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

6801

I N S E N A T E

February 8, 2010

Introduced by Sens. HANNON, LARKIN, VOLKER -- 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 establishing the neurological impairment program to provide compensation of neurologically-impaired persons

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

Section 1. The public health law is amended by adding a new article 49-A to read as follows:

ARTICLE 49-A

NEUROLOGICAL IMPAIRMENT PROGRAM OF NEW YORK STATE

S 4920. DEFINITIONS. WHEN USED IN THIS ARTICLE, THE FOLLOWING TERMS SHALL HAVE THE FOLLOWING MEANINGS:

1. "CASE MANAGEMENT" MEANS CASE MANAGEMENT SERVICES FURNISHED IN ACCORDANCE WITH THE NEUROLOGICAL IMPAIRMENT PROGRAM OF NEW YORK STATE AND WHICH ASSIST ALL ELIGIBLE IMPAIRED PERSONS TO ACCESS NECESSARY CASE MANAGEMENT SERVICES IN ACCORDANCE WITH GOALS CONTAINED IN A WRITTEN CASE MANAGEMENT PLAN.

2. "CASE MANAGEMENT SERVICES" MEANS SERVICES WHICH WILL ASSIST ELIGIBLE IMPAIRED PERSONS IN OBTAINING NEEDED MEDICAL, SOCIAL, PSYCHOSOCIAL, EDUCATIONAL AND ANY OTHER SERVICES DEEMED NECESSARY. SUCH SERVICES ENHANCE THE QUALITY OF LIFE FOR ELIGIBLE IMPAIRED PERSONS AND ASSIST

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

LBD15423-01-0

SUCH PERSONS AND THEIR PARENT, GUARDIAN OR CARETAKER IN NAVIGATING THE PROGRAM'S BENEFITS AS WELL AS IN ACCESSING ANY SUCH SERVICES NECESSARY AND APPROPRIATE TO THE ELIGIBLE IMPAIRED PERSONS LEVEL OF IMPAIRMENT AND NEED.

3. "CLAIMANT" MEANS A PERSON WHO FILES A CLAIM PURSUANT TO THIS ARTICLE ON BEHALF OF AN IMPAIRED PERSON FOR COMPENSATION, AND INCLUDES AN AUTHORIZED LEGAL REPRESENTATIVE FILING A CLAIM ON BEHALF OF AN IMPAIRED PERSON.

4. "COMPENSATION" MEANS BENEFITS PROVIDED TO OR ON BEHALF OF AN IMPAIRED NEWBORN OR PERSON PURSUANT TO THIS ARTICLE.

5. "HEALTHCARE PROVIDER" MEANS A HOSPITAL, A HEALTH CARE ORGANIZATION ESTABLISHED PURSUANT TO ARTICLE FORTY-FOUR OF THIS CHAPTER, A LICENSED PHYSICIAN, A LICENSED MIDWIFE, A REGISTERED PROFESSIONAL NURSE OR A LICENSED PRACTICAL NURSE.

6. "HOSPITAL" MEANS A HOSPITAL ESTABLISHED PURSUANT TO ARTICLE TWENTY-EIGHT OF THIS CHAPTER. FOR THE PURPOSES OF ANY CLAIM FILED UNDER THIS ARTICLE, A HOSPITAL SHALL INCLUDE THE TRUSTEES, DIRECTORS, OFFICERS, EMPLOYEES AND AGENTS OF THE HOSPITAL.

7. "IMPAIRED PERSON" MEANS A NEWBORN OR CHILD WHO HAS A NEUROLOGICAL MOTOR IMPAIRMENT.

8. "NEUROLOGICAL IMPAIRMENT TRUST FUND" OR "TRUST FUND" MEANS THE TRUST FUND ESTABLISHED PURSUANT TO SECTION FORTY-NINE HUNDRED TWENTY-THREE OF THIS ARTICLE.

9. "NEUROLOGICAL MOTOR IMPAIRMENT" OR "IMPAIRMENT" MEANS A SUBSTANTIAL, NON-PROGRESSIVE MOTOR DEFICIT, OCCURRING IN A CHILD OF THIRTY-FOUR OR MORE WEEKS GESTATIONAL AGE, THAT MAY HAVE ORIGINATED DURING GESTATION, LABOR, DELIVERY, OR WITHIN TWENTY-EIGHT DAYS OF DELIVERY OR BEFORE DISCHARGE OF THE NEWBORN, WHICHEVER OCCURRED SOONER; PROVIDED THAT IMPAIRMENTS DUE TO GENETIC OR METABOLIC CONDITIONS ARE EXCLUDED.

10. "NURSE PRACTITIONER" MEANS A REGISTERED PROFESSIONAL NURSE CERTIFIED AS A NURSE PRACTITIONER UNDER ARTICLE ONE HUNDRED THIRTY-NINE OF THE EDUCATION LAW.

11. "PARTICIPATING PHYSICIAN" OR "PHYSICIAN" MEANS A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN THIS STATE. FOR PURPOSES OF ANY CLAIM FILED UNDER THIS ARTICLE, "PHYSICIAN" SHALL ALSO INCLUDE THE EMPLOYEES AND AGENTS OF THE PHYSICIAN AND ANY PHYSICIAN-OPERATED PROFESSIONAL CORPORATION.

12. "PHYSICIAN ASSESSOR" MEANS AN EXPERIENCED, BOARD CERTIFIED PHYSICIAN CERTIFIED BY A BOARD RECOGNIZED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES WHO, WITHIN TWO YEARS OF THE CLAIM, WAS IN ACTIVE MEDICAL PRACTICE OR DEVOTED A SUBSTANTIAL PORTION OF HIS OR HER TIME TO TEACHING AT AN ACCREDITED MEDICAL SCHOOL, OR WAS ENGAGED IN UNIVERSITY-BASED RESEARCH IN RELATION TO THE MEDICAL CARE AND TYPE OF TREATMENT AT ISSUE, WHO IS APPROVED BY HIS OR HER SPECIALTY SOCIETY, AND WHO IS CONTRACTED BY THE PROGRAM TO PERFORM LEVEL I OR LEVEL II ASSESSMENTS OF THE STANDARD OF CARE.

13. "PHYSICIAN EXPERT" MEANS A CHILD NEUROLOGIST OR DEVELOPMENTAL PEDIATRICIAN CERTIFIED IN THE SAME SPECIALTY BY A BOARD RECOGNIZED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES WHO, WITHIN TWO YEARS OF THE CLAIM, WAS IN ACTIVE MEDICAL PRACTICE OR DEVOTED A SUBSTANTIAL PORTION OF HIS OR HER TIME TO TEACHING AT AN ACCREDITED MEDICAL SCHOOL, OR ENGAGED IN UNIVERSITY-BASED RESEARCH IN RELATION TO THE MEDICAL CARE AND TYPE OF TREATMENT AT ISSUE, WHO IS APPROVED BY HIS OR HER SPECIALTY SOCIETY, AND WHO IS CONTRACTED BY THE PROGRAM TO PHYSICALLY EXAMINE AND DETERMINE WHETHER THE IMPAIRED PERSON HAS A NEUROLOGICAL MOTOR IMPAIRMENT THAT QUALIFIES FOR ELIGIBILITY IN THE PROGRAM.

