

6676

2009-2010 Regular Sessions

I N   A S S E M B L Y

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Introduced by M. of A. SCHIMMINGER, CHRISTENSEN, SCHROEDER, DelMONTE --  
Multi-Sponsored by -- M. of A. LAVINE, MAGEE, REILLY -- read once and  
referred to the Committee on Health

AN ACT to amend the social services law, in relation to authorizing the  
commissioner of health to apply for a medicaid reform demonstration  
waiver

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

1     Section 1. Section 366 of the social services law is amended by adding  
2     a new subdivision 6-b to read as follows:  
3     6-B. A. THE COMMISSIONER OF HEALTH SHALL APPLY FOR A MEDICAID REFORM  
4     DEMONSTRATION WAIVER PURSUANT TO SECTION ELEVEN HUNDRED FIFTEEN OF THE  
5     FEDERAL SOCIAL SECURITY ACT IN ORDER TO CREATE AN INITIATIVE TO PROVIDE  
6     FOR A MORE EFFICIENT AND EFFECTIVE MEDICAID SERVICES DELIVERY SYSTEM IN  
7     NEW YORK THAT EMPOWERS MEDICAID PATIENTS, BRIDGES PUBLIC AND PRIVATE  
8     COVERAGE, IMPROVES PATIENT OUTCOMES AND STABILIZES PROGRAM COSTS.  
9     B. THE DEMONSTRATION WAIVER SHALL INCLUDE, BUT SHALL NOT BE LIMITED  
10    TO, THE FOLLOWING COMPONENTS:  
11    (I) A RISK ADJUSTED CAPITATED MANAGED CARE PILOT PROGRAM FOR RECIPI-  
12    ENTS CURRENTLY SERVED IN MEDICAID-FEE-FOR SERVICE OR MEDICAID MANAGED  
13    CARE THAT PROVIDES BENEFIT PLANS THAT MORE CLOSELY RESEMBLE PRIVATE  
14    PLANS YET ARE ACTUARIALLY EQUIVALENT TO THE CURRENT MEDICAID BENEFIT  
15    PACKAGE. RISK ADJUSTED CAPITATION RATES SHALL BE SEPARATED INTO THREE  
16    COMPONENTS TO COVER COMPREHENSIVE CARE, CATASTROPHIC CARE AND ENHANCED  
17    SERVICES AND MAY PHASE-IN FINANCIAL RISK FOR APPROVED PROVIDERS. HEALTH  
18    PLANS SHALL PROVIDE COMPREHENSIVE CARE WHICH SHALL COVER ALL EXPENSES  
19    UNTIL A PREDETERMINED THRESHOLD OF EXPENSES IS REACHED AT WHICH TIME THE  
20    CATASTROPHIC COMPONENT SHALL TAKE OVER. HEALTH PLANS MAY CHOOSE TO  
21    ASSUME THE CATASTROPHIC RISK FOR TARGET POPULATIONS THEY SERVE. THE  
22    CATASTROPHIC COMPONENT SHALL ENCOURAGE PROVIDER NETWORKS TO IDENTIFY  
23    RECIPIENTS WITH UNDIAGNOSED CHRONIC ILLNESS AND ENSURE PROPER DISEASE

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

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1 MANAGEMENT OF THE ENROLLEES CONDITION. THE ENHANCED SERVICES COMPONENT  
2 SHALL ENCOURAGE ENROLLEES TO ENGAGE IN APPROVED HEALTH ACTIVITIES BY  
3 INCLUDING THE FLEXIBILITY FOR HEALTH SPENDING ACCOUNTS. PLANS SHALL BE  
4 ENCOURAGED TO ESTABLISH CUSTOMIZED BENEFIT PACKAGES TARGETED TO SPECIFIC  
5 SPECIAL NEEDS POPULATIONS THAT SHALL FOSTER ENROLLEE CHOICE AND ENABLE  
6 ENROLLEES TO ACCESS HEALTH CARE SERVICES THEY NEED. THE PACKAGES MAY  
7 VARY THE AMOUNT, DURATION AND SCOPE OF SOME TRADITIONAL MEDICAID  
8 SERVICES, PROVIDED THE MANDATORY MEDICAID SERVICES ARE INCLUDED, THE  
9 BENEFITS ARE ACTUARIALLY EQUIVALENT TO THE VALUE OF TRADITIONAL MEDICAID  
10 SERVICES, AND THEY PASS A SUFFICIENCY TEST TO ENSURE THE PACKAGE IS  
11 SUFFICIENT TO MEET THE MEDICAL NEEDS OF THE TARGET POPULATION. THESE  
12 BENEFIT PACKAGES SHALL BE PRIOR APPROVED BY THE COMMISSIONER. PARTIC-  
13 IPATION SHALL BE MANDATORY IN DEMONSTRATION AREAS FOR ALL MEDICAID POPU-  
14 LATIONS NOT SPECIFICALLY EXCLUDED BY THE COMMISSIONER OF HEALTH. THOSE  
15 NOT REQUIRED TO PARTICIPATE SHALL BE PROVIDED THE OPTION TO VOLUNTARILY  
16 PARTICIPATE IN THE DEMONSTRATION WAIVER;

