STATE OF NEW YORK

6664--A

2021-2022 Regular Sessions

IN SENATE

May 11, 2021

Introduced by Sens. MAY, RIVERA -- read twice and ordered printed, and when printed to be committed to the Committee on Aging -- recommitted to the Committee on Aging 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 public health law, in relation to establishing a state-level program of all-inclusive care for the elderly; to amend the social services law, in relation to making technical corrections to such law; and repealing certain provisions of the social services law relating thereto

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

Section 1. Legislative findings and intent. The legislature finds that the Program of All-Inclusive Care for the Elderly ("PACE") is a federally recognized model of comprehensive care for persons 55 years of age or older, qualifying for nursing home levels of care who wish to remain in their community (see, Sections 1894 and 1934 to Title XVIII of the Social Security Act; 42 CFR 460). The PACE program includes both Medicaid and Medicare covered benefits. Federal preemption of state laws with respect to PACE has inhibited the ability of state agencies - particularly the New York State Department of Health ("DOH") - to regulate PACE plans similarly to other public and commercial health plans.

The legislature further finds that: Research has demonstrated that PACE has delivered marked improvements for enrollees in the programs nationwide including, but not limited to reduced hospitalizations and readmissions; reduced reliance on emergency medical services; improved quality of life; and higher satisfaction with the totality of their care. In conjunction with these improvements, the implementation of PACE in New York has realized significant savings to the state's Medicaid program compared to costs that would have been incurred under fee-for-service. As neither a fee-for-service model nor a managed long-term care

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

LBD11336-02-2

plan, PACE represents a unique approach to care and coverage for those with long-term care needs. PACE organizations are currently required to be licensed and are regulated under multiple provisions of state and federal law. Uniformity of regulation of PACE organizations promotes both efficiency for organizations and for the state.

For all the foregoing reasons, it is the intent of the legislature through this act to provide a more efficient and uniform structure to promote the prudent development of PACE organizations in the state, to promote better health outcomes for New Yorkers enrolled in such programs, and to realize administrative efficiencies through these programs. It is the intent of the legislature to recognize PACE organizations as integrated providers of care and to that end, nothing in this article is intended to construe PACE organizations as a managed care organization as defined by article 44 of the public health law.

§ 2. The public health law is amended by adding a new article 29-EE to read as follows:

ARTICLE 29-EE
PROGRAMS OF ALL-INCLUSIVE
CARE FOR THE ELDERLY

Section 2999-s. Definitions.
2999-t. PACE program establishment.
2999-u. Criteria for program eligibility and licensure.
2999-v. Eligibility and enrollment.
2999-w. Included program benefits.
2999-x. Reimbursement.
2999-y. Severability.

§ 2999-s. Definitions. For the purposes of this article, the following terms shall have the following meanings:

1. "PACE organization" means a PACE provider, as defined in 42 U.S.C. §1395eee and established in accordance with federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997.

2. "Program of all-inclusive care for the elderly" or "PACE program" means the federally recognized model of comprehensive care that provides Medicaid and Medicare covered services to eligible individuals, and shall include those programs defined as "operating demonstrations" by section forty-four hundred three-f of this chapter.

3. "PACE center" means a diagnostic and treatment center established under article twenty-eight of this chapter and operated by a PACE organization where primary care and other services are furnished to enrollees of such program.

4. "PACE program agreement" shall have the same meaning as defined by 42 U.S.C. § 1395eee.

§ 2999-t. PACE program establishment. 1. Notwithstanding any inconsistent provision of law to the contrary, the commissioner shall establish a state program of all-inclusive care for the elderly, to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medicaid state plan and any applicable waivers, as well as under contracts entered into between the federal centers for Medicare and Medicaid services, the department, and PACE organizations.

2. The establishment of such a program shall not preclude the continued operation of existing approved PACE organizations at the time of enactment of this article. The department may establish a process, if deemed necessary, to assist the transition of such existing programs through processes and requirements set forth pursuant to this article.

§ 2999-u. Criteria for program eligibility and licensure. 1. Program criteria. The requirements of the PACE program, as provided for pursuant to 42 U.S.C. § 1395eee and 42 U.S.C. § 1396u-4 shall not be waived or modified. New York state PACE organization requirements shall include:

(a) The provision of a PACE center; and

(b) The adoption and implementation of an interdisciplinary team approach to care management, care delivery, and care planning.

2. Contracting. The department may enter into contracts with public or private organizations for implementation of the state's PACE program, and may enter into additional contracts as necessary to implement such program, or any other requirement deemed necessary to provide comprehensive community-based, risk-based and capitated long-term care to eligible populations. Additionally:

(a) PACE organizations shall contract with the federal center for Medicare and Medicaid services to enter into a PACE organization agreement.

