STATE OF NEW YORK

8591

IN SENATE

March 18, 2022

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

AN ACT to amend the public health law, in relation to qualifying health care costs and case management services under the New York state medical indemnity fund; and to amend chapter 517 of the laws of 2016, amending the public health law relating to payments from the New York state medical indemnity fund, in relation to the effectiveness thereof

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

Section 1. Section 2999-h of the public health law, as added by section 52 of part H of chapter 59 of the laws of 2011, subdivision 1 as amended by chapter 517 of the laws of 2016, subdivision 3 as amended by chapter 4 of the laws of 2017 and subdivision 4 as amended by section 1 of part K of chapter 57 of the laws of 2019, is amended to read as follows:

§ 2999-h. Definitions. As used in this title, unless the context or subject matter requires otherwise:

1. **"Activities of daily living" mean basic self-care tasks such as dressing and undressing, self-feeding, bowel and bladder management, ambulation with or without the use of an assistive device, communication, functional transfers from one place to another, and personal hygiene and grooming.**

2. "Birth-related neurological injury" means an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation, or by other medical services provided or not provided during delivery admission, that rendered the infant with a permanent and substantial motor impairment or with a developmental disability as that term is defined by section 1.03 of the mental hygiene law, or both. This definition shall apply to live births only.

[~~2.~~] **3. "Custodial care" means non-medical services provided by home health aides, nurse aides, personal care aides, and other qualified health care providers to assist enrollees with activities of daily**

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

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living, instrumental activities of daily living, and daily or ongoing medical care and support.

4. "Fund" means the New York state medical indemnity fund.

[~~3.~~] 5. "Instrumental activities of daily living" mean those functions not necessary for fundamental functioning but necessary for an individual to be able to live independently in the community such as taking medications as prescribed, performing housekeeping tasks, managing money, using the telephone or other form of communication, shopping for groceries and clothing, and managing transportation within the community.

6. "Qualifying health care costs" means the future costs for medical, hospital, surgical, nursing, dental, rehabilitation services, habilitation services, [~~respite, custodial, durable medical equipment, home modifications, assistive technology, vehicle modifications,~~] and custodial care; behavioral and mental health care; respite care, subject to a maximum of one thousand eighty hours per year unless prior approval has been obtained for additional respite care; durable medical equipment; environmental home modifications (emods), assistive technology, and vehicle modifications; prescription and over the counter medications when prescribed by an authorized health care provider licensed or certified under title eight of the education law and as otherwise defined in regulation; transportation for purposes of health care related appointments[~~, prescription and non-prescription medications, and other health care costs actually incurred for services rendered to and supplies utilized by qualified plaintiffs, which are necessary to meet their health care needs, as determined by their treating physicians, physician assistants, or nurse practitioners and as otherwise defined by the commissioner in regulation~~] in accordance with regulations; copayments and deductibles for services, items, equipment or medication paid for by commercial insurance; and any other health care costs actually incurred for services rendered to and supplies utilized by a qualified plaintiff that his or her physician, physician assistant, or nurse practitioner has stated in writing on his or her letterhead, or on the supervising or collaborating physician's letterhead, if applicable, is necessary to meet the qualified plaintiff's health care needs. The statement of necessity may be based on the assessment of a health care provider licensed or certified under title eight of the education law and as otherwise defined in regulation. The fund administrator may make coverage of ongoing therapeutic services subject to the receipt of periodic treatment plans and progress reports. Health care providers as used in this section shall mean health care providers licensed or certified under title eight of the education law and as otherwise defined in regulation.

[~~4.~~] 7. "Qualified plaintiff" means every plaintiff or claimant who (i) has been found by a jury or court to have sustained a birth-related neurological injury as the result of medical malpractice, or (ii) has sustained a birth-related neurological injury as the result of alleged medical malpractice, and has settled his or her lawsuit or claim therefor; and (iii) has been ordered to be enrolled in the fund by a court in New York state.

§ 2. Section 2999-j of the public health law is amended by adding a new subdivision 4-a to read as follows:

4-a. Qualifying health care costs actually incurred for services rendered to and supplies utilized by qualified plaintiffs in the home or in a residential or other facility shall be paid from the fund. The commissioner shall promulgate regulations regarding billing procedures

and reimbursement calculation methodology for qualifying health care costs. The reimbursement calculation methodology shall adhere to subdivision four of this section and shall consider the schedule of qualifying health care services rendered to qualified plaintiffs.

