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

2737--A

2013-2014 Regular Sessions

I N S E N A T E

January 23, 2013

Introduced by Sen. RANZENHOFER -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- recommitted to the Committee on Health in accordance with Senate Rule 6, sec. 8 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the social services law, in relation to mandatory managed care for certain recipients of medical assistance

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

Section 1. Paragraph (b) of subdivision 1 of section 364-j of the social services law, as amended by chapter 649 of the laws of 1996, subparagraph (i) as amended by section 35-a and subparagraph (ii) as amended and subparagraph (iii) as added by section 77 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(b) "Managed care provider". An entity that provides or arranges for the provision of medical assistance services and supplies to participants directly or indirectly (including by referral), including case management; and:

(i) is authorized to operate under article forty-four of the public health law or article forty-three of the insurance law and provides or arranges, directly or indirectly (including by referral) for covered comprehensive health services on a full capitation basis, including a special needs managed care plan or comprehensive HIV special needs plan CERTIFICATE OF AUTHORITY PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE-C OF THE PUBLIC HEALTH LAW; [or]

(ii) is authorized as a partially capitated program pursuant to section three hundred sixty-four-f of this title or section forty-four hundred three-e of the public health law or section 1915b of the social security act; [or]

(iii) is authorized to operate under section forty-four hundred three-g of the public health law[.]; OR

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

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(IV) IS A RURAL HEALTH NETWORK AS DEFINED IN SUBDIVISION TWO OF SECTION TWENTY-NINE HUNDRED FIFTY-ONE OF THE PUBLIC HEALTH LAW.

S 2. Paragraph (e) of subdivision 3 of section 364-j of the social services law, as amended by section 38 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(e) The following categories of individuals [may] SHALL be required to enroll with a managed care program [when] FOLLOWING THE APPROVAL OF program features and reimbursement rates [are approved] by the commissioner of health and, as appropriate, the commissioners of the office of mental health, the office for people with developmental disabilities, the office of children and family services, and the office of alcoholism and substance abuse services:

(i) an individual dually eligible for medical assistance and benefits under the federal Medicare program; provided, however, nothing herein shall: (a) require an individual enrolled in a managed long term care plan, pursuant to section forty-four hundred three-f of the public health law, to disenroll from such program; or (b) make enrollment in a Medicare managed care plan a condition of the individual's participation in the managed care program pursuant to this section, or affect the individual's entitlement to payment of applicable Medicare managed care or fee for service coinsurance and deductibles by the individual's managed care provider.

(ii) an individual eligible for supplemental security income;

(iii) HIV positive individuals;

(iv) persons with serious mental illness and children and adolescents with serious emotional disturbances[, as defined in section forty-four hundred one of the public health law];

(v) a person receiving services provided by a residential alcohol or substance abuse program or facility for the developmentally disabled;

(vi) a person receiving services provided by an intermediate care facility for the developmentally disabled or who has characteristics and needs similar to such persons;

(vii) a person with a developmental or physical disability who receives home and community-based services or care-at-home services through existing waivers under section nineteen hundred fifteen (c) of the federal social security act or who has characteristics and needs similar to such persons;

(viii) a person who is eligible for medical assistance pursuant to subparagraph twelve or subparagraph thirteen of paragraph (a) of subdivision one of section three hundred sixty-six of this title;

(ix) a person receiving services provided by a long term home health care program, or a person receiving inpatient services in a state-operated psychiatric facility or a residential treatment facility for children and youth;

(x) certified blind or disabled children living or expected to be living separate and apart from the parent for thirty days or more;

(xi) residents of nursing facilities;

(xii) a foster child in the placement of a voluntary agency or in the direct care of the local social services district;

(xiii) a person or family that is homeless;

(xiv) individuals for whom a managed care provider is not geographically accessible so as to reasonably provide services to the person. A managed care provider is not geographically accessible if the person cannot access the provider's services in a timely fashion due to distance or travel time;

(xv) a person eligible for Medicare participating in a capitated demonstration program for long term care;
(xvi) an infant living with an incarcerated mother in a state or local correctional facility as defined in section two of the correction law;
(xvii) a person who is expected to be eligible for medical assistance for less than six months;
(xviii) a person who is eligible for medical assistance benefits only with respect to tuberculosis-related services;
(xix) individuals receiving hospice services at time of enrollment; provided, however, that this clause shall not be construed to require an individual enrolled in a managed long term care plan or another care coordination model, who subsequently elects hospice, to disenroll from such program;
(xx) a person who has primary medical or health care coverage available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost sharing amounts, when payment of such premium or cost sharing amounts would be cost-effective, as determined by the local social services district;
(xxi) a person receiving family planning services pursuant to subparagraph six of paragraph (b) of subdivision one of section three hundred sixty-six of this title;
(xxii) a person who is eligible for medical assistance pursuant to paragraph (d) of subdivision four of section three hundred sixty-six of this title;
(xxiii) individuals with a chronic medical condition who are being treated by a specialist physician that is not associated with a managed care provider in the individual's social services district; and
(xxiv) Native Americans.

S 3. Section 364-j of the social services law is amended by adding two new subdivisions 29 and 30 to read as follows:

29. THE COMMISSIONER OF HEALTH SHALL TAKE ALL MEASURES NECESSARY AND CONVENIENT TO CAUSE ALL SOCIAL SERVICES DISTRICTS IN THE STATE NOT ALREADY DOING SO TO PROVIDE MEDICAL ASSISTANCE AND IMPLEMENT THE STATE'S MANAGED CARE PROGRAM AND PARTICIPATE IN SUCH PROGRAM AUTHORIZED BY THIS SECTION.

30. THE COMMISSIONER OF HEALTH SHALL SUBMIT THE APPROPRIATE WAIVERS, STATE PLAN AMENDMENTS AND FEDERAL APPLICATIONS, INCLUDING BUT NOT LIMITED TO, WAIVER REQUESTS AUTHORIZED PURSUANT TO SECTIONS ELEVEN HUNDRED FIFTEEN AND NINETEEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT, OR SUCCESSOR PROVISIONS, AS THE COMMISSIONER OF HEALTH SHALL DEEM NECESSARY TO SECURE APPROPRIATE FEDERAL FINANCIAL SUPPORT FOR THE COST OF A PROGRAM TO AUTHORIZE MANDATORY MANAGED CARE FOR MEDICAL ASSISTANCE RECIPIENTS RESIDING IN ALL AREAS OF THE STATE, INCLUDING RECIPIENTS OF SUPPLEMENTAL INCOME AND PERSONS ENROLLED OR ELIGIBLE TO BE ENROLLED IN A MEDICARE TEFRA PLAN.

S 4. Section two of this act shall not take effect unless and until the commissioner of health receives all necessary approvals under federal law and regulation to implement its provisions, and provided that such provisions do not prevent the receipt of federal financial participation under the medical assistance program. The commissioner of health shall submit such waiver applications and/or state plan amendments as may be necessary to obtain such approvals and to ensure continued federal financial participation.

S 5. This act shall take effect immediately; provided, however, that:

(a) the amendments to section 364-j of the social services law made by sections two and three of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

(b) the amendment to subparagraphs (ii) and (iii) of paragraph (b) of section 364-j of the social services law shall not affect the expiration or repeal of such subparagraphs and the repeal of such section;

(c) provided that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of the enactment of the legislation provided for in section two of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effecting the provisions of section 44 of the legislative law and section 70-b of the public officers law.