14. "PROGRAM" MEANS THE NEUROLOGICAL IMPAIRMENT PROGRAM OF NEW YORK STATE ESTABLISHED IN SECTION FORTY-NINE HUNDRED TWENTY-TWO OF THIS ARTICLE.

S 4921. EXCLUSIVENESS OF REMEDY. 1. RECOVERY OF COMPENSATION PURSUANT TO THIS ARTICLE FOR NEUROLOGICAL IMPAIRMENT SUSTAINED BY AN IMPAIRED PERSON AS A RESULT OF HEALTH CARE SERVICES RENDERED BY A HEALTH CARE PROVIDER AT A HOSPITAL, WHETHER RESULTING IN DEATH OR NOT, SHALL BE THE EXCLUSIVE REMEDY AGAINST A HEALTH CARE PROVIDER OR HOSPITAL, OR ANY OFFICER, AGENT OR EMPLOYEE OF THE PROVIDER OR HOSPITAL. EXCEPT AS PROVIDED FOR BY THIS ARTICLE, A COVERED HEALTH CARE PROVIDER OR HOSPITAL, OR ANY OFFICER, AGENT OR EMPLOYEE OF SAID PROVIDER OR HOSPITAL, SHALL NOT BE SUBJECT TO ANY LIABILITY FOR THE INJURY, DISABILITY OR DEATH OF AN IMPAIRED PERSON; AND ALL CAUSES OF ACTION, INCLUDING ACTIONS AT LAWSUITS, IN EQUITY, PROCEEDINGS, AND STATUTORY AND COMMON LAW RIGHTS AND REMEDIES FOR AND ON ACCOUNT OF SAID INJURY, DISABILITY OR DEATH ARE ABOLISHED EXCEPT AS PROVIDED FOR IN THIS ARTICLE.

2. IF ANY CLAIM IS FILED IN ANY COURT OR OTHER FORUM BY OR ON BEHALF OF ANY CHILD ALLEGING NEUROLOGICAL IMPAIRMENT AS A RESULT OF MEDICAL MALPRACTICE BY A HEALTH CARE PROVIDER OR PROVIDERS, THE COURT OR FORUM SHALL, IF REQUESTED BY THE HEALTH CARE PROVIDER OR PROVIDERS, REFER THE CASE TO THE PROGRAM FOR A DETERMINATION OF ELIGIBILITY AND SHALL STAY ALL PROCEEDINGS PENDING A DETERMINATION OF ELIGIBILITY BY THE PROGRAM.

3. THE DETERMINATION OF ELIGIBILITY AS DETERMINED PURSUANT TO SECTIONS FORTY-NINE HUNDRED TWENTY-SIX AND FORTY-NINE HUNDRED TWENTY-SEVEN OF THIS ARTICLE SHALL BE BINDING UPON THE IMPAIRED PERSON, AND UPON HIS OR HER PARENTS, NEXT OF KIN, AGENT, PROXY, EXECUTOR, GUARDIAN OR ANY OTHER PERSON OR ENTITY CLAIMING COMPENSATION AS A RESULT OF IMPAIRMENT UNDER THIS ARTICLE AS PROVIDED PURSUANT THERETO. THE PROVISIONS OF THIS ARTICLE SHALL APPLY TO ALL PERSONS, REGARDLESS OF MINORITY OR LEGAL DISABILITY.

4. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PRECLUDE OR IMPAIR ANY ACTION BY AN APPROPRIATE AGENCY OR CIVIL AUTHORITY TO IMPOSE UPON A HEALTH CARE PROVIDER OR PARTICIPATING HOSPITAL CRIMINAL PENALTIES, LICENSURE RESTRICTIONS, OR OTHER SANCTIONS FOR VIOLATION OF LAW OR REGULATIONS.

S 4922. THE NEUROLOGICAL IMPAIRMENT PROGRAM OF NEW YORK STATE. 1. THERE IS HEREBY ESTABLISHED WITHIN THE DEPARTMENT, THE NEUROLOGICAL IMPAIRMENT PROGRAM OF NEW YORK STATE.

2. THE PROGRAM SHALL EMPLOY PERMANENT STAFF.

3. THE DIRECTOR OF THE PROGRAM SHALL BE APPOINTED BY THE GOVERNOR WITH THE ADVICE AND CONSENT OF THE SENATE AND ASSEMBLY.

4. NO CIVIL ACTION SHALL BE BROUGHT IN ANY COURT AGAINST ANY EMPLOYEE OR PERSON ENGAGED BY THE PROGRAM FOR ANY ACT DONE, FAILURE TO ACT, OR STATEMENT OR OPINION MADE, WITHIN THE SCOPE OF HIS OR HER DUTIES AS AN EMPLOYEE OF SUCH PROGRAM.

5. POWERS AND DUTIES OF THE PROGRAM. THE PROGRAM SHALL HAVE THE FOLLOWING POWERS AND DUTIES:

(A) TO SCREEN OUT PERSONS WHO COULD NOT BE ELIGIBLE FOR THE PROGRAM AND TO REFER ALL CASES THAT COULD BE ELIGIBLE TO A PHYSICIAN EXPERT FOR DETERMINATION OF ELIGIBILITY;

(B) TO ACCEPT AND COLLECT ALL ELIGIBLE CLAIMS FOR CARE FILED WITH THE PROGRAM PURSUANT TO THIS ARTICLE AND TO REINVESTIGATE OR REOPEN CLAIMS AS THE PROGRAM DEEMS NECESSARY, INCLUDING UPON THE FILING OF A PETITION FOR ADDITIONAL COMPENSATION;

(C) TO SOLICIT, THROUGH CONTRACT OR OTHERWISE, PHYSICIAN EXPERTS TO DETERMINE ELIGIBILITY FOR THE PROGRAM AND TO MAINTAIN A LIST OF SUCH PHYSICIAN EXPERTS;

(D) TO MAKE REFERRALS OF ALL POTENTIALLY ELIGIBLE CLAIMS TO ONE SUCH PHYSICIAN EXPERT FOR EVALUATION AND DETERMINATION OF ELIGIBILITY AS DETERMINED BY THE DEFINITION OF IMPAIRMENT;

(E) TO ESTABLISH A DATABASE OF ALL CLAIMS THAT HAVE BEEN DETERMINED ELIGIBLE FOR COMPENSATION, AND SUMMARIES OF ALL ELIGIBLE PERSONS FOR AN ASSESSMENT OF THE STANDARD OF CARE;

