STATE OF NEW YORK

4973

2019-2020 Regular Sessions

IN SENATE

April 3, 2019

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

AN ACT to amend the social services law and the public health law, in relation to needs assessment and rate adequacy for medicaid

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

Section 1. Section 365-a of the social services law is amended by adding a new subdivision 10 to read as follows:

10. For any determination of the amount, nature and manner of providing assistance under this article for which an assessment tool is used, the department, in consultation with the independent actuary, representatives of medical assistance recipients, representatives of the managed care programs, representatives of long term care providers and other interested parties, shall evaluate existing assessment tools and develop additional professionally and statistically valid assessment tools to be used to assist in determining the amount, nature and manner of services and care needs of individuals which shall involve consideration of variables including but not limited to physical and behavioral functioning; activities of daily living and instrumental activities of daily living; family, social or geographic determinants of health; primary or secondary diagnoses of cognitive impairment or mental illness; and other appropriate conditions or factors.

§ 2. Paragraphs (c) of subdivision 18 of section 364-j of the social services law, as added by sections 40-c and 55 of part B of chapter 57 of the laws of 2015, are amended to read as follows:

(c) **(i)** In setting such reimbursement methodologies, the department shall consider costs borne by the managed care program to ensure actuarially sound and adequate rates of payment to ensure quality of care **for its enrollees and shall comply with all applicable federal and state laws and regulations, including, but not limited to, those relating to wages, labor, and actuarial soundness**.

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

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[~~(c)~~] (ii) The department [~~of health~~] shall require the independent actuary selected pursuant to paragraph (b) of this subdivision to provide a complete actuarial memorandum, along with all actuarial assumptions made and all other data, materials and methodologies used in the development of rates, to managed care providers thirty days prior to submission of such rates to the centers for medicare and medicaid services for approval. Managed care providers may request additional review of the actuarial soundness of the rate setting process and/or methodology.

(iii) In fulfilling the requirements of this paragraph, the department shall establish separate rate cells or risk adjustments to reflect the costs of care for specific high-need enrollees in managed care providers. The commissioner shall make any necessary amendments to the state plan for medical assistance under section three hundred sixty-three-a of this title, and submit any applications for waivers of the federal social security act, as may be necessary to ensure federal financial participation. As used in this subparagraph and subparagraph (iv) of this paragraph, "managed care provider" shall mean a managed care provider operating on a full capitation basis or a managed long term care plan operating under section forty-four hundred three-f of the public health law; and "long term care entity" shall mean a home care services agency under article thirty-six of the public health law, a fiscal intermediary in the consumer directed personal assistance program, other long term care provider authorized under a home and community based waiver administered by the department or the office for people with developmental disabilities. The high-need rate cells or risk adjustments established in accordance with this subparagraph shall be consistent with subdivision ten of section three hundred sixty-five-a of this title and include, but shall not be limited to:

(A) individuals enrolled with a managed care provider, who remain in the community and who daily receive live-in twenty-four hour personal care or home health services or twelve hours or more of personal care, home health services or home and community support services;

(B) such other individuals who, based on the assessment of their care needs, their diagnosis or other factors, are determined to present especially high needs related to factors that would influence the delivery (including but not limited to home location) or their use of services, as may be identified by the department.

(iv) Any contract for services under this title by a managed care provider with a long term care entity shall ensure that resources made available by the payer under such contract will support the recruitment, hiring, training and retention of a qualified workforce capable of providing quality care, including compliance with all applicable federal and state laws and regulations, including, but not limited to, those relating to wages and labor. A managed care provider with a long term care entity shall report its method of compliance with this subdivision to the department as a component of cost reports required under section forty-four hundred three-f of the public health law.

(v) A long term care entity that contracts with a managed care provider shall annually submit written certification to the department as a component of cost reports required under section thirty-six hundred twelve of the public health law and sections three hundred sixty-five-a and three hundred sixty-seven-q of this title, as applicable, as to how it applied the amounts paid in compliance with this subdivision to support the recruitment, hiring, training and retention of a qualified

workforce capable of providing quality care and consistent with section three hundred sixty-five-a of this title.

