commissioner of health shall prepare and submit an interim report to the governor and legislature on the implementation of the initiatives specified in paragraph (b) of this subdivision no later than December first, two thousand seven. Such report shall also include recommendations for any revisions that would further facilitate the goals of such paragraph, including recommendations for expansion. In addition, the commissioner of health shall submit a final report not later than December first, two thousand eight. In preparing such interim and final reports, the commissioner of health shall consult with the Medicaid inspector general, third-party agents, providers and recipients associated with the implementation of paragraph (b) of this subdivision.

9. (a) In order to accomplish a more orderly transition to the medical assistance information and payment system authorized by this section, and to continue for a limited transition period the rate at which advanced revenues have been made available by local governmental units to certain hospitals providing services to persons eligible for medical assistance, the department is authorized to promulgate regulations establishing a system of accelerated payments to hospitals meeting the criteria set forth in this section.

(b) Such system of accelerated payments shall only be available to a general hospital, other than a public general hospital:

(i) which prior to January first, nineteen hundred seventy-eight received regular, periodic and recurring advanced revenues from a local governmental unit, the amount of which was based on anticipated medical assistance claims payments; and

(ii) which has demonstrated that its continued financial viability depends in substantial part on the rate at which such advanced revenues were made available by local governmental units prior to the time the department, pursuant to this section, assumed payment for such hospital responsibilities on behalf of the social services district in which it is located, taking into account any funds remaining available from the local governmental unit under its system of advanced revenues. For purposes of this subdivision, it shall be presumed that a hospital does not depend in substantial part on the rate at which advanced revenues were made available by a local governmental unit if it received such revenues for a period of less than nine months preceding the month in

which the department assumed payment responsibilities for such hospital;

(iii) for which payment responsibility is initially assumed by the department pursuant to this section during the period beginning June first, nineteen hundred seventy-eight and ending November thirtieth, nineteen hundred seventy-eight; and

(iv) which meets performance criteria established by department regulation relating to the ratio of acceptable claims for patient days submitted for medical assistance payment compared to the total patient days of the hospital and compared to such claims submitted in one or more previous months, and the time lapse between the date the service was provided and the date the claim was submitted.

(c) The regulations promulgated by the department pursuant to paragraph (a) of this subdivision shall provide that the amount of the accelerated payment for any month shall be determined for each hospital meeting the criteria set forth in this section on the basis of acceptable medical assistance claims submitted by the hospital in one or more previous months and the amount of accelerated revenues made available to the hospital by a local governmental unit prior to the time the department assumed payment responsibilities for the hospital. The amount of the accelerated payment for any given month shall not exceed the amount of a monthly aggregate claim to be submitted by the hospital to the department, which claim shall reflect items of care, services and supplies authorized under the medical assistance program pursuant to this title which are in fact provided prior to the date of the aggregate claim to persons who have been determined eligible for medical assistance, or based on the past performance of the hospital are likely to be determined eligible for medical assistance, when no other source of payment including third party health insurance and payments pursuant to title eighteen of the Federal Social Security Act are available for such items of care, service and supplies. Such aggregate claims shall be subject to the audit and warrant of the state comptroller.

(d) Any schedule of accelerated payments established by the department pursuant to this section shall assure that such payments are made for a period of no more than six months from the month in which the department assumes payment responsibility for the hospital, and shall provide for repayment of any amounts in excess of current audited claims, through reductions in current claims, at a rate that will assure full repayment

at the earliest time consistent with the purposes of this section, but in no event more than twenty-four months following the month in which the department assumes payment responsibilities for the hospital. However, where the commissioner of health has determined with the concurrence of the state hospital review and planning council that a hospital has satisfied the department of health regulations and is or has been authorized to participate in the emergency hospital reimbursement program pursuant to which repayment of all or part of any accelerated payments made by the department have been deferred in accordance with such regulations, notwithstanding the time limitations set forth above repayment of such deferred amounts shall be made in accordance with an orderly schedule of repayment established by the commissioner of health after consultation with the commissioner. In no event shall any reduction be made against current claims, grant funds or any amounts due said hospital in settlement of rate appeals, claims or lawsuits to satisfy such repayment obligations.

