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

5986--A

2015-2016 Regular Sessions

I N A S S E M B L Y

March 9, 2015

Introduced by M. of A. SCHIMMINGER, LAVINE, MAGEE, GIGLIO -- read once and referred to the Committee on Health -- recommitted to the Committee on Health in accordance with Assembly Rule 3, sec. 2 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

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 ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Section 366 of the social services law is amended by adding a new subdivision 6-b to read as follows:

6-B. A. THE COMMISSIONER OF HEALTH SHALL APPLY FOR A MEDICAID REFORM DEMONSTRATION WAIVER PURSUANT TO SECTION ELEVEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT IN ORDER TO CREATE AN INITIATIVE TO PROVIDE FOR A MORE EFFICIENT AND EFFECTIVE MEDICAID SERVICES DELIVERY SYSTEM IN NEW YORK THAT EMPOWERS MEDICAID PATIENTS, BRIDGES PUBLIC AND PRIVATE COVERAGE, IMPROVES PATIENT OUTCOMES AND STABILIZES PROGRAM COSTS.

B. THE DEMONSTRATION WAIVER SHALL INCLUDE, BUT SHALL NOT BE LIMITED TO, THE FOLLOWING COMPONENTS:

(I) A RISK ADJUSTED CAPITATED MANAGED CARE PILOT PROGRAM FOR RECIPIENTS CURRENTLY SERVED IN MEDICAID-FEE-FOR SERVICE OR MEDICAID MANAGED CARE THAT PROVIDES BENEFIT PLANS THAT MORE CLOSELY RESEMBLE PRIVATE PLANS YET ARE ACTUARIALLY EQUIVALENT TO THE CURRENT MEDICAID BENEFIT PACKAGE. RISK ADJUSTED CAPITATION RATES SHALL BE SEPARATED INTO THREE COMPONENTS TO COVER COMPREHENSIVE CARE, CATASTROPHIC CARE AND ENHANCED SERVICES AND MAY PHASE IN FINANCIAL RISK FOR APPROVED PROVIDERS. HEALTH PLANS SHALL PROVIDE COMPREHENSIVE CARE WHICH SHALL COVER ALL EXPENSES UNTIL A PREDETERMINED THRESHOLD OF EXPENSES IS REACHED AT WHICH TIME THE CATASTROPHIC COMPONENT SHALL TAKE OVER. HEALTH PLANS MAY CHOOSE TO ASSUME THE CATASTROPHIC RISK FOR TARGET POPULATIONS THEY SERVE. THE

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

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CATASTROPHIC COMPONENT SHALL ENCOURAGE PROVIDER NETWORKS TO IDENTIFY RECIPIENTS WITH UNDIAGNOSED CHRONIC ILLNESS AND ENSURE PROPER DISEASE MANAGEMENT OF THE ENROLLEE'S CONDITION. THE ENHANCED SERVICES COMPONENT SHALL ENCOURAGE ENROLLEES TO ENGAGE IN APPROVED HEALTH ACTIVITIES BY INCLUDING THE FLEXIBILITY FOR HEALTH SPENDING ACCOUNTS. PLANS SHALL BE ENCOURAGED TO ESTABLISH CUSTOMIZED BENEFIT PACKAGES TARGETED TO SPECIFIC SPECIAL NEEDS POPULATIONS THAT SHALL FOSTER ENROLLEE CHOICE AND ENABLE ENROLLEES TO ACCESS HEALTH CARE SERVICES THEY NEED. THE PACKAGES MAY VARY THE AMOUNT, DURATION AND SCOPE OF SOME TRADITIONAL MEDICAID SERVICES, PROVIDED THE MANDATORY MEDICAID SERVICES ARE INCLUDED, THE BENEFITS ARE ACTUARIALLY EQUIVALENT TO THE VALUE OF TRADITIONAL MEDICAID SERVICES, AND THEY PASS A SUFFICIENCY TEST TO ENSURE THE PACKAGE IS SUFFICIENT TO MEET THE MEDICAL NEEDS OF THE TARGET POPULATION. THESE BENEFIT PACKAGES SHALL BE PRIOR APPROVED BY THE COMMISSIONER OF HEALTH. PARTICIPATION SHALL BE MANDATORY IN DEMONSTRATION AREAS FOR ALL MEDICAID POPULATIONS NOT SPECIFICALLY EXCLUDED BY THE COMMISSIONER OF HEALTH. THOSE NOT REQUIRED TO PARTICIPATE SHALL BE PROVIDED THE OPTION TO VOLUNTARILY PARTICIPATE IN THE DEMONSTRATION WAIVER;

(II) A CHOICE OF MANAGED CARE PROVIDER WHICH SHALL REST WITH THE INDIVIDUAL RECIPIENT, PROVIDED FAILURE TO CHOOSE SHALL RESULT IN AN AUTOMATIC ASSIGNMENT. AFTER A LIMITED OPEN ENROLLMENT PERIOD, RECIPIENTS MAY BE LOCKED IN A CAPITATED MANAGED CARE NETWORK FOR TWELVE MONTHS. A RECIPIENT SHALL BE ALLOWED TO SELECT ANOTHER CAPITATED MANAGED CARE NETWORK AFTER TWELVE MONTHS OF ENROLLMENT. HOWEVER, NOTHING SHALL PREVENT A MEDICAID RECIPIENT FROM CHANGING PRIMARY CARE PROVIDERS WITHIN THE CAPITATED MANAGED CARE NETWORK DURING THE TWELVE MONTH PERIOD;

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

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

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

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

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

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

(IX) A GRIEVANCE RESOLUTION PROCESS FOR HEALTH CARE PROVIDERS EMPLOYED BY OR CONTRACTED WITH A CAPITATED MANAGED CARE NETWORK UNDER THE DEMONSTRATION 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 DEPARTMENT OF FINANCIAL SERVICES.

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 NINETEEN.

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.