(F) FOR EACH CLAIMANT DETERMINED TO BE ELIGIBLE PRIOR TO THE CLAIMANT'S SECOND BIRTHDAY, TO REEVALUATE EACH SUCH CLAIMANT AT AGE TWO YEARS TO DETERMINE WHETHER THE CHILD REMAINS ELIGIBLE FOR COMPENSATION AND SERVICES. REEVALUATIONS SHALL BE PERFORMED BY A PHYSICIAN EXPERT. SUCH REEVALUATION WILL PERMIT THE EARLY ENTRY INTO THE PROGRAM OF CHILDREN WHO APPEAR TO HAVE SUBSTANTIAL NEUROLOGICAL MOTOR IMPAIRMENT BUT FOR WHOM, BY THE AGE OF TWO YEARS, THAT IMPAIRMENT NO LONGER SUBSTANTIALLY LIMITS DAILY FUNCTIONS;

(G) TO ADOPT, PROMULGATE, AMEND AND RESCIND RULES AND REGULATIONS TO CARRY OUT THE PROVISIONS AND PURPOSES OF THIS ARTICLE, INCLUDING RULES FOR THE APPROVAL OF ATTORNEY'S FEES FOR REPRESENTATION BEFORE THE PROGRAM;

(H) TO ESTABLISH A LIST OF CONDITIONS THAT MEET THE DEFINITION OF IMPAIRMENT AND A LIST OF THOSE CONDITIONS WHICH DO NOT MEET THE DEFINITION OF IMPAIRMENT AND ARE EXCLUDED. SUCH LIST SHALL BE REVISED WHEN APPROPRIATE. THE PROGRAM SHALL REVIEW THE LIST AT LEAST ANNUALLY AND SHALL MAKE THE LIST AVAILABLE TO THE PUBLIC;

(I) TO AUTHORIZE THE COMMISSIONER OF TAXATION AND FINANCE AND THE COMPTROLLER TO MAKE PAYMENTS FROM THE TRUST FUND TO PROVIDE COMPENSATION PURSUANT TO THIS ARTICLE;

(J) TO COLLECT ASSESSMENTS, INCLUDING ANY AUTHORIZED ASSESSMENTS REMAINING UNPAID, FOR DEPOSIT IN THE TRUST FUND IN ACCORDANCE WITH THE PROVISIONS OF THIS ARTICLE;

(K) TO EMPLOY SUCH EMPLOYEES AS IT MAY DEEM NECESSARY AND PRESCRIBE THEIR DUTIES;

(L) TO ENTER INTO ANY AGREEMENTS AND CONTRACTS AS ARE NECESSARY OR PROPER IN THE JUDGMENT OF THE PROGRAM TO ADMINISTER THE PROGRAM, INCLUDING WITHOUT LIMITATION CONTRACTS WITH ANY ARTICLE FORTY-THREE INSURANCE LAW PLANS AND SUCH OTHER ADMINISTRATORS AS THE PROGRAM SHALL DESIGNATE, AND AGREEMENTS WITH HEALTH CARE PROVIDERS, PEDIATRICIANS, LOCAL GOVERNMENTS AND OTHER PUBLIC CORPORATIONS, SCHOOL DISTRICTS AND SCHOOL DISTRICT COMMITTEES, EARLY INTERVENTION OFFICIALS DESIGNATED UNDER TITLE II-A OF ARTICLE TWO OF THIS CHAPTER, AND OTHERS, PROVIDING FOR DISTRIBUTION OF MATERIALS AND INFORMATION CONCERNING THE BENEFITS AVAILABLE UNDER THE PROGRAM, ENSURING WIDE ACCESS TO ITS BENEFITS, AND COORDINATING RECEIPT OF BENEFITS AND SERVICES AVAILABLE UNDER OTHER PROGRAMS;

(M) TO SEEK REFUNDS AND TO TAKE ANY LEGAL ACTION NECESSARY TO AVOID OR RECOVER THE PAYMENT OF IMPROPER CLAIMS OR OTHER FUNDS IT IS OWED;

(N) TO GRANT EXTENSIONS TO THE TIME LIMITATIONS OF THIS ARTICLE IN EXCEPTIONAL CASES;

(O) TO PREPARE WRITTEN INFORMATION ABOUT THE PROGRAM'S ACTIVITIES AND PROCEDURES AND THE BENEFITS AVAILABLE TO IMPAIRED PERSONS UNDER THIS ARTICLE;

(P) TO ENCOURAGE ALL PEDIATRICIANS, FAMILY PRACTITIONERS AND HOSPITALS THAT PROVIDE PEDIATRIC CARE TO PROVIDE THE INFORMATION REFERRED TO IN THIS ARTICLE TO THE PARENTS OR GUARDIANS OF THEIR PEDIATRIC PATIENTS; AND

(Q) TO HAVE AND EXERCISE ALL POWERS NECESSARY TO EFFECT ANY OR ALL OF THE PURPOSES OF THIS ARTICLE.

S 4923. NEUROLOGICAL IMPAIRMENT TRUST FUND. THE PROGRAM SHALL ESTABLISH AND MAINTAIN A TRUST FUND, TO BE KNOWN AS THE "NEUROLOGICAL IMPAIRMENT TRUST FUND", OF WHICH THE PROGRAM SHALL BE THE TRUSTEE. ALL REVENUES COLLECTED BY THE PROGRAM PURSUANT TO THIS ARTICLE SHALL BE DEPOSITED BY THE PROGRAM INTO THE TRUST FUND AND SHALL BE AVAILABLE FOR USE BY THE PROGRAM FOR ITS ORDINARY AND NECESSARY OPERATIONS' EXPENSES AND FOR THE PAYMENT OF COMPENSATION TO IMPAIRED PERSONS PURSUANT TO THE PROVISIONS OF THIS ARTICLE. FUNDS AND EXPENSES FOR THIS PROGRAM SHALL BE DERIVED FROM FUNDS APPROPRIATED AS NECESSARY TO MEET THE REQUIREMENTS OF THIS ARTICLE.