(b) PACE organizations licensed under this article shall be authorized to act as fiscal intermediaries for their enrollees without entering into additional contracts with the state to conduct such duties on behalf of enrollees.

3. Licensure. In setting forth requirements to establish the state's PACE program, the department shall provide for a unified licensure process for PACE organizations that is inclusive of program requirements set forth under articles forty-four, thirty-six, and twenty-eight of this chapter, as well as pertinent regulatory requirements for PACE organizations in accordance with a regulatory approach which shall be established by the department. For the purposes of subdivision one of section sixty-five hundred twenty-seven of the education law, a PACE organization shall be deemed to be a health maintenance organization as defined by section forty-four hundred one of this chapter.

4. Operations and oversight. The department shall:

(a) Establish requirements for financial solvency for PACE organizations in compliance with those set forth in paragraph (c) of subdivision one of section forty-four hundred three of this chapter, and shall establish a contingent reserve requirement for PACE organizations which, pursuant to regulations, may be different than other programs;

(b) Provide oversight of PACE organization operations in coordination with the centers for Medicare and Medicaid services, including any rules appropriate for the safe, efficient and orderly administration of the program; and

(c) Develop a single process for PACE organizations to complete all reports, audits, surveys, and other data or information collection required by federal, state or local authorities.

§ 2999-v. Eligibility and enrollment. 1. To be eligible for enrollment in the PACE program, an individual must:

(a) (i) Be at least fifty-five years old;

(ii) Meet the state's eligibility criteria for nursing home level of care;

(iii) Reside within the PACE program-approved service area; and

(iv) Be able to be maintained safely in the community-based setting at the time of enrollment with the assistance of a PACE organization; or

(b) Be otherwise eligible for participation in a PACE demonstration or specialty program authorized by the federal PACE Innovation Act and approved by the centers for Medicare and Medicaid services.

2. Notwithstanding any law or regulation to the contrary, if federal law or regulation sets forth broader eligibility or enrollment require-

ments than those set forth under subdivision one of this section, eligibility for the PACE program shall conform to such federal requirements.

3. Enrollment and participation by individuals in the PACE program shall be voluntary.

§ 2999-w. Included program benefits. Enrollees in the PACE program shall be provided a benefit package by their PACE organization, regardless of source of payment, that includes:

(a) All Medicare-covered items and services;

(b) All Medicaid-covered items and services, as specified in the state's Medicaid plan and in section three hundred sixty-four-j of the social services law; and

(c) Other such services as determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

§ 2999-x. Reimbursement. The department shall develop and implement, in conformance with applicable federal requirements, a methodology for establishing rates of payment for costs of benefits provided by PACE organizations to its Medicaid eligible PACE program enrollees.

1. Methodology. To the extent required by federal law, such rate methodologies for PACE organizations shall result in a payment amount no greater than the amount that would otherwise have been paid for comparable services provided pursuant to the state plan if the participants were not enrolled in the PACE program. PACE program rates shall be set in compliance with relevant centers for Medicare and Medicaid services rate setting rules and guidance.

2. Transparency. The department shall provide, or shall require any independent actuary used to review PACE program reimbursement rates to provide, to PACE organizations the documents and information regarding PACE program reimbursement rates submitted to the centers for Medicare and Medicaid services in a form and time frame consistent with the requirements for the department to provide or cause to be provided documents and information to Medicaid managed care providers under paragraph (c) of subdivision eighteen of section three hundred sixty-four-j of the social services law.

§ 2999-y. Severability. If any provision of this article, or any application of any provision of this article, is held to be invalid, or to violate or be inconsistent with any federal law or regulation, such violation or inconsistency shall not affect the validity or effectiveness of any other provision of this article, or of any other application of any provision of this article, which can be given effect without such provision or application; and to such end, the provisions and applications of this article shall be severable.

§ 3. Paragraph (c) of subdivision 18 of section 364-j of the social services law, as added by section 55 of part B of chapter 57 of the laws of 2015, is REPEALED.

§ 4. Paragraph (c) of subdivision 18 of section 364-j of the social services law, as added by section 40-c of part B of chapter 57 of the laws of 2015, is amended to read as follows:

(c) 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. The department 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.

§ 5. This act shall take effect January 1, 2023, provided, however, that the amendments made to section 364-j of the social services law made by section four of this act shall not affect the repeal of such section and shall be deemed repealed therewith. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.