S T A T E O F N E W Y O R K

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I N S E N A T E

March 1, 2010

Introduced by Sen. DUANE -- 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 medical home multipayor programs

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. The article heading of article 27-L of the public health law, as added by section 16 of part OO of chapter 57 of the laws of 2008, is amended to read as follows:

MEDICAL HOME [DEMONSTRATION] PROGRAMS

S 2. The public health law is amended by adding a new section 2799-t to read as follows:

S 2799-T. MEDICAL HOME MULTIPAYOR PROGRAMS. 1. (A) THE COMMISSIONER IS AUTHORIZED TO ESTABLISH MEDICAL HOME MULTIPAYOR PROGRAMS (REFERRED TO IN THIS SECTION AS A "PROGRAM") AND IN RELATION TO A PROGRAM MAY CERTIFY CERTAIN CLINICIANS AND CLINICS AS MEDICAL HOMES ELIGIBLE FOR ENHANCED PAYMENTS FOR SERVICES PROVIDED TO: RECIPIENTS ELIGIBLE FOR MEDICAID FEE-FOR-SERVICE; ENROLLEES ELIGIBLE FOR AND ENROLLED IN MEDICAID MANAGED CARE; ENROLLEES ELIGIBLE FOR AND ENROLLED IN FAMILY HEALTH PLUS; ENROLLEES ELIGIBLE FOR AND ENROLLED IN CHILD HEALTH PLUS; ENROLLEES AND SUBSCRIBERS OF COMMERCIAL MANAGED CARE PLANS OPERATING UNDER ARTICLE FORTY-FOUR OF THIS CHAPTER OR HEALTH MAINTENANCE ORGANIZATIONS OPERATING UNDER ARTICLE FORTY-THREE OF THE INSURANCE LAW; ENROLLEES AND SUBSCRIBERS OF OTHER COMMERCIAL INSURANCE PRODUCTS; AND EMPLOYEES OF EMPLOYER-SPONSORED SELF-INSURED PLANS. THE PURPOSE OF THE PROGRAMS IS TO IMPROVE HEALTH CARE OUTCOMES AND EFFICIENCY THROUGH IMPROVED ACCESS, PATIENT CARE CONTINUITY, AND COORDINATION OF HEALTH SERVICES.

(B) AS USED IN THIS SECTION:

(I) "CLINIC" MEANS A GENERAL HOSPITAL PROVIDING OUTPATIENT CARE OR A DIAGNOSTIC AND TREATMENT CENTER, LICENSED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER; AND

(II) "CLINICIAN" MEANS A HEALTH CARE PRACTITIONER ACTING WITHIN HIS OR HER LAWFUL SCOPE OF PRACTICE UNDER TITLE EIGHT OF THE EDUCATION LAW WHO IS: (A) A PHYSICIAN OR NURSE PRACTITIONER PRACTICING IN A PRIMARY CARE

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

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SPECIALTY; (B) A PHYSICIAN, NURSE PRACTITIONER, OR MIDWIFE PRACTICING PRIMARY GYNECOLOGICAL CARE FOR FEMALE PATIENTS; OR (C) A PHYSICIAN OR NURSE PRACTITIONER PRACTICING IN A NON-PRIMARY CARE SPECIALTY, FOR A PATIENT WHO HAS A CHRONIC CONDITION THAT REQUIRES SPECIALTY CARE, WHERE THE SPECIALIST HEALTH CARE PRACTITIONER REGULARLY AND CONTINUALLY PROVIDES TREATMENT FOR THAT CONDITION TO THE PATIENT.