S 4924. FILING OF CLAIMS. 1. A CLAIM MAY BE FILED UNDER THIS ARTICLE BY EITHER A CLAIMANT OR BY A HEALTH CARE PROVIDER BY SUBMITTING A STANDARDIZED CLAIM FORM TO THE PROGRAM, SETTING FORTH THE FOLLOWING INFORMATION AND ATTACHING DOCUMENTATION WHERE REQUIRED:

(A) THE NAME AND ADDRESS OF THE PERSON OR ENTITY FILING THE CLAIM; IF THE CLAIM IS FILED ON BEHALF OF AN IMPAIRED PERSON, THE CLAIMANT SHALL IDENTIFY THE CHILD'S LEGAL REPRESENTATIVE AND THE BASIS FOR HIS OR HER REPRESENTATION OF THE IMPAIRED PERSON;

(B) THE NAME, ADDRESS AND DATE OF BIRTH OF THE IMPAIRED NEWBORN OR CHILD AND THE NAME AND ADDRESS OF HIS OR HER PARENTS AND ANY LEGAL REPRESENTATIVES;

(C) THE NAME AND ADDRESS OF ANY PHYSICIAN, MIDWIFE OR NURSE PRACTITIONER WHO PARTICIPATED IN THE MANAGEMENT OF THE LABOR AND/OR DELIVERY AND CARE OF THE IMPAIRED NEWBORN, THE NAME OF THE HOSPITAL IN WHICH THE DELIVERY AND/OR NEONATAL MANAGEMENT OCCURRED AND THE NAME OF ANY OTHER PHYSICIAN OR NURSE PRACTITIONER WHO IS PROVIDING OR HAS PROVIDED CARE FOR THE IMPAIRED CHILD;

(D) THE NAMES AND ADDRESSES OF ANY PHYSICIAN, MIDWIFE OR NURSE PRACTITIONER WHO PARTICIPATED IN THE MANAGEMENT OF CARE FOR THE IMPAIRED PERSON, THE NAMES OF THE HOSPITALS IN WHICH ANY CARE WAS PROVIDED, AND THE NAME OF ANY OTHER PHYSICIAN OR NURSE PRACTITIONER WHO IS PROVIDING OR HAS PROVIDED CARE FOR THE IMPAIRED PERSON;

(E) A DESCRIPTION OF THE IMPAIRMENT FOR WHICH THE CLAIM IS MADE AND THE APPLICABLE DIAGNOSIS OR ETIOLOGY OF THE IMPAIRMENT;

(F) THE TIME AND PLACE THE IMPAIRMENT WAS THOUGHT TO HAVE OCCURRED;

(G) A STATEMENT OF THE CIRCUMSTANCES SURROUNDING THE IMPAIRMENT AND GIVING RISE TO THE CLAIM, INCLUDING THE ROLE OF ANY HEALTH CARE PROVIDER ASSOCIATED WITH THE IMPAIRMENT;

(H) A SCHEDULE, WITH DOCUMENTATION, OF EXPENSES AND SERVICES INCURRED TO DATE, TOGETHER WITH A DESCRIPTION OF ANY PAYMENT THAT HAS BEEN MADE FOR SUCH SERVICES, AND THE IDENTITY OF THE PAYER; AND

(I) A SCHEDULE, WITH DOCUMENTATION, OF ANY SOURCE OF REIMBURSEMENT OR CARE, SUCH AS HEALTH INSURANCE OR A GOVERNMENT PROGRAM, WHICH MAY CONSTITUTE AN EXCLUSION FROM COMPENSATION, AS PROVIDED IN THIS ARTICLE.

2. A CLAIMANT OR HEALTH CARE PROVIDER SHALL ALSO PROVIDE THE PROGRAM, AT THE TIME THE PETITION IS SUBMITTED, WITH THE FOLLOWING MATERIALS AND INFORMATION, TO THE EXTENT AVAILABLE:

(A) ALL RELEVANT MEDICAL RECORDS OF THE IMPAIRED PERSON, AND IDENTIFICATION OF ANY UNAVAILABLE RECORDS KNOWN TO THE CLAIMANT OR HEALTH CARE PROVIDER AND THE REASONS FOR THEIR UNAVAILABILITY; AND

(B) ALL APPROPRIATE ASSESSMENTS, EVALUATIONS, DIAGNOSES, DETERMINATIONS OF ETIOLOGY AND PROGNOSES AND SUCH OTHER RECORDS NECESSARY FOR THE DETERMINATION OF THE COMPENSATION TO BE PAID TO THE IMPAIRED NEWBORN OR CHILD.

3. THE CLAIMANT'S FAILURE TO PROVIDE ALL OF THE INFORMATION DESCRIBED IN SUBDIVISIONS ONE AND TWO OF THIS SECTION SHALL NOT DEPRIVE THE PROGRAM OF JURISDICTION OVER THE CLAIM PENDING RECEIPT BY THE PROGRAM OF INFORMATION SUFFICIENT TO REVIEW THE CLAIM.

4. NOTWITHSTANDING ANY LAW TO THE CONTRARY, THE CLAIMANT AND, UPON THE SUBMISSION OF A PETITION, THE PROGRAM SHALL HAVE THE RIGHT TO OBTAIN ALL RELEVANT MEDICAL RECORDS OF THE IMPAIRED PERSON, AND UPON A REQUEST BY A CLAIMANT OR THE PROGRAM PURSUANT TO THIS ARTICLE, A HEALTH CARE PROVIDER SHALL HAVE THE DUTY TO PROVIDE FOR COPYING AT NO CHARGE, ALL SUCH RECORDS WITHIN THE PROVIDER'S POSSESSION.

5. UPON RECEIPT OF A PETITION FROM A CLAIMANT, THE PROGRAM SHALL NOTIFY ANY HEALTH CARE PROVIDER IDENTIFIED IN THE PETITION AND ANY PHYSICIAN OR HOSPITAL INVOLVED IN THE LABOR OR DELIVERY OF THE CHILD WHO IS NOT IDENTIFIED IN THE PETITION. UPON RECEIPT OF A PETITION FROM A HEALTH CARE PROVIDER, THE PROGRAM SHALL NOTIFY ANY PARENTS OR LEGAL REPRESENTATIVES IDENTIFIED IN THE PETITION AND SHALL MAKE REASONABLE EFFORTS TO IDENTIFY AND NOTIFY ANY PARENT OR LEGAL REPRESENTATIVE WHO IS NOT IDENTIFIED IN THE PETITION. SUCH PHYSICIAN, HOSPITAL, PARENT OR LEGAL REPRESENTATIVE SHALL HAVE FORTY-FIVE DAYS FROM THE DATE OF SUCH NOTICE TO SUBMIT ANY COMMENTS OR OTHER INFORMATION RELEVANT TO THE CLAIM, AND TO ELECT TO BE NOTIFIED OF ANY APPEAL HELD ON THE DETERMINATION OF ELIGIBILITY.

6. BEFORE RECEIVING THE FIRST CLAIM, THE PROGRAM SHALL PREPARE AND, AS APPROPRIATE, UPDATE A DOCUMENT DESCRIBING THE BENEFITS AVAILABLE UNDER THIS ARTICLE, THE PROCEDURES FOR OBTAINING SUCH BENEFITS, AND OTHER PROGRAMS AVAILABLE TO ASSIST IMPAIRED PERSONS. THE PROGRAM SHALL SEND THIS DOCUMENT TO ALL CLAIMANTS AND MAKE IT AVAILABLE TO THE PUBLIC.

