

STATE OF NEW YORK

1197--A

Cal. No. 519

2023-2024 Regular Sessions

IN SENATE

January 10, 2023

Introduced by Sens. RIVERA, BROUK, COONEY, MAY, MYRIE, RAMOS, SEPULVEDA -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- reported favorably from said committee, ordered to first and second report, ordered to a third reading, -- committed to the Committee on Rules -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law and the social services law, in relation to primary care investment

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

1 Section 1. The insurance law is amended by adding a new section 3217-k
2 to read as follows:

3 § 3217-k. Primary care spending. (a) Definitions. As used in this
4 section, the following terms shall have the following meanings:

5 (1) "Overall healthcare spending" means the total cost of care for the
6 patient population of a payor or provider entity for a given calendar
7 year, where cost is calculated for such year as the sum of (A) all
8 claims-based spending paid to providers by public and private payors and
9 (B) all non-claim payments for such year, including, but not limited to,
10 incentive payments and care coordination payments.

11 (2) "Plan or payor" means every insurance entity providing managed
12 care products, individual comprehensive accident and health insurance or
13 group or blanket comprehensive accident and health insurance, as defined
14 in this chapter, corporation organized under article forty-three of this
15 chapter providing comprehensive health insurance, entity licensed under
16 article forty-four of this chapter providing comprehensive health insur-
17 ance, every other plan over which the department has jurisdiction, and
18 every third-party payor providing health coverage.

19 (3) "Primary care" means integrated, accessible healthcare, provided
20 by clinicians accountable for addressing most of a patient's healthcare

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

LBD03591-02-3

1 needs, developing a sustained partnership with patients, and practicing
2 in the context of family and community.

3 (4) "Primary care services" means services provided in an outpatient,
4 non-emergency setting by or under the supervision of a physician, nurse
5 practitioner, physician assistant, or midwife, who is practicing general
6 primary care in the following fields, including as evidenced by billing
7 and reporting codes: family practice; general pediatrics; primary care
8 internal medicine; primary care obstetrics; or primary care gynecology.
9 Behavioral or mental health and substance use disorder services are
10 included in primary care services when integrated into a primary care
11 setting, including when provided by a behavioral healthcare psychia-
12 trist, social worker or psychologist. Primary care services shall not
13 include inpatient services, emergency department services, ambulatory
14 surgical center services, or services provided in an urgent care setting
15 that are billed with non-primary care billing and reporting codes.

16 (5) "Primary care spending" means any expenditure of funds made by
17 third party payors, public entities, or the state, for the purpose of
18 paying for primary care services directly or paying to improve the
19 delivery of primary care. Primary care spending includes all payment
20 methods, such as fee-for-service, capitation, incentives, value-based
21 payments or other methodologies, and all non-claim payments including
22 but not limited to incentive payments and care coordination payments.
23 Any spending shall be adjusted appropriately to exclude any portion of
24 the expenditure that is reasonably attributed to inpatient services or
25 other non-primary care services.

26 (b) Reporting. (1) Beginning on April first, two thousand twenty-five,
27 each plan or payor as defined in this section shall annually report to
28 the department the percentage of the plan or payor's overall annual
29 healthcare spending that constituted primary care spending.

30 (2) Nothing herein shall require any plan or payor to report or
31 publicly disclose any specific rates of reimbursement for any specific
32 primary care services.

33 (3) No plan or payor shall require any healthcare provider to provide
34 additional data or information in order to fulfill this reporting
35 requirement.

36 (c) Regulation and publication. (1) The commissioner of health and the
37 superintendent shall each promulgate consistent regulations to carry out
38 the provisions of this section, including but not limited to setting
39 deadlines for the reporting required in this section, and adopting
40 further specific definitions of the primary care services for which
41 costs must be reported under this section, including specific billing
42 and reporting codes.

43 (2) The department of health and the department shall together provide
44 an annual report to the legislature with a summary of the primary care
45 spending data required in this section, and shall also make the report
46 publicly available on both agencies' websites, no later than three
47 months after the data has been collected. The first annual report shall
48 provide the spending information without identifying any individual
49 payor or plan's primary care spending. Each year thereafter, the report
50 spending data shall be published including information specific to each
51 plan or payor.