(e) In making accelerated payments pursuant to this subdivision and department regulations, the department shall utilize federal funds made available, and local funds, for such purposes or for purposes of payment by the department of medical assistance payments pursuant to this section.

* 10. a. For the purpose of timely payment, the department is hereby authorized to develop a concurrent payment system for general hospitals which elect to participate in the concurrent payment system and which are included in the payment component of the medical assistance information and payment system, and to promulgate regulations to govern such a system. The department may implement the concurrent payment system for any general hospital which has elected to participate and for which the department has chosen to implement the system.

b. For all participating general hospitals the department shall determine a biweekly concurrent payment which shall equal one twenty-sixth of the portion of the hospital's imputed or certified inpatient revenue cap (as defined in section twenty-eight hundred seven-a of the public health law) allocated for medical assistance payments. The concurrent payment shall be reviewed at the beginning of each quarter and adjusted to reflect any changes to the inpatient

revenue cap or portion allocated for medical assistance payments.

c. The department shall promulgate regulations, consistent with federal requirements for participation, governing the concurrent payment system. The regulations shall address, among other things, the method of calculating the concurrent payment, the method of reconciliation, the adjustment of the concurrent payment for the calculated difference, the manner of eliminating underpayments or overpayments to hospitals in exceptional circumstances such as significantly changing utilization, changes in bed or service capacity, or imminent insolvency. The department shall promulgate regulations establishing a procedure for recognizing open cases as of the date of reconciliation. The department shall also promulgate regulations setting forth standards for the timeliness and quality of billings and may lower the concurrent payment calculated in accordance with paragraph b of this subdivision for noncompliance with such regulations.

d. Any payment claims made to the department for days of inpatient care provided prior to the effective date of this subdivision shall be paid or denied in accordance with department regulations in effect when the care was provided.

e. For any general hospital which is not afforded the opportunity of participating in the concurrent payment system and which is in compliance with the billing requirements of the department, the department shall pay any financing or working capital charge levied by the hospital as authorized in section twenty-eight hundred seven-a of the public health law.

f. This subdivision shall be effective only if federal participation is available.

* NB Expires January 1, 1986

11. a. For the purpose of timely payment, the department is hereby authorized to develop a concurrent payment system for general hospitals which elect to participate in the concurrent payment system and which are included in the payment component of the medical assistance

information and payment system, and to promulgate regulations to govern such a system. The department may implement the concurrent payment system for any general hospital which has elected to participate and for which the department has chosen to implement the system.

b. For all participating general hospitals the department shall determine a biweekly concurrent payment which shall equal one twenty-sixth of the hospital's estimated yearly inpatient revenue from medical assistance payments. The concurrent payment shall be reviewed at the beginning of each quarter and adjusted to reflect any changes to the rates for medical assistance payments.

c. The department shall promulgate regulations, consistent with federal requirements for participation, governing the concurrent payment system. The regulations shall address, among other things, the method of calculating the concurrent payment, the method of reconciliation, the adjustment of the concurrent payment for the calculated difference, the manner of eliminating underpayments or overpayments to hospitals in exceptional circumstances such as significantly changing utilization, changes in bed or service capacity, or imminent insolvency. The department shall promulgate regulations establishing a procedure for recognizing open cases as of the date of reconciliation. The department shall promulgate regulations setting forth standards for the timeliness and quality of billings and may lower the concurrent payment calculated in accordance with paragraph b of this subdivision for noncompliance with such regulations.

d. Any payment claims made to the department for days of inpatient care provided prior to the effective date of this subdivision shall be paid or denied in accordance with department regulations in effect when the care was provided.

e. For any general hospital which is not afforded the opportunity of participating in the concurrent payment system and which is in compliance with the billing requirements of the department, the department shall pay any financing or working capital charge levied by the hospital as authorized in section twenty-eight hundred seven-a of

the public health law.

f. This subdivision shall be effective only if federal participation is available.

12. (a) For the purpose of regulating cash flow for general hospitals, the department shall develop and implement a payment methodology to provide for timely payments for inpatient hospital services eligible for case based payments per discharge based on diagnosis-related groups provided during the period January first, nineteen hundred eighty-eight through March thirty-first two thousand twenty-nine, by such hospitals which elect to participate in the system.