7. THE PROGRAM SHALL ESTABLISH A CLAIMS ASSISTANCE UNIT WHICH SHALL PROVIDE INFORMATION TO CLAIMANTS ABOUT THE PROGRAM'S ACTIVITIES AND PROCEDURES, A DESCRIPTION OF THE ELIGIBILITY PROCESS, THE BENEFITS AVAILABLE TO CLAIMANTS AND THE REQUIREMENTS OF THIS SECTION, INCLUDING THE PHYSICAL EXAMINATION OF THE INFANT WHICH MAY BE NECESSARY TO RECEIVE COMPENSATION UNDER THE PROGRAM. THE PROGRAM SHALL ESTABLISH AT LEAST ONE TOLL-FREE TELEPHONE NUMBER FOR CENTRALIZED ASSISTANCE, INCLUDING ANSWERING QUESTIONS AND REFERRAL TO LOCAL SOURCES OF ASSISTANCE MADE AVAILABLE UNDER ANY CONTRACTS OR AGREEMENTS AUTHORIZED PURSUANT TO THIS ARTICLE. ANY CLAIMANT WHO HAS FILED A PETITION THAT THE PROGRAM FINDS DOES NOT CONTAIN ALL INFORMATION NECESSARY TO PROCESS THE CLAIM SHALL BE REFERRED TO THE CLAIMS ASSISTANCE UNIT FOR GUIDANCE.

8. A CLAIM SEEKING ADDITIONAL COMPENSATION ON BEHALF OF AN IMPAIRED NEWBORN OR CHILD FOR WHICH COMPENSATION HAS ALREADY BEEN AWARDED MAY BE FILED ON BEHALF OF THE IMPAIRED PERSON AT ANY POINT DURING THE REMAINDER OF HIS OR HER LIFE. SUCH CLAIM SHALL PROVIDE THE FOLLOWING DOCUMENTATION IN ADDITION TO THE INFORMATION SPECIFIED IN SUBDIVISIONS ONE AND TWO OF THIS SECTION:

(A) A STATEMENT AND SUPPORTING DOCUMENTATION REGARDING THE REASON OR REASONS WHY ADDITIONAL COMPENSATION IS BEING SOUGHT;

(B) A SCHEDULE, WITH DOCUMENTATION, OF EXPENSES AND SERVICES INCURRED FOR THE CALENDAR YEAR PRIOR TO THE DATE OF THE PETITION, ANY PAYMENTS MADE FOR SUCH SERVICES, AND THE IDENTITY OF THE PAYER; AND

(C) A SCHEDULE, WITH DOCUMENTATION, OF ANY PRESENT SOURCES OF REIMBURSEMENT FOR CARE, SUCH AS HEALTH INSURANCE OR A GOVERNMENT PROGRAM.

S 4925. CASE MANAGEMENT PROGRAM. 1. CASE MANAGEMENT SERVICES. CASE MANAGEMENT SERVICES AS DEFINED IN SECTION FORTY-NINE HUNDRED TWENTY OF THIS ARTICLE SHALL NOT:

(A) BE UTILIZED TO RESTRICT THE CHOICE OF AN ELIGIBLE IMPAIRED PERSON IN OBTAINING NECESSARY CASE MANAGEMENT SERVICES FROM ANY PROVIDER PARTICIPATING IN THE PROGRAM WHO IS QUALIFIED TO PROVIDE SUCH SERVICES AND WHO UNDERTAKES TO PROVIDE SUCH SERVICES, INCLUDING AN ORGANIZATION WHICH PROVIDES SUCH SERVICES;

(B) DUPLICATE CASE MANAGEMENT SERVICES CURRENTLY PROVIDED UNDER THE MEDICAL ASSISTANCE PROGRAM OR UNDER ANY OTHER PROGRAM THAT THE ELIGIBLE IMPAIRED PERSON IS ENROLLED OR WHICH SUCH ELIGIBLE IMPAIRED PERSON ACCESSES;

(C) BE UTILIZED BY PROVIDERS OF CASE MANAGEMENT SERVICES TO CREATE A DEMAND FOR UNNECESSARY SERVICES OR PROGRAMS, PARTICULARLY THOSE SERVICES OR PROGRAMS WITHIN THEIR SCOPE OF AUTHORITY; AND

(D) BE PROVIDED TO ANY AND ALL ELIGIBLE IMPAIRED PERSONS ALSO RECEIVING INSTITUTIONAL CARE REIMBURSED UNDER THE MEDICAL ASSISTANCE PROGRAM OR TO ANY AND ALL ELIGIBLE IMPAIRED PERSONS IN RECEIPT OF CASE MANAGEMENT SERVICES UNDER A FEDERAL HOME AND COMMUNITY BASED WAIVER.

2. CASE MANAGEMENT FUNCTIONS. CASE MANAGEMENT FUNCTIONS ARE TO BE DETERMINED ON THE BASIS OF THE ELIGIBLE IMPAIRED PERSON'S ENTRANCE INTO THE PROGRAM. A SEPARATE CASE RECORD MUST BE ESTABLISHED FOR EACH ELIGIBLE IMPAIRED PERSON RECEIVING CASE MANAGEMENT SERVICES AND EACH CASE MANAGEMENT FUNCTION PROVIDED, INCLUDING BUT NOT LIMITED TO INTAKE AND SCREENING WHICH CONSISTS OF INITIATING CONTACT WITH THE ELIGIBLE IMPAIRED PERSON AND PROVIDING INFORMATION CONCERNING ALL CASE MANAGEMENT SERVICES AVAILABLE UNDER THE PROGRAM.

3. ASSESSMENT AND REASSESSMENT. THE CASE MANAGER SHALL SECURE THROUGH BOTH THE PROGRAM AND THE DEPARTMENT, AND WITH THE ELIGIBLE IMPAIRED PERSON'S PERMISSION OR PERMISSION OF THE ELIGIBLE IMPAIRED PERSON'S PARENT, GUARDIAN OR CARETAKER:

(A) AN ASSESSMENT OF THE ELIGIBLE IMPAIRED PERSON'S SERVICE NEEDS INCLUDING MEDICAL, SOCIAL, PSYCHOSOCIAL, EDUCATIONAL AND ANY OTHER SERVICES DEEMED NECESSARY;

(B) INFORMATION IDENTIFYING THE BARRIERS TO CARE AND EXISTING GAPS IN SERVICE RELATIVE TO THE ELIGIBLE IMPAIRED PERSON'S NEED; AND

(C) A DESCRIPTION OF FACTORS RELATIVE TO THE ELIGIBLE IMPAIRED PERSON'S CARE.