17 (II) A CHOICE OF MANAGED CARE PROVIDER WHICH SHALL REST WITH THE INDI-  
18 VIDUAL RECIPIENT, PROVIDED FAILURE TO CHOOSE SHALL RESULT IN AN AUTOMAT-  
19 IC ASSIGNMENT. AFTER A LIMITED OPEN ENROLLMENT PERIOD, RECIPIENTS MAY BE  
20 LOCKED IN A CAPITATED MANAGED CARE NETWORK FOR TWELVE MONTHS. A RECIPI-  
21 ENT SHALL BE ALLOWED TO SELECT ANOTHER CAPITATED MANAGED CARE NETWORK  
22 AFTER TWELVE MONTHS OF ENROLLMENT. HOWEVER, NOTHING SHALL PREVENT A  
23 MEDICAID RECIPIENT FROM CHANGING PRIMARY CARE PROVIDERS WITHIN THE CAPI-  
24 TATED MANAGED CARE NETWORK DURING THE TWELVE MONTH PERIOD;

25 (III) AN OPT-OUT PROVISION WHEREBY MEDICAID RECIPIENTS SHALL BE ABLE  
26 TO USE THEIR MEDICAID PREMIUM TO PURCHASE HEALTH CARE COVERAGE THROUGH  
27 AN EMPLOYER SPONSORED HEALTH INSURANCE PLAN INSTEAD OF THROUGH A MEDI-  
28 CAID CERTIFIED PLAN;

29 (IV) AN ENHANCED BENEFIT PACKAGE UNDER WHICH MEDICAID RECIPIENTS WILL  
30 RECEIVE FINANCIAL INCENTIVES AS A REWARD FOR HEALTHIER BEHAVIOR. FUNDS  
31 SHALL BE DEPOSITED INTO A SPECIAL HEALTH SAVINGS ACCOUNT AND AVAILABLE  
32 TO THE INDIVIDUAL TO OFFSET HEALTH CARE RELATED COSTS SUCH AS OVER THE  
33 COUNTER MEDICINES, VITAMINS OR OTHER EXPENSES NOT COVERED UNDER THEIR  
34 PLAN OR TO RETAIN FOR USE IN PURCHASING EMPLOYER PROVIDED INSURANCE;

35 (V) A MECHANISM TO REQUIRE CAPITATED MANAGED CARE PLANS TO REIMBURSE  
36 QUALIFIED EMERGENCY SERVICE PROVIDERS, INCLUDING AMBULANCE SERVICES AND  
37 EMERGENCY MEDICAL SERVICES, PROVIDED THE DEMONSTRATION SHALL INCLUDE A  
38 PROVISION FOR CONTINUING FEE-FOR-SERVICE PAYMENTS FOR EMERGENCY SERVICES  
39 FOR INDIVIDUALS WHO ARE SUBSEQUENTLY DETERMINED TO BE ELIGIBLE FOR MEDI-  
40 CAID;

41 (VI) A CHOICE COUNSELING SYSTEM TO ASSIST RECIPIENTS IN SELECTING A  
42 CAPITATED MANAGED CARE PLAN THAT BEST MEETS THEIR NEEDS, INCLUDING  
43 INFORMATION ON BENEFITS PROVIDED, COST SHARING AND OTHER CONTRACT INFOR-  
44 MATION. THE COMMISSIONER OF HEALTH SHALL PROHIBIT PLANS, THEIR EMPLOYEES  
45 OR CONTRACTEES FROM RECRUITING RECIPIENTS, SEEKING ENROLLMENT THROUGH  
46 INDUCEMENTS, OR PREJUDICING RECIPIENTS AGAINST OTHER CAPITATED PLANS;

47 (VII) A SYSTEM TO MONITOR THE PROVISIONS OF HEALTH CARE SERVICES IN  
48 THE PILOT PROGRAM, INCLUDING UTILIZATION AND QUALITY OF CARE TO ENSURE  
49 ACCESS TO MEDICALLY NECESSARY SERVICES;

50 (VIII) A GRIEVANCE RESOLUTION PROCESS FOR MEDICAID RECIPIENTS ENROLLED  
51 IN THE PILOT PROGRAM INCLUDING AN EXPEDITED REVIEW IF THE LIFE OF A  
52 MEDICAID RECIPIENT IS IN IMMINENT AND EMERGENT JEOPARDY;