(b) In developing a payment methodology the department shall consider a system under which hospitals may be reimbursed on the basis of inpatient admissions, adjusted to payment on the basis of discharge data, with reconciliations established at time periods specified by the department. Under such a system variances between amounts paid on an admission basis and actual amounts due and to be paid on a discharge basis may be reflected in the amounts to be paid in a subsequent period.

13. Notwithstanding any inconsistent provision of law, in lieu of payments authorized by this chapter and/or any of the general fund or special revenue other appropriations made to the office of temporary and disability assistance and the office of children and family services, from funds otherwise due to local social services districts or in lieu of payments of federal funds otherwise due to local social services districts for programs provided under the federal social security act or the federal food stamp act or the low income home energy assistance program, funds in amounts certified by the commissioner of the office of temporary and disability assistance or the commissioner of the office of children and family services or the commissioner of health as due from local social services districts as their share of payments made pursuant to this section, may be set-aside by the state comptroller in an interest-bearing account with such interest accruing to the credit of the locality, pursuant to an estimate provided by the commissioner of health of a local social services district's share of medical assistance payments, except that in the case of the city of New York, such

set-aside shall be subject first to the requirements of a section of the chapter of the laws of two thousand one which enacted this provision, and then subject to the requirements of paragraph (i) of subdivision (b) of section two hundred twenty-two-a of chapter four hundred seventy-four of the laws of nineteen hundred ninety-six prior to the application of this subdivision. Should funds otherwise payable to a local social services district from appropriations made to the office of temporary and disability assistance, the office of children and family services, and the department of health be insufficient to fully fund the amounts identified by the commissioner of health as necessary to liquidate the local share of payments to be made pursuant to this section on behalf of the local social services district, the commissioner of health may identify other state or federal payments payable to that local social services district or any other county agency including, but not limited to the county department of health, from appropriations made to the state department of health, and may authorize the state comptroller, upon no less than five days written notice to such local social services district or such other county agency, to set-aside such payments in the interest-bearing account with such interest accruing to the credit of the locality. Upon such determination by the commissioner of health that insufficient funds are payable to a local social services district and any other county agency receiving payments from the office of temporary and disability assistance, the office of children and family services, and the state department of health from appropriations made to these agencies, the state comptroller shall, upon no less than five days written notice to such local social services district or such other county agency, withhold payments from any of the general fund - local assistance accounts or payments made from any of the special revenue - federal local assistance accounts, provided, however, that such federal payments shall be withheld only after such federal funds are properly credited to the county through vouchers, claims or other warrants properly received, approved, and paid by the state comptroller, and set-aside such disbursements in the interest-bearing account with such interest accruing to the credit of the locality until such time that the amount withheld from each county is determined by the commissioner of health to be sufficient to fully liquidate the local share of payments, as estimated by the commissioner of health, to be made pursuant to this

section on behalf of that local social services district.

14. Notwithstanding any other provision of law, effective on or before January first, two thousand one, the local social services district share of medical assistance payments made by the state on behalf of the local social services district shall be paid to the state by the local social services district using electronic funds transfer under the supervision of the state comptroller and pursuant to rules and regulations of the commissioner of health. The state comptroller shall deposit such funds in the medicaid management information system statewide escrow fund to the credit of each local district. In the event that the state comptroller and commissioner of health determine that there are insufficient funds available from the local district to liquidate their local share of medical assistance payments, the commissioner of health shall issue a repayment schedule to the state comptroller for purposes of reducing reimbursement from other sources of payment from the state to the city or county of which the local social services district is a part in accordance with subdivision thirteen of this section, until the amounts due from the local district are recovered in full plus any interest that would have otherwise accrued to the fund had such fund had sufficient balances from the local district. Upon determination by the state comptroller that insufficient sources of payment are available to fully liquidate the local social services district share of medical assistance payments, the commissioner of health shall include in such schedule a charge to the county equal to the amount of interest otherwise earned by the state short-term interest pool, plus any interest penalty as the commissioner of health may determine, until such time as the district has fully liquidated its liability pursuant to the provisions of this chapter.