4. CASE MANAGEMENT PLAN AND COORDINATION. THE CASE MANAGEMENT ACTIVITIES REQUIRED TO ESTABLISH A COMPREHENSIVE WRITTEN CASE MANAGEMENT PLAN AND TO EFFECTUATE THE COORDINATION OF SERVICES INCLUDE:

(A) IDENTIFICATION OF THE NATURE, AMOUNT, TYPE, FREQUENCY AND POTENTIAL DURATION OF THE CASE MANAGEMENT SERVICES REQUIRED BY AN ELIGIBLE IMPAIRED PERSON;

(B) SELECTION OF THE NATURE, AMOUNT, TYPE, FREQUENCY AND POTENTIAL DURATION OF SERVICES TO BE PROVIDED TO THE ELIGIBLE IMPAIRED PERSON WITH THE PARTICIPATION OF THE ELIGIBLE IMPAIRED PERSON, AND/OR HIS OR HER PARENT, GUARDIAN OR CARETAKER, AND PROVIDERS OF SERVICES;

(C) SPECIFICATION OF THE LONG-TERM AND SHORT-TERM GOALS TO BE ACHIEVED THROUGH THE CASE MANAGEMENT PROCESS;

(D) COLLABORATION WITH HEALTH CARE PROVIDERS AND OTHER FORMAL AND INFORMAL SERVICE PROVIDERS, INCLUDING DISCHARGE PLANNERS AND OTHER CASE MANAGERS AS APPROPRIATE, THROUGH CASE CONFERENCES TO ENCOURAGE THE EXCHANGE OF CLINICAL INFORMATION AND TO ASSURE:

(I) INTEGRATION OF CLINICAL CARE PLANS THROUGHOUT THE CASE MANAGEMENT PROCESS,

(II) CONTINUITY OF CASE MANAGEMENT SERVICES,

(III) AVOIDANCE OF DUPLICATION OF SERVICES, INCLUDING CASE MANAGEMENT SERVICES, AND

(IV) ESTABLISHMENT OF A COMPREHENSIVE CASE MANAGEMENT PLAN THAT ADDRESSES THE MEDICAL, SOCIAL, PSYCHOSOCIAL, EDUCATIONAL AND ANY OTHER NEEDS DEEMED NECESSARY BY THE ELIGIBLE IMPAIRED PERSON;

(E) IMPLEMENTATION OF THE CASE MANAGEMENT PLAN BY THE PROGRAM, IN CONJUNCTION AND CONSULTATION WITH THE DEPARTMENT, INCLUDES:

(I) SECURING THE SERVICES DETERMINED IN THE CASE MANAGEMENT PLAN TO BE APPROPRIATE FOR AN ELIGIBLE IMPAIRED PERSON THROUGH REFERRAL TO THOSE AGENCIES OR PERSONS WHO ARE QUALIFIED TO PROVIDE THE IDENTIFIED SERVICES,

(II) ASSISTING THE ELIGIBLE IMPAIRED PERSON WITH REFERRAL AND/OR APPLICATION FORMS REQUIRED FOR THE ACQUISITION OF SERVICES,

(III) ADVOCATING FOR THE ELIGIBLE IMPAIRED PERSON WITH ALL PROVIDERS OF SERVICES, AND

(IV) DEVELOPING ALTERNATIVE SERVICES TO ASSURE CONTINUITY IN THE EVENT OF SERVICE DISRUPTION;

(F) CRISIS INTERVENTION BY A CASE MANAGER OR HEALTH CARE PROVIDER, WHEN NECESSARY, INCLUDES:

(I) ASSESSMENT OF THE NATURE OF THE ELIGIBLE IMPAIRED PERSON'S IMPAIRMENT AND CIRCUMSTANCES,

(II) DETERMINATION OF THE ELIGIBLE IMPAIRED PERSON'S EMERGENCY SERVICE NEEDS, AND

(III) REVISION OF THE CASE MANAGEMENT PLAN, INCLUDING ANY CHANGES IN ACTIVITIES OR OBJECTIVES REQUIRED TO ACHIEVE THE ESTABLISHED GOAL, AS DETERMINED THROUGH THE CASE MANAGEMENT PROCESS; AND

(G) MONITORING AND FOLLOW-UP OF CASE MANAGEMENT SERVICES INCLUDE:

(I) VERIFYING THAT QUALITY SERVICES, AS IDENTIFIED IN THE CASE MANAGEMENT PLAN, ARE BEING RECEIVED BY THE ELIGIBLE IMPAIRED PERSON,

(II) ASSURING THAT THE RECIPIENT IS ADHERING TO THE CASE MANAGEMENT PLAN,

(III) ASCERTAINING THE ELIGIBLE IMPAIRED PERSON'S SATISFACTION WITH THE SERVICES PROVIDED AND ADVISING THE PREPARER OF THE CASE MANAGEMENT PLAN OF THE FINDINGS IF THE PLAN HAS BEEN FORMULATED BY A HEALTH CARE PROVIDER,

(IV) COLLECTING DATA AND DOCUMENTING IN THE CASE RECORD THE PROGRESS OF THE ELIGIBLE IMPAIRED PERSON,

(V) ASCERTAINING WHETHER THE SERVICES TO WHICH THE ELIGIBLE IMPAIRED PERSON HAS BEEN REFERRED ARE AND CONTINUE TO BE APPROPRIATE TO HIS OR HER NEEDS, AND MAKING NECESSARY REVISIONS TO THE CASE MANAGEMENT PLAN,

(VI) MAKING ALTERNATE ARRANGEMENTS WHEN SERVICES ARE POTENTIALLY UNAVAILABLE TO THE ELIGIBLE IMPAIRED PERSON, AND

(VII) ASSISTING THE ELIGIBLE IMPAIRED PERSON AND/OR HIS OR HER PARENT, GUARDIAN, CARETAKER AND/OR ANY AND ALL PROVIDERS OF SERVICES TO RESOLVE DISAGREEMENTS, QUESTIONS OR PROBLEMS WITH IMPLEMENTATION OF THE CASE MANAGEMENT PLAN.

5. COUNSELING AND EXIT PLANNING. THE FOLLOWING MEASURES SHALL BE INCLUDED WITHIN ANY COUNSELING AND EXIT PLANNING PROVIDED BY THE CASE MANAGEMENT PLAN AND DEVELOPED IN CONJUNCTION WITH THE PROGRAM AND THE DEPARTMENT:

(A) ASSURING THAT THE ELIGIBLE IMPAIRED PERSON OBTAINS, ON AN ONGOING BASIS, THE MAXIMUM BENEFIT FROM THE SERVICES RECEIVED;

(B) DEVELOPING SUPPORT GROUPS FOR THE ELIGIBLE IMPAIRED PERSON, HIS OR HER PARENT, GUARDIAN OR CARETAKER AND INFORMAL PROVIDERS OF SERVICES;

(C) MEDIATING WITH THE ELIGIBLE IMPAIRED PERSON, HIS OR HER PARENT, GUARDIAN OR CARETAKER AND/OR INFORMAL PROVIDERS OF SERVICES ANY PROBLEMS WITH SERVICE PROVISION THAT MAY OCCUR; AND

(D) FACILITATING THE ELIGIBLE IMPAIRED PERSON'S ACCESS TO OTHER APPROPRIATE CARE AS NEEDED.

