STATE OF NEW YORK

4557

2017-2018 Regular Sessions

IN SENATE

February 17, 2017

Introduced by Sen. ORTT -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the social services law, in relation to preserving access to quality complex rehabilitation technology for patients with complex medical needs

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Short title. This act shall be known and may be cited as the "complex needs patient act".

§ 2. Legislative intent. It is the intent of the legislature to:

1. protect access for complex needs patients to quality complex rehabilitation technology;

2. establish and improve standards and safeguards relating to the provision of complex rehabilitation technology; and

3. provide quality support for complex needs patients to stay in the home or community setting, prevent institutionalization, and prevent hospitalizations and other costly secondary complications.

§ 3. The social services law is amended by adding a new section 367-j to read as follows:

§ 367-j. Complex needs patient act. 1. Definitions. As used in this section:

(a) "Complex needs patient" means an individual with significant physical or functional impairment resulting from a medical condition or disease including, but not limited to: spinal cord injury, traumatic brain injury, cerebral palsy, muscular dystrophy, spina bifida, osteogenesis imperfecta, arthrogryposis, amyotrophic lateral sclerosis, multiple sclerosis, demyelinating disease, myelopathy, myopathy, progressive muscular atrophy, anterior horn cell disease, post-polio syndrome, cerebellar degeneration, dystonia, huntington's disease, spinocerebellar disease, and certain types of amputation, paralysis or paresis.

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

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(b) "Complex rehabilitation technology" means products classified as durable medical equipment within the medicare program as of January first, two thousand fifteen that are individually configured for individuals to meet their specific and unique medical, physical and functional needs and capacities for basic and functional activities of daily living. Such products include, but are not limited to: individually configured manual and power wheelchairs and accessories, adaptive seating and positioning items and accessories, and other specialized equipment such as standing frames and gait trainers and accessories.

(c) "Employee" means a person whose taxes are withheld by a qualified complex rehabilitation technology supplier and reported to the internal revenue service.

(d) "Healthcare common procedure coding system", or "HCPCS", means the billing codes used by medicare and overseen by the federal centers for medicare and medicaid services that are based on the current procedural technology codes developed by the American medical association.

(e) "Individually configured" means a device with a combination of sizes, features, adjustments or modifications that are configured or designed by a qualified complex rehabilitation technology supplier for a specific individual by measuring, fitting, programming, adjusting or adapting the device so that the device is consistent with the individual's medical condition, physical and functional needs and capabilities, body size, period of need and intended use as determined by an assessment or evaluation by a qualified health care professional.

(f) "Mixed HCPCS codes" means Healthcare Common Procedure Coding System codes that refer to a mix of complex rehabilitation technology products and standard mobility and accessory products.

(g) "Pure HCPCS codes" means Healthcare Common Procedure Coding System codes that refer exclusively to complex rehabilitation technology products.

(h) "Qualified complex rehabilitation technology professional" means an individual who is certified as an assistive technology professional (ATP) by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

(i) "Qualified complex rehabilitation technology supplier" means a company or entity that:

(i) is accredited by a recognized accrediting organization;

(ii) is an enrolled medicare supplier and meets the supplier and quality standards established for durable medical equipment suppliers including those for complex rehabilitation technology under the medicare program;

(iii) has at least one employee who is a qualified complex rehabilitation technology professional available to analyze the needs and capacities of complex needs patients in consultation with a qualified health care professional and participate in the selection of appropriate complex rehabilitation technology and provide training in the proper use of the complex rehabilitation technology;

(iv) requires a qualified complex rehabilitation technology professional be physically present for the evaluation and determination of appropriate complex rehabilitation technology for complex needs patients;

(v) has the capability to provide service and repair by qualified technicians for all complex rehabilitation technology it sells;

(vi) has at least one storefront location within New York state; and

(vii) provides written information regarding how to receive service and repair of complex rehabilitation technology to the complex needs patient prior to the ordering of such technology.

(j) "Qualified health care professional" means a health care professional licensed by the state education department who has no financial relationship with a qualified complex rehabilitation technology supplier, including but not limited to a physician, physical therapist, occupational therapist, or other licensed health care professional who performs specialty evaluations within the professional's scope of practice.

2. Reimbursement and billing procedures. (a) To the extent permissible under federal law, the commissioner shall maintain specific reimbursement and billing procedures within the state medicaid program for complex rehabilitation technology products and services to ensure that medicaid payments for such products and services permit adequate access to complex needs patients and takes into account the significant resources, infrastructure, and staff needed to meet their needs.

(b) Pursuant to paragraph (a) of this subdivision, the commissioner shall, not later than October first, two thousand nineteen: (i) designate products and services included in mixed and pure HCPCS billing codes as complex rehabilitation technology, and as deemed necessary and appropriate by the commissioner, create new billing codes or code modifiers for services and products covered for complex needs patients; (ii) set minimum standards consistent with paragraph (i) of subdivision one of this section in order for suppliers to be considered qualified complex rehabilitation technology suppliers eligible for medicaid reimbursement; (iii) exempt products or services billed under mixed or pure HCPCS codes from inclusion in any bidding, selective contracting, request for proposal, or similar initiative; (iv) require complex needs patients receiving a complex rehabilitation manual wheelchair, power wheelchair, or seating component to be evaluated by a qualified health care professional and a qualified complex rehabilitation technology professional to qualify for reimbursement (such evaluation shall be exempt from any health care professional cap); and (v) make other changes as needed to protect access to complex rehabilitation technology for complex needs patients. The reimbursement rate paid to providers for complex rehabilitation technology products and services by managed care organizations pursuant to section forty-four hundred three-f of the public health law and section three hundred sixty-four-j of this title shall be determined by agreement between the provider and managed care organization. The amount of any reimbursement rate increase resulting from the implementation of this section shall be specifically identified in the managed care organization's premiums and the commissioner shall provide for the expeditious increase of such premiums to ensure the actuarial soundness and adequacy of such premiums and to accurately account for the cost of the amounts paid to providers pursuant to this section. The commissioner, in his or her judgment, may establish a minimum benchmark reimbursement rate for managed care organizations to pay contracted providers pursuant to this section, provided such benchmark rate is specifically identified and included in the managed care organizations premiums.

§ 4. This act shall take effect on the first of January next succeeding the date on which it shall have become a law, and shall apply to contracts and policies issued, renewed, modified or amended on or after such effective date.