§ 3. Subparagraph (ii) of paragraph (a) and paragraph (g) of subdivision 7 and subdivision 8 of section 4403-f of the public health law, subparagraph (ii) of paragraph (a) of subdivision 7 as amended by section 43 of part C of chapter 60 of the laws of 2014, paragraph (g) of subdivision 7 as amended by section 41-b of part H of chapter 59 of the laws of 2011, subparagraph (i) of paragraph (g) of subdivision 7 as amended by section 1 of part GGG of chapter 59 of the laws of 2017, subparagraph (iii) of paragraph (g) of subdivision 7 as amended by section 54 of part A of chapter 56 of the laws of 2013 and subdivision 8 as amended by section 21 of part B of chapter 59 of the laws of 2016, are amended to read as follows:

(ii) Notwithstanding any inconsistent provision of the social services law to the contrary, the commissioner shall, pursuant to regulation, determine whether and the extent to which the applicable provisions of the social services law or regulations relating to approvals and authorizations of, and utilization limitations on, health and long term care services reimbursed pursuant to title XIX of the federal social security act, including, but not limited to, fiscal assessment requirements, are inconsistent with the flexibility necessary for the efficient administration of managed long term care plans and such regulations shall provide that such provisions shall not be applicable to enrollees or managed long term care plans, provided that such determinations are consistent with applicable federal law and regulation, and subject to the provisions of [~~subdivision~~] **subdivisions** eight **and ten** of section three hundred sixty-five-a **and paragraph (c) of subdivision eighteen of section three hundred sixty-four-j** of the social services law.

(g) (i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment [~~that shall include, but not be limited to, an evaluation of the medical, social, cognitive, and environmental needs~~] of each prospective enrollee in such program **consistent with section three hundred sixty-five-a of the social services law**. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the enrollee. Upon approval of federal waivers pursuant to paragraph (b) of this subdivision which require medical assistance recipients who require community-based long term care services to enroll in a plan, and upon approval of the commissioner, a plan may enroll an applicant who is currently receiving home and community-based services and complete the comprehensive assessment within thirty days of enrollment provided that the plan continues to cover transitional care until such time as the assessment is completed.

(ii) The assessment shall be completed by a representative of the managed long term care plan or demonstration, in consultation with the prospective enrollee's health care practitioner as necessary. The commissioner shall prescribe the forms on which the assessment shall be made.

(iii) The enrollment application shall be submitted by the managed long term care plan or demonstration to the entity designated by the department prior to the commencement of services under the managed long term care plan or demonstration. Enrollments conducted by a plan or demonstration shall be subject to review and audit by the department or a contractor selected pursuant to paragraph (d) of this subdivision.

(iv) Continued enrollment in a managed long term care plan or demonstration paid for by government funds shall be based upon a comprehen-

sive assessment [~~of the medical, social and environmental needs~~] of the recipient of the services **consistent with section three hundred sixty-five-a of this social services law**. Such assessment shall be performed at least every six months by the managed long term care plan serving the enrollee. The commissioner shall prescribe the forms on which the assessment will be made.

8. Payment rates for managed long term care plan enrollees eligible for medical assistance. The commissioner shall establish payment rates for services provided to enrollees eligible under title XIX of the federal social security act. Such payment rates shall be subject to approval by the director of the division of the budget and shall reflect savings to both state and local governments when compared to costs which would be incurred by such program if enrollees were to receive comparable health and long term care services on a fee-for-service basis in the geographic region in which such services are proposed to be provided. Payment rates shall be risk-adjusted to take into account the characteristics of enrollees, or proposed enrollees, including, but not limited to: frailty, disability level, health and functional status, age, gender, the nature of services provided to such enrollees, and other factors as determined by the commissioner. The risk adjusted premiums may also be combined with disincentives or requirements designed to mitigate any incentives to obtain higher payment categories. In setting such payment rates, the commissioner shall consider costs borne by the managed care program to ensure actuarially sound and adequate rates of payment to ensure quality of care **and** shall comply with all applicable laws and regulations, state and federal, including [~~regulations as to~~]**,** **but not limited to, those relating to wages, labor and** actuarial soundness [~~for medicaid managed care~~].

§ 4. Subparagraph (i) of paragraph (g) of subdivision 7 of section 4403-f of the public health law, as added by section 65-c of part A of chapter 57 of the laws of 2006 and such paragraph as relettered by section 20 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment [~~that shall include, but not be limited to, an evaluation of the medical, social and environmental needs~~] of each prospective enrollee in such program **consistent with section three hundred sixty-five-a of the social services law**. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the prospective enrollee.

§ 5. This act shall take effect immediately; provided that sections two and three of this act shall take effect April 1, 2020; and provided, further that:

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

b. the amendments to section 4403-f of the public health law made by section three of this act shall not affect the repeal of such section and shall be deemed repealed therewith; and

c. the amendments to subparagraph (i) of paragraph (g) of subdivision 7 of section 4403-f of the public health law made by section three of this act shall not affect the expiration and reversion of such subparagraph, pursuant to subdivision (i) of section 111 of part H of chapter 59 of the laws of 2011, as amended, when upon such date the provisions of section four of this act shall take effect.