6. PROCEDURAL REQUIREMENTS FOR THE ASSESSMENT AND PROVISION OF SERVICES.

(A) AN ASSESSMENT PROVIDES VERIFICATION OF THE ELIGIBLE IMPAIRED PERSON'S LEVEL OF IMPAIRMENT, HIS OR HER CONTINUING NEED FOR SERVICES AND THE SERVICE PRIORITIES AND EVALUATION OF THE ELIGIBLE IMPAIRED PERSON'S ABILITY TO BENEFIT FROM SUCH SERVICES.

(B) AN ASSESSMENT MUST BE COMPLETED BY A CASE MANAGER WITHIN THIRTY DAYS OF THE DATE OF ENTRY INTO THE PROGRAM. THE REFERRAL FOR SERVICES MAY INCLUDE A PLAN OF CARE CONTAINING SIGNIFICANT INFORMATION DEVELOPED BY THE PROGRAM WHICH SHOULD BE INCLUDED AS AN INTEGRAL PART OF THE CASE MANAGEMENT PLAN.

(C) AN UPDATED ASSESSMENT OF THE ELIGIBLE IMPAIRED PERSON'S NEED FOR CASE MANAGEMENT AND OTHER SERVICES DEEMED NECESSARY MUST BE COMPLETED BY THE CASE MANAGER EVERY SIX MONTHS, OR SOONER IF REQUIRED BY CHANGES IN THE ELIGIBLE IMPAIRED PERSON'S LEVEL OF IMPAIRMENT, CONDITION OR CIRCUMSTANCES.

7. CASE MANAGEMENT PLAN. A WRITTEN CASE MANAGEMENT PLAN SHALL BE COMPLETED BY THE CASE MANAGER FOR EACH ELIGIBLE IMPAIRED PERSON WITHIN THIRTY DAYS OF THE DATE OF ENTRY INTO THE PROGRAM.

(A) THE CASE MANAGEMENT PLAN SHALL BE REVIEWED AND UPDATED BY THE CASE MANAGER AS REQUIRED BY CHANGES IN THE ELIGIBLE IMPAIRED PERSON'S LEVEL OF IMPAIRMENT, CONDITION OR CIRCUMSTANCES, BUT NOT LESS FREQUENTLY THAN EVERY SIX MONTHS SUBSEQUENT TO THE INITIAL PLAN AND INITIAL ENTRY INTO THE PROGRAM.

(B) THE CASE MANAGEMENT PLAN SHALL SPECIFY:

(I) THOSE ACTIVITIES WHICH THE ELIGIBLE IMPAIRED PERSON IS EXPECTED TO UNDERTAKE WITHIN A GIVEN PERIOD OF TIME TOWARD THE ACCOMPLISHMENT OF EACH CASE MANAGEMENT GOAL;

(II) THE NAME OF THE PERSON OR AGENCY, INCLUDING THE INDIVIDUAL AND/OR PARENT, GUARDIAN OR CARETAKER, WHO WILL PERFORM NEEDED TASKS;

(III) THE TYPE OF TREATMENT PROGRAM OR SERVICE PROVIDERS TO WHICH THE RECIPIENT WILL BE REFERRED;

(IV) THE METHOD OF PROVISION AND THOSE ACTIVITIES TO BE PERFORMED BY A SERVICE PROVIDER OR OTHER PERSON TO ACHIEVE THE ELIGIBLE IMPAIRED PERSON'S RELATED GOAL AND OBJECTIVE; AND

(V) THE TYPE, AMOUNT, FREQUENCY AND POTENTIAL DURATION OF SERVICES TO BE DELIVERED OR TASKS TO BE PERFORMED.

8. CONTINUITY OF SERVICE. (A) CASE MANAGEMENT SERVICES MUST BE ONGOING FROM THE TIME THE ELIGIBLE IMPAIRED PERSON IS ACCEPTED BY THE PROGRAM THROUGHOUT HIS OR HER LIFETIME UNLESS:

(I) THE COORDINATION OF SERVICES PROVIDED THROUGH CASE MANAGEMENT IS NOT REQUIRED OR IS NO LONGER REQUIRED BY THE ELIGIBLE IMPAIRED PERSON;

(II) THE ELIGIBLE IMPAIRED PERSON MOVES OUT OF STATE; OR

(III) THE ELIGIBLE IMPAIRED PERSON AND/OR HIS OR HER PARENT, GUARDIAN OR CARETAKER, ON THE ELIGIBLE IMPAIRED PERSON'S BEHALF, REFUSES TO ACCEPT CASE MANAGEMENT SERVICES.

(B) CONTACT WITH THE ELIGIBLE IMPAIRED PERSON AND/OR HIS OR HER PARENT, GUARDIAN OR CARETAKER ON THE ELIGIBLE IMPAIRED PERSON'S BEHALF MUST BE MAINTAINED BY THE CASE MANAGER AT LEAST MONTHLY, OR MORE FREQUENTLY AS SPECIFIED IN THE PROVIDER AGREEMENT WITH THE PROGRAM AND THE DEPARTMENT.

9. QUALIFICATIONS OF PROVIDERS OF CASE MANAGEMENT SERVICES. CASE MANAGEMENT SERVICES SHALL BE PROVIDED BY SOCIAL SERVICES AGENCIES, FACILITIES, PERSONS, AND GROUPS POSSESSING THE CAPABILITY TO PROVIDE

SUCH SERVICES AND WHICH ARE APPROVED BY THE PROGRAM, IN CONJUNCTION WITH THE COMMISSIONERS OF HEALTH, MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES AND MENTAL HEALTH PURSUANT TO CASE MANAGEMENT PROVIDER QUALIFICATIONS, INCLUDING:

(A) FACILITIES LICENSED OR CERTIFIED UNDER STATE LAW OR REGULATION;

(B) HEALTH CARE OR SOCIAL WORK PROFESSIONALS LICENSED OR CERTIFIED IN ACCORDANCE WITH STATE LAW;

(C) STATE AND LOCAL GOVERNMENTAL AGENCIES; AND

(D) HOME HEALTH AGENCIES CERTIFIED UNDER STATE LAW.

10. CASE MANAGERS. EACH CASE MANAGER SHALL HAVE TWO YEARS EXPERIENCE, INCLUDING THE PERFORMANCE OF ASSESSMENTS AND THE DEVELOPMENT OF CASE MANAGEMENT PLANS. VOLUNTARY OR PART-TIME EXPERIENCE WHICH CAN BE VERIFIED WILL BE ACCEPTED ON A PRO RATA BASIS. THE FOLLOWING MAY BE SUBSTITUTED FOR THIS REQUIREMENT:

(A) ONE YEAR OF CASE MANAGEMENT EXPERIENCE AND A DEGREE IN A HEALTH OR HUMAN SERVICES FIELD;

(B) ONE YEAR OF CASE MANAGEMENT EXPERIENCE AND AN ADDITIONAL YEAR OF EXPERIENCE IN OTHER ACTIVITIES RELATED TO PERSONS WITH NEUROLOGICAL IMPAIRMENT;

(C) A BACHELOR'S OR MASTER'S DEGREE WHICH INCLUDES THE PERFORMANCE OF ASSESSMENTS AND DEVELOPMENT OF CASE MANAGEMENT PLANS; OR

(D) MEETING THE REGULATORY REQUIREMENTS OF A STATE AGENCY FOR A CASE MANAGER.