2. (A) IN ORDER TO PROMOTE IMPROVED QUALITY AND EFFICIENCY OF, AND ACCESS TO, HEALTH CARE SERVICES AND PROMOTE IMPROVED CLINICAL OUTCOMES, IT SHALL BE THE POLICY OF THE STATE RELATING TO THE PROGRAMS TO ENCOURAGE COOPERATIVE, COLLABORATIVE AND INTEGRATIVE ARRANGEMENTS BETWEEN PAYORS OF HEALTH CARE SERVICES AND HEALTH CARE PROVIDERS WHO MIGHT OTHERWISE BE COMPETITORS, UNDER THE ACTIVE SUPERVISION OF THE COMMISSIONER. TO THE EXTENT SUCH ARRANGEMENTS MIGHT BE ANTI-COMPETITIVE WITHIN THE MEANING AND INTENT OF THE FEDERAL ANTITRUST LAWS, THE INTENT OF THE STATE IS TO SUPPLANT COMPETITION WITH SUCH ARRANGEMENTS TO THE EXTENT NECESSARY TO ACCOMPLISH THE PURPOSES OF THIS SECTION RELATING TO THE PROGRAMS, AND PROVIDE STATE ACTION IMMUNITY UNDER THE STATE AND FEDERAL ANTITRUST LAWS WITH RESPECT TO THE PLANNING, IMPLEMENTATION AND OPERATION OF THE PROGRAMS AND PAYORS OF HEALTH CARE SERVICES AND HEALTH CARE PROVIDERS.

(B) THE COMMISSIONER OR HIS OR HER DULY AUTHORIZED REPRESENTATIVE MAY ENGAGE IN APPROPRIATE STATE SUPERVISION NECESSARY TO PROMOTE STATE ACTION IMMUNITY UNDER THE STATE AND FEDERAL ANTITRUST LAWS, AND MAY INSPECT OR REQUEST ADDITIONAL DOCUMENTATION TO VERIFY THAT THE PROGRAM IS IMPLEMENTED IN ACCORDANCE WITH ITS INTENT AND PURPOSE.

3. THE COMMISSIONER, FOR PURPOSES OF THE PROGRAM, IS AUTHORIZED TO PARTICIPATE IN, ACTIVELY SUPERVISE, FACILITATE AND APPROVE A PRIMARY CARE MEDICAL HOME COLLABORATIVE (AN ENTITY WHICH SHALL INCLUDE BUT NOT BE LIMITED TO HEALTH CARE PROVIDERS, WHICH MAY INCLUDE BUT NOT BE LIMITED TO HOSPITALS, DIAGNOSTIC AND TREATMENT CENTERS, AND PRIVATE PRACTICES, AND PAYORS OF HEALTH CARE SERVICES, WHICH MAY INCLUDE BUT NOT BE LIMITED TO EMPLOYERS, HEALTH PLANS AND INSURERS) TO ESTABLISH:

(A) THE BOUNDARIES OF THE PROGRAM AND THE HEALTH CARE PROVIDERS ELIGIBLE TO PARTICIPATE; PROVIDED THAT THE BOUNDARIES OF PROGRAMS MAY OVERLAP;

(B) PRACTICE STANDARDS FOR THE MEDICAL HOME CONSISTENT WITH EXISTING STANDARDS DEVELOPED BY NATIONAL ACCREDITING AND PROFESSIONAL ORGANIZATIONS INCLUDING, BUT NOT LIMITED TO, THE JOINT PRINCIPLES OF THE AMERICAN COLLEGE OF PHYSICIANS ("ACP"), THE AMERICAN ACADEMY OF FAMILY PHYSICIANS ("AAFP"), THE AMERICAN ACADEMY OF PEDIATRICS ("AAP"), THE AMERICAN OSTEOPATHIC ASSOCIATION ("AOA"), AND AS FURTHER DEFINED BY "PATIENT CENTERED MEDICAL HOME," AS REPRESENTED IN CERTIFICATION PROGRAMS DEVELOPED BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE ("NCQA");

(C) METHODOLOGIES BY WHICH PAYORS WILL PROVIDE ENHANCED RATES OF PAYMENT TO CERTIFIED MEDICAL HOMES;