52 (d) Primary care spending. (1) Beginning on April first, two thousand
53 twenty-six, each plan or payor that reports less than twelve percent of
54 its total expenditures on physical and mental health is primary care
55 spending, as defined by this section, shall additionally submit to the
56 superintendent a plan to increase primary care spending as a percentage

1 of its total overall healthcare spending by at least one percent each
2 year. Beginning on April first, two thousand twenty-seven and on April
3 first of every subsequent year after such plan has been submitted, and
4 until such time as the plan or payor's reported primary care spending is
5 equal to or more than twelve percent of that plan or payor's overall
6 healthcare spending, the plan or payor's annual reporting shall include
7 information regarding steps that have been taken to increase its propor-
8 tion of primary care spending.

9 (2) The commissioner of health and the superintendent may jointly
10 issue guidelines or promulgate regulations regarding the areas on which
11 primary care spending could be increased, including but not limited to:

12 (A) reimbursement;

13 (B) capacity-building, technical assistance and training;

14 (C) upgrading technology, including electronic health record systems
15 and telehealth capabilities;

16 (D) incentive payments, including but not limited to per-member-per-
17 month, value-based-payment arrangements, shared savings, quality-based
18 payments, risk-based payments; and

19 (E) transitioning to value-based-payment arrangements.

20 § 2. The social services law is amended by adding a new section 368-g
21 to read as follows:

22 § 368-g. Primary care spending. 1. Definitions. As used in this
23 section the terms "overall healthcare spending", "plan or payor",
24 "primary care", "primary care services" and "primary care spending"
25 shall have the same meanings as such terms are defined in section thir-
26 ty-two hundred seventeen-k of the insurance law.

27 2. Reporting. (a) Beginning on April first, two thousand twenty-five,
28 each Medicaid managed care provider under section three hundred sixty-
29 four-j of this title and any payor that provides coverage through Medi-
30 caid fee-for-service, as such term is defined in paragraph (e) of subdivi-
31 sion thirty-eight of section two of this chapter, shall annually
32 report to the department the percentage of the provider's overall annual
33 healthcare spending that constituted primary care spending.

34 (b) Nothing herein shall require any Medicaid managed care provider to
35 report or publicly disclose any specific rates of reimbursement for any
36 specific primary care services.

37 (c) No Medicaid managed care provider shall require any healthcare
38 provider to provide additional data or information in order to fulfill
39 this reporting requirement.

40 3. Primary care spending. (a) Beginning on April first, two thousand
41 twenty-six, and in each subsequent year, each Medicaid managed care
42 provider under section three hundred sixty-four-j of this title and any
43 payor that provides coverage through Medicaid fee-for-service, as such
44 term is defined in paragraph (e) of subdivision thirty-eight of section
45 two of this chapter, that reports less than twelve percent of its total
46 expenditures on physical and mental health are on primary care spending
47 shall additionally submit to the commissioner a plan to increase primary
48 care spending as a percentage of its total overall healthcare spending
49 by at least one percent each year. Beginning on April first, two thou-
50 sand twenty-seven, and in each subsequent year thereafter, until twelve
51 percent of that provider or payor's expenditures are on primary care
52 spending, the payor or provider's annual reporting under this section
53 shall include information on steps that have been taken to increase
54 their proportion of primary care spending.

1 (b) The commissioner and the superintendent of financial services may
2 jointly issue guidelines or promulgate regulations regarding the areas
3 on which spending could be increased, including but not limited to:

- 4 (i) reimbursement;
- 5 (ii) capacity-building, technical assistance and training;
- 6 (iii) upgrading technology, including electronic health record systems
7 and telehealth capabilities;
- 8 (iv) incentive payments, including but not limited to per-member-per-
9 month, value-based-payment arrangements, shared savings, quality-based
10 payments, risk-based payments; and
- 11 (v) transitioning to value-based-payment arrangements.

12 (c) The provisions of this section are subject to compliance with all
13 applicable federal and state laws and regulations, including the Centers
14 for Medicare and Medicaid Services approved Medicaid state plan. To the
15 extent required by federal law, the commissioner shall seek any federal
16 approvals necessary to implement this section, including, but not limit-
17 ed to, any state-directed payments, permissions, state plan amendments
18 or federal waivers by the federal Centers for Medicare and Medicaid
19 Services. The commissioner may also apply for appropriate waivers or
20 state directed payments under federal law and regulation or take other
21 actions to secure federal financial participation to assist in promoting
22 the objectives of this section.

23 § 3. This act shall take effect immediately.