11. REQUIREMENTS FOR THE PROVISION OF SERVICES. THOSE ENTITIES SEEKING TO PROVIDE CASE MANAGEMENT SERVICES THROUGH THE PROGRAM AND THE DEPARTMENT TO ELIGIBLE IMPAIRED PERSONS MUST:

(A) ESTABLISH A WRITTEN MEMORANDUM OF UNDERSTANDING OR REFERRAL AGREEMENT DESCRIBING THEIR CURRENT OR PROJECTED RELATIONSHIP WITH THE SOCIAL SERVICES DISTRICT OR DISTRICTS WHERE CASE MANAGEMENT SERVICES WILL BE PROVIDED. A COPY OF THE PROPOSED MEMORANDUM OF UNDERSTANDING OR REFERRAL AGREEMENT MUST ACCOMPANY THE PROPOSAL SUBMITTED TO BOTH THE PROGRAM AND THE DEPARTMENT. SUCH PROPOSALS AND AGREEMENTS OR MEMORANDA OF UNDERSTANDING SHALL BECOME THE BASIS FOR A PROVIDER AGREEMENT BETWEEN THE PROGRAM AND THE DEPARTMENT AND THE PROVIDER OF CASE MANAGEMENT SERVICES;

(B) SUBMIT TO THE PROGRAM AND THE DEPARTMENT A WRITTEN PROPOSAL SETTING FORTH THEIR PLAN FOR PROVISION OF CASE MANAGEMENT SERVICES. SUCH PROPOSAL SHALL BECOME THE BASIS FOR A WRITTEN PROVIDER AGREEMENT BETWEEN THE PROVIDER OF SERVICES AND THE DEPARTMENT;

(C) SUBMIT TO THE PROGRAM AND DEPARTMENT A WRITTEN PROPOSAL SETTING FORTH ITS PLAN AND RATES OR FEES FOR PROVISION OF CASE MANAGEMENT SERVICES. SUCH PROPOSAL WILL BECOME THE BASIS FOR A WRITTEN PROVIDER AGREEMENT BETWEEN THE PROGRAM AND THE DEPARTMENT.

(I) ALL PROPOSALS FOR PROVISION OF CASE MANAGEMENT SERVICES BECOME THE PROPERTY OF THE PROGRAM AND THE DEPARTMENT AND MUST BE FOR A PERIOD OF NOT MORE THAN FIVE YEARS AND SHALL BE COMPLETED ON FORMS PRESCRIBED BY THE DEPARTMENT.

(II) AT THE DISCRETION OF THE PROGRAM AND THE DEPARTMENT, ANY PROPOSAL SUBMITTED MAY BE REFERRED TO OTHER APPROPRIATE STATE AGENCIES FOR CONSULTATION PRIOR TO FINAL APPROVAL BY THE PROGRAM AND THE DEPARTMENT.

(III) ALL PROPOSALS ARE SUBJECT TO REVIEW AND FINAL APPROVAL BY THE DEPARTMENT, THE DEPARTMENT OF TAXATION AND FINANCE AND THE DIVISION OF THE BUDGET.

12. REFERRAL AGREEMENTS AND MEMORANDA OF UNDERSTANDING. REFERRAL AGREEMENTS AND MEMORANDA OF UNDERSTANDING BETWEEN PROVIDERS OF SERVICES, THE PROGRAM AND THE DEPARTMENT SHALL:

(A) INCLUDE ALL TERMS OF THE AGREEMENT IN ONE INSTRUMENT, AND BE DATED AND SIGNED BY AUTHORIZED REPRESENTATIVES OF THE PARTIES TO THE AGREEMENT SUBSEQUENT TO THE PROGRAM AND DEPARTMENT'S APPROVAL;

(B) DEFINE THOSE SPECIFIC FUNCTIONS AND ACTIVITIES TO BE PERFORMED THROUGH THE CASE MANAGEMENT PROCESSES;

(C) DESCRIBE THE AMOUNT, DURATION, SCOPE AND METHOD OF PROVIDING SUCH CASE MANAGEMENT SERVICES UNDER THE AGREEMENT INCLUDING THE PROJECTED FREQUENCY AND TYPES OF CONTACT THAT WILL BE SUSTAINED WITH THE ELIGIBLE IMPAIRED PERSON, IN CONSULTATION WITH HIS OR HER PARENT, GUARDIAN OR CARETAKER;

(D) SPECIFY THE LOCATIONS OF THE FACILITIES, IF NECESSARY, TO BE USED IN PROVIDING CASE MANAGEMENT SERVICES;

(E) SPECIFY THE QUALIFICATIONS REQUIRED FOR CASE MANAGERS SERVING ANY AND ALL ELIGIBLE IMPAIRED PERSONS, INCLUDING COPIES OF THEIR JOB DESCRIPTIONS;

(F) CONTAIN ASSURANCES THAT ELIGIBLE IMPAIRED PERSONS AND THEIR PARENT, GUARDIAN OR CARETAKER WILL BE INFORMED OF SERVICES AVAILABLE TO ADDRESS EMERGENCIES THAT OCCUR OUTSIDE OF USUAL WORKING HOURS;

(G) SPECIFY THE REQUIREMENTS FOR CASE MANAGEMENT PROGRAM RESPONSIBILITY, RECORDKEEPING AND REPORTS, AND ANY FORMATS PRESCRIBED BY THE DEPARTMENT FOR SUCH RECORDKEEPING AND REPORTS;

(H) PROVIDE FOR ACCESS BY STATE AND FEDERAL OFFICIALS TO FINANCIAL AND OTHER RECORDS SPECIFIED BY THE DEPARTMENT WHICH PERTAIN TO THE CASE MANAGEMENT PROCESS;

(I) CONTAIN ASSURANCES THAT NO RESTRICTIONS WILL BE IMPOSED UPON AN ELIGIBLE IMPAIRED PERSON'S CHOICE OF PROVIDER OF CASE MANAGEMENT SERVICES OFFERED UNDER THE PROGRAM AND THAT EACH ELIGIBLE IMPAIRED PERSON WILL BE ADVISED THAT THE REFUSAL OF SUCH SERVICES INCLUDED IN THE CASE MANAGEMENT PLAN DOES NOT CARRY THE THREAT OF FISCAL OR OTHER SANCTIONS;

(J) OUTLINE THE PROVIDER'S CONTINGENCY PLAN FOR ASSURING SMOOTH TRANSITION OF ELIGIBLE IMPAIRED PERSONS