(D) METHODOLOGIES TO PAY ADDITIONAL AMOUNTS FOR MEDICAL HOMES THAT MEET SPECIFIC PROCESS OR OUTCOME STANDARDS ESTABLISHED BY THE PRIMARY CARE MEDICAL HOME COLLABORATIVE OF THE PROGRAM;

(E) ALTERNATIVE METHODOLOGIES FOR PAYORS OF HEALTH CARE SERVICES TO HEALTH CARE PROVIDERS UNDER THE PROGRAM;

(F) PROVISIONS FOR PAYMENTS TO PROVIDERS THAT MAY VARY BY SIZE OR FORM OF ORGANIZATION OF THE PROVIDER, TO ACCOMMODATE DIFFERENT LEVELS OF RESOURCES AND DIFFICULTY TO MEET THE STANDARDS OF THE PROGRAM;

(G) PROVISIONS FOR PAYMENTS TO NOT-FOR-PROFIT ENTITIES THAT PROVIDE SERVICES TO HEALTH CARE PROVIDERS TO ASSIST THEM IN MEETING MEDICAL HOME STANDARDS UNDER THE PROGRAM;

(H) REQUIREMENTS FOR COLLECTING DATA RELATING TO THE PROVIDING AND PAYING FOR HEALTH CARE SERVICES UNDER THE PROGRAM AND PROVIDING OF DATA TO THE COMMISSIONER, PAYORS AND HEALTH CARE PROVIDERS UNDER THE PROGRAM, TO PROMOTE THE EFFECTIVE OPERATION AND EVALUATION OF THE PROGRAM, CONSISTENT WITH PROTECTION OF THE CONFIDENTIALITY OF INDIVIDUAL PATIENT INFORMATION; AND

(I) PROVISIONS UNDER WHICH THE COMMISSIONER MAY TERMINATE THE PROGRAM.

4. PATIENT AND HEALTH CARE PROVIDER PARTICIPATION IN THE PROGRAM SHALL BE ON A VOLUNTARY BASIS.

5. CLINICS AND CLINICIANS PARTICIPATING IN A PROGRAM ARE NOT ELIGIBLE FOR ADDITIONAL ENHANCEMENTS OR BONUSES UNDER THE STATEWIDE MEDICAL HOME PROGRAM, ESTABLISHED PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-M OF THE SOCIAL SERVICES LAW, FOR SERVICES PROVIDED TO PARTICIPANTS IN MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS OR CHILD HEALTH PLUS.

6. SUBJECT TO THE AVAILABILITY OF FUNDING AND FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER IS AUTHORIZED:

(A) TO PAY ENHANCED RATES OF PAYMENT UNDER MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS TO CLINICS AND CLINICIANS THAT ARE CERTIFIED AS MEDICAL HOMES UNDER THIS SECTION;

(B) TO PAY ADDITIONAL AMOUNTS FOR MEDICAL HOMES THAT MEET SPECIFIC PROCESS OR OUTCOME STANDARDS SPECIFIED BY THE COMMISSIONER, IN CONSULTATION WITH THE PRIMARY CARE MEDICAL HOME COLLABORATIVE OF THE PROGRAM; AND

(C) TO AUTHORIZE ALTERNATIVE PAYMENT METHODOLOGIES UNDER MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS FOR HEALTH CARE PROVIDERS AND TO SERVE THE PURPOSES OF THE PROGRAM, INCLUDING PAYMENTS TO NOT-FOR-PROFIT ENTITIES UNDER PARAGRAPH (G) OF SUBDIVISION THREE OF THIS SECTION.