§ 3. The public health law is amended by adding two new sections 2999-k and 2999-l to read as follows:

§ 2999-k. Case management. 1. As used in this article: "case management" means functions, including but not limited to:

(a) conducting a new enrollee orientation session by telephone or video technology within ten days of the enrollee being accepted into the fund, for the enrollee and the enrollee's parent, guardian, or legal representative, which shall include review of the following and time to answer questions posed by the enrollee or the enrollee's parent, guardian, or legal representative:

(i) the New York State Medical Indemnity Fund Enrollee Handbook;

(ii) case management services available to the enrollee and the enrollee's parent, guardian, or legal representative;

(iii) qualifying health care costs actually incurred for services rendered to and supplies utilized by enrollees in the home or in a residential facility;

(iv) qualifying health care costs actually incurred for services rendered to and supplies utilized by enrollees in the home or in a residential facility that require prior approval or documentation of medical necessity and recertification;

(v) the claims reimbursement and appeals processes, including how and with whom to file an appeal;

(vi) required forms that must be completed, how to request the forms, and where forms are located online if applicable; and

(vii) how to contact the fund administrator and the department with questions or concerns;

(b) conducting an initial assessment and periodic reassessments of the enrollee's medical needs;

(c) evaluating the enrollee's strengths, informal support system and environmental factors relevant to his/her care;

(d) reviewing information provided by the enrollee, the enrollee's informal support system, and current providers (including any school related or habilitation services) regarding the services presently being provided to the enrollee and any existing gaps in the services being provided to the enrollee;

(e) establishing a comprehensive, written case management plan to assist the enrollee or the enrollee's caregiver to manage the delivery of all qualifying health care services needed by the enrollee;

(f) assisting an enrollee or the enrollee's caregiver to obtain services set forth in the case management plan for the enrollee through referral to agencies or persons qualified to provide those services;

(g) assisting the enrollee with any forms necessary for the receipt of or payment for services;

(h) assisting with crisis intervention in the event that the enrollee has emergency service needs;

(i) developing and maintaining a list of alternative provider sources that may be available to the enrollee in the event of service disruption, and making that list available upon the request of the enrollee or the enrollee's caregiver; and

(j) monitoring the services provided under the case management plan by:

(i) verifying that the services identified in the case management plan are being received by the enrollee in the amount and frequency specified in the case plan; and

(ii) documenting the case record regarding the enrollee's medical condition and progress made.

2. If the enrollee already has a case manager in another health related program, the fund administrator's case manager shall coordinate the enrollee's care in conjunction with the other case manager.

3. A case manager shall have significant experience or educational training in health or social services, preferably including work experience or a practicum that involved the performance of assessments and the development of case management plans. Voluntary or part-time experience that can be verified will be accepted on a pro rata basis.

4. An enrollee or person acting on an enrollee's behalf can request a change in case manager at any time by submitting a written request for reassignment on a form provided by the fund administrator. Reassignments will occur as promptly as possible based on case manager availability and existing caseloads.

5. The enrollee or the enrollee's parent, guardian or legal representative is responsible for participating in an initial case management conference and subsequent, periodic case management conferences on a schedule determined by the needs of the enrollee. The repeated failure of the responsible individual to participate in necessary case management conferences may result in the fund administrator not processing any claims or requests until compliance with this requirement occurs.

§ 2999-l. Explanation of benefits forms relating to claims for qualifying health care costs under the fund. 1. The fund administrator is required to provide the qualified plaintiff with an explanation of benefits form in response to the filing of any claim for qualifying health care costs.

2. The explanation of benefits form must include at least the following:

(a) the name of the provider of service, the admission or financial control number, if applicable;

(b) the date of service;

(c) an identification of the service for which the claim is made;

(d) the provider's charge or rate;

(e) the amount or percentage paid by the primary third-party payor and the amount payable under the fund;

(f) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed;

(g) a telephone number, digital information, and address where the qualified plaintiff or their parent, guardian, or legal representative may obtain clarification of the explanation of benefits; and

(h) a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the fund.

3. The provisions of this section requiring an explanation of benefits form for qualifying health care cost claims shall be provided by a written summary of the information prescribed by paragraph (a) of subdivision two of this section or by making such information available electronically on the member portal of the administrator's website, provided that the member consents to receiving the information electronically. Members may change how they elect to receive the explanation of benefits.

4. Explanation of benefits forms for qualifying health care costs that result from pharmaceutical claims shall be provided on a quarterly basis.

§ 4. Section 5 of chapter 517 of the laws of 2016, amending the public health law relating to payments from the New York state medical indemnity fund, as amended by section 8 of part S of chapter 57 of the laws of 2021, is amended to read as follows:

§ 5. This act shall take effect on the forty-fifth day after it shall have become a law, provided that the amendments to subdivision 4 of section 2999-j of the public health law made by section two of this act shall take effect on June 30, 2017 [~~and shall expire and be deemed repealed December 31, 2022~~].

§ 5. This act shall take effect on the thirtieth day after it shall have become a law. 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.