

April 25, 1988

SUBJECT: INSURANCE

WITHDRAWN

Circular Letter No. 11 (1988)

TO: ALL INSURERS LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE, WORKERS' COMPENSATION AID NO-FAULT MOTOR VEHICLE INSURANCE

SUBJECT: INSURANCE PAYMENTS FOR HOSPITAL SERVICES UNDER 1988 LEGISLATION REQUIRING A CASE PAYMENT METHODOLOGY

The Insurance Department has been made aware that certain insurers have failed to comply with the provisions of Chapter 2 of the Laws of 1988 which established a case payment reimbursement system to hospitals by diagnosis-related group (DRG) for, all non-Medicare payors making payments directly to hospitals on an expense incurred basis, except self-pay patients. The new financing methodology for general hospital inpatient services is effective from January 1, 1988 through December 31, 1990.

Chapter 2 of the Laws of 1988 sets forth three general classifications of payors. An explanation of these classifications and their payment responsibility as set forth in statute are as follows:

Medicaid, Article 43 Corporations, Health Maintenance Organizations (HMO's)

Payments to general hospitals for reimbursement of inpatient hospital services, in a non-exempt unit, provided to Medicaid, Article 43 Corporation, or HMO patients shall be case based payments per discharge for each DRG, adjusted for uncovered services.

Workers' Compensation/No-Fault Motor Vehicle, Volunteer Firemen' Benefit Law, Commercial Health Insurance, Self Insured/Self Administered Employee Benefit Funds which pay hospital directly on an expense incurred basis.

Payments made to general hospitals for reimbursement of inpatient hospital services, in a non-exempt unit, provided to patients eligible pursuant to the Workers' Compensation Law, the Volunteer Firemen's Benefit Law, the Comprehensive Motor Vehicle Insurance Reparations Act, as well as those patients covered under commercial health insurance policies or self-insured funds where payment is made directly to the hospital on an expense incurred basis shall be the Blue Cross case payment per discharge rate adjusted for uncovered services, and increased by a differential of 13%.

SELF-PAY OR COMMERCIAL AND SELF-INSURED/SELF-ADMINISTERED EMPLOYEE BENEFIT FUNDS WHICH DO NOT PAY DIRECTLY ON AN EXPENSE INCURRED BASIS.

Payments made to general hospitals for reimbursement of inpatient hospital services in a non-exempt unit provided to patients shall be based upon the lower of the Blue Cross case payment rate, adjusted for uncovered services increased by 13% plus up to an additional 20% or charges.

It should be noted that the legislation does not provide an option to an insurer to pay the lesser of hospital charge or the DRG payment unless the insurer qualifies under the third category as defined immediately above. Commercial insurers and those self-insured/self-administered plans which make payment directly to general hospitals on an expense incurred basis are obligated to pay the Blue Cross rate for a DRG, adjusted for uncovered services, and increased by a differential of 13%. If a commercial insurer or self-insured/self-administered plan do not make payment directly to general hospitals, they are obligated to reimburse on the basis of the lower of hospital charges or the Blue Cross case payment rate, adjusted for uncovered services, increased by 13% plus up to an additional 20%.

While it is recognized that the abrupt change to the hospital reimbursement system established under Chapter 2 of the Laws of 1988 has created some temporary administrative difficulties, recent efforts have been made through meetings with representatives of the Department of Health, the Hospital Association of New York State, Workers' Compensation/No-Fault and commercial health insurers to address issues which may be contributing to a delay in proper payments for services to hospitals.

Those insurers desiring to obtain specific information concerning the calculation of DRG case payment rates should write to Donald MacDonald, Records Access Office, New York State Department of Health, Room 2230, Corning Tower, Empire State Plaza, Albany, New York 12237 and request the insurance carrier case payment information package. The cost of the package is \$34 and checks should be made payable to the New York State Health Department.

All insurers obligated by contract to make reimbursement for inpatient hospital services should be aware of the provisions of Chapter 2 of the Laws of 1988 and make certain that claims personnel make the appropriate payments for hospital services as required by the legislation.

Very truly yours,

James P. Corcoran

Superintendent of Insurance