7. THE COMMISSIONER MAY DIRECTLY, OR BY CONTRACT WITH NOT-FOR-PROFIT ORGANIZATIONS, PROVIDE:

(A) CONSUMER ASSISTANCE TO PATIENTS PARTICIPATING IN A PROGRAM AS TO MATTERS RELATING TO THE PROGRAM;

(B) TECHNICAL AND OTHER ASSISTANCE TO HEALTH CARE PROVIDERS PARTICIPATING IN A PROGRAM AS TO MATTERS RELATING TO THE PROGRAM, INCLUDING ACHIEVING MEDICAL HOME STANDARDS;

(C) CARE COORDINATION PROVIDER TECHNICAL AND OTHER ASSISTANCE TO INDIVIDUALS AND ENTITIES PROVIDING CARE COORDINATION SERVICES TO HEALTH CARE PROVIDERS UNDER A PROGRAM; AND

(D) INFORMATION SHARING AND OTHER ASSISTANCE AMONG PROGRAMS TO IMPROVE THE OPERATION OF PROGRAMS.

8. THE COMMISSIONER SHALL, TO THE EXTENT NECESSARY FOR THE PURPOSE OF THIS SECTION, SUBMIT THE APPROPRIATE WAIVERS AND OTHER APPLICATIONS, INCLUDING, BUT NOT LIMITED TO, THOSE AUTHORIZED PURSUANT TO SECTIONS ELEVEN HUNDRED FIFTEEN AND NINETEEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT, OR SUCCESSOR PROVISIONS, AND ANY OTHER WAIVERS OR APPLICATIONS NECESSARY TO ACHIEVE THE PURPOSES OF HIGH QUALITY, INTEGRATED, AND COST EFFECTIVE CARE AND INTEGRATED FINANCIAL ELIGIBILITY POLICIES UNDER MEDICAID, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS OR MEDICARE. COPIES OF SUCH ORIGINAL WAIVER AND OTHER APPLICATIONS SHALL BE PROVIDED TO THE CHAIRMAN OF THE SENATE FINANCE COMMITTEE AND THE CHAIRMAN OF THE ASSEMBLY WAYS AND MEANS COMMITTEE SIMULTANEOUSLY WITH THEIR SUBMISSION TO THE FEDERAL GOVERNMENT.

9. THE ADIRONDACK MEDICAL HOME MULTIPAYOR DEMONSTRATION PROGRAM (INCLUDING THE ADIRONDACK MEDICAL HOME COLLABORATIVE) PREVIOUSLY ESTAB-

LISHED UNDER SECTION TWENTY-NINE HUNDRED FIFTY-NINE OF THIS CHAPTER IS CONTINUED AND SHALL BE DEEMED TO BE A PROGRAM UNDER THIS SECTION.

10. THE COMMISSIONER SHALL ANNUALLY REPORT TO THE GOVERNOR AND THE LEGISLATURE ON THE OPERATION OF THE PROGRAMS AND THEIR EFFECTIVENESS IN ACHIEVING THE PURPOSES OF THIS SECTION, WITH PARTICULAR REFERENCE TO THE QUALITY, COST, AND OUTCOMES FOR ENROLLEES IN MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS.

11. NO PROGRAM SHALL BE APPROVED UNDER THIS SECTION AFTER APRIL FIRST, TWO THOUSAND SIXTEEN.

S 3. Subdivision 1 of section 2 of the public health law is amended by adding six new paragraphs (o), (p), (q), (r), (s) and (t), to read as follows:

(O) "MEDICAID" OR "MEDICAL ASSISTANCE" MEANS TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW AND THE PROGRAM THEREUNDER.

(P) "FAMILY HEALTH PLUS" MEANS TITLE ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW AND THE PROGRAM THEREUNDER.

(Q) "CHILD HEALTH PLUS" MEANS TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER AND THE PROGRAM THEREUNDER.

(R) "MEDICAID MANAGED CARE" MEANS MEDICAID PROVIDED UNDER SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW.

(S) "MEDICAID FEE-FOR-SERVICE" MEANS MEDICAID PROVIDED OTHER THAN UNDER MEDICAID MANAGED CARE.

(T) "MEDICARE" MEANS TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND THE PROGRAMS THEREUNDER.

S 4. This act shall take effect immediately; provided, however, that the amendments to article 27-L of the public health law made by sections one and two of this act shall not affect the repeal of such article and shall be deemed repealed therewith.