53 (IX) A GRIEVANCE RESOLUTION PROCESS FOR HEALTH CARE PROVIDERS EMPLOYED  
54 BY OR CONTRACTED WITH A CAPITATED MANAGED CARE NETWORK UNDER THE DEMON-  
55 STRATION WAIVER TO SETTLE DISPUTES; AND

(X) A TECHNICAL ADVISORY PANEL CONVENED BY THE COMMISSIONER OF HEALTH TO ADVISE THE AGENCY IN THE AREAS OF RISK-ADJUSTED-RATE SETTING, BENEFIT DESIGN INCLUDING THE ACTUARIAL EQUIVALENCE AND SUFFICIENCY STANDARDS TO BE USED, CHOICE COUNSELING AND ANY OTHER ASPECTS OF THE DEMONSTRATION IDENTIFIED BY THE COMMISSIONER OF HEALTH. THE PANEL SHALL INCLUDE, BUT SHALL NOT BE LIMITED TO, REPRESENTATIVES FROM THE STATE'S HEALTH PLANS, REPRESENTATIVES FROM PROVIDER-SPONSORED NETWORKS, A MEDICAID CONSUMER REPRESENTATIVE, AND A REPRESENTATIVE FROM THE STATE INSURANCE DEPARTMENT.

C. THE DEMONSTRATION WAIVER SHALL BE IMPLEMENTED IN NO LESS THAN THREE GEOGRAPHIC AREAS OF THE STATE TO BE DETERMINED BY THE COMMISSIONER OF HEALTH.

D. THE DEPARTMENT OF HEALTH SHALL COMPREHENSIVELY EVALUATE THE PROGRAMS CREATED IN THIS SUBDIVISION AND CONTINUE SUCH EVALUATION FOR TWENTY-FOUR MONTHS AFTER THE PILOT PROGRAMS HAVE ENROLLED MEDICAID RECIPIENTS AND PROVIDED HEALTH CARE SERVICES. THE EVALUATION SHALL INCLUDE ASSESSMENTS OF THE LEVEL OF CONSUMER EDUCATION, CHOICE AND ACCESS TO SERVICES, COORDINATION OF CARE, QUALITY OF CARE BY EACH ELIGIBILITY CATEGORY AND MANAGED CARE PLAN IN EACH PILOT SITE AND ANY COST SAVINGS. THE EVALUATION SHALL DESCRIBE ADMINISTRATIVE OR LEGAL BARRIERS TO THE IMPLEMENTATION AND OPERATION OF EACH PILOT PROGRAM AND INCLUDE RECOMMENDATIONS REGARDING STATEWIDE EXPANSION OF THE MANAGED CARE PILOT PROGRAMS. THE DEPARTMENT OF HEALTH SHALL SUBMIT AN EVALUATION REPORT TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY BY DECEMBER THIRTY-FIRST, TWO THOUSAND TWELVE.

E. UPON COMPLETION OF THE EVALUATION CONDUCTED UNDER PARAGRAPH D OF THIS SUBDIVISION, THE COMMISSIONER OF HEALTH MAY REQUEST STATEWIDE EXPANSION OF THE DEMONSTRATION PROJECTS. STATEWIDE EXPANSION INTO ADDITIONAL AREAS SHALL BE CONTINGENT UPON REVIEW AND APPROVAL BY THE LEGISLATURE.

F. THIS WAIVER AUTHORITY IS CONTINGENT UPON FEDERAL APPROVAL AND FEDERAL FINANCIAL PARTICIPATION (FFP) FOR:

(I) THOSE MEDICAID BENEFITS AND ELIGIBILITY CATEGORIES PARTICIPATING IN THE WAIVER, INCLUDING THE LOCK-IN PROVISIONS;

(II) THE EMPLOYER SPONSORED INSURANCE OPTION WITH COST SHARING;

(III) ANY ENHANCED BENEFIT EXPENDITURES, INCLUDING THE ABILITY TO DISBURSE HEALTH SAVINGS ACCOUNT FUNDS TO FORMER MEDICAID RECIPIENTS WHO ACCRUED FUNDS WHILE ON MEDICAID; AND

(IV) ANY OTHER FEDERAL APPROVALS OR FEDERAL FINANCIAL PARTICIPATION CONTINGENCIES THAT THE COMMISSIONER OF HEALTH MAY DEEM NECESSARY.

S 2. This act shall take effect immediately; provided, however, that the department of health shall submit the medicaid reform demonstration waiver pursuant to the provisions of subdivision 6-b of section 366 of the social services law, as added by section one of this act, within six months of the effective date of this act.