S T A T E O F N E W Y O R K

9835--A

I N A S S E M B L Y

April 12, 2016

Introduced by M. of A. ABINANTI -- read once and referred to the Committee on Health -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law, in relation to payments from the New York state medical indemnity fund

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Section 2999-j of the public health law is amended by adding two new subdivisions 2-a and 7-a to read as follows:

2-A. A REQUEST FOR REVIEW OF A DENIAL OF A CLAIM OR A DENIAL OF A REQUEST FOR PRIOR AUTHORIZATION FOR THE PAYMENT OR REIMBURSEMENT FROM THE FUND FOR QUALIFYING HEALTH CARE COSTS MUST BE MADE BY THE CLAIMANT NO LATER THAN SIXTY DAYS FROM RECEIPT OF THE DENIAL AND, AT A CLAIMANT'S OPTION, BY EITHER (A) MAKING APPLICATION TO THE COURT WHEREIN THE JUDGEMENT WAS AWARDED OR THE CASE WAS SETTLED, OR (B) FOLLOWING THE PROCESS ESTABLISHED BY REGULATIONS OF THE COMMISSIONER FOR THE ADMINISTRATIVE REVIEW OF A DENIAL OF A CLAIM OR REQUEST FOR PRIOR AUTHORIZATION.

7-A. A REQUEST FOR A REVIEW OF A DETERMINATION BY THE FUND ADMINISTRATOR THAT THE RELEVANT PROVISIONS OF SUBDIVISION SIX OF THIS SECTION HAVE NOT BEEN MET AND/OR THAT THE PLAINTIFF OR CLAIMANT IS NOT A QUALIFIED PLAINTIFF MAY BE MADE BY ANY OF THE PARTIES, NO LATER THAN SIXTY DAYS FROM RECEIPT OF THE DENIAL, BY MAKING APPLICATION TO THE COURT WHEREIN THE JUDGMENT WAS AWARDED OR THE CASE WAS SETTLED.

S 2. Subdivisions 2 and 4 of section 2999-j of the public health law, as added by section 52 of part H of chapter 59 of the laws of 2011, are amended to read as follows:

2. The provision of qualifying health care costs to qualified plaintiffs shall not be subject to prior authorization, except as described by the commissioner in regulation; provided, however[, that]:

(A) such regulation shall not prevent qualified plaintiffs from receiving care or assistance that would, at a minimum, be authorized under the medicaid program; [and provided, further, that]

(B) if any prior authorization is required by such regulation, the regulation shall require that requests for prior authorization be processed within a reasonably prompt period of time and, SUBJECT TO THE PROVISIONS OF SUBDIVISION TWO-A OF THIS SECTION, shall identify a proc-

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

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ess for prompt administrative review of any denial of a request for prior authorization[.]; AND

(C) SUCH REGULATIONS SHALL NOT PROHIBIT QUALIFYING HEALTH CARE COSTS SOLELY ON THE BASIS THAT THE QUALIFYING HEALTH CARE COST IS THERAPEUTIC IN NATURE OR ON THE GROUNDS THAT THE QUALIFYING HEALTH CARE COST IS NOT LIMITED TO THE DIRECT NEED OF THE PATIENT AND MAY BENEFIT OTHER MEMBERS OF THE HOUSEHOLD.

4. The amount of qualifying health care costs to be paid from the fund shall be calculated[: (a) with respect to services provided in private physician practices on the basis of one hundred percent of the usual and customary rates,] ON THE BASIS OF ONE HUNDRED PERCENT OF THE USUAL AND CUSTOMARY COST. FOR THE PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COSTS" SHALL MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT OF FINANCIAL SERVICES. IF NO SUCH RATES ARE AVAILABLE QUALIFYING HEALTH CARE COSTS SHALL BE CALCULATED ON THE BASIS OF NO LESS THAN ONE HUNDRED THIRTY PERCENT OF MEDICAID OR MEDICARE RATES OF REIMBURSEMENT, WHICHEVER IS HIGHER. IF NO SUCH RATE EXISTS, COSTS SHALL BE REIMBURSED as defined by the commissioner in regulation[; or (b) with respect to all other services, on the basis of Medicaid rates of reimbursement or, where no such rates are available, as defined by the commissioner in regulation].

S 3. Subdivision 1 of section 2999-h of the public health law, as added by section 52 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

1. "Birth-related neurological injury" means an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation or by other medical services provided or not provided during delivery [admission] that rendered the infant with a permanent and substantial motor impairment or with a developmental disability as that term is defined by section 1.03 of the mental hygiene law, or both. This definition shall apply to live births only.

S 4. The public health law is amended by adding a new section 2999-k to read as follows:

S 2999-K. CONSUMER AND STAKEHOLDER WORKGROUP. THE DEPARTMENT SHALL CONVENE A WORKGROUP COMPRISED OF QUALIFIED PLAINTIFFS OR REPRESENTATIVES OF QUALIFIED PLAINTIFFS, PHYSICIANS, ADVOCATES AND OTHER INTERESTED PARTIES. SUCH WORKGROUP SHALL BE CO-CHAIRED BY THE COMMISSIONER AND THE SUPERINTENDENT OF FINANCIAL SERVICES, AND SHALL BE COMPOSED OF NOT LESS THAN NINE MEMBERS APPOINTED BY THE GOVERNOR, OF WHICH TWO SHALL BE APPOINTED UPON RECOMMENDATION OF THE TEMPORARY PRESIDENT OF THE SENATE AND TWO SHALL BE APPOINTED UPON THE RECOMMENDATION OF THE SPEAKER OF THE ASSEMBLY. IF THE COMMISSIONER SEEKS TO PROMULGATE RULES AND REGULATIONS PURSUANT TO THIS TITLE, HE OR SHE SHALL SUBMIT THE PROPOSED RULES AND REGULATIONS TO THE WORKGROUP FOR ITS INPUT AND COMMENTS. THE COMMISSIONER SHALL CONSIDER THE INPUT AND COMMENTS OF THE WORKGROUP PRIOR TO THE IMPLEMENTATION OF ANY PROPOSED RULE OR REGULATION, AND IF HE OR SHE SHALL ACT IN A MANNER INCONSISTENT WITH THE WORKGROUP'S INPUT AND COMMENTS, THE COMMISSIONER SHALL PROVIDE THE REASONS THEREFOR IN WRITING.

S 5. This act shall take effect on the forty-fifth day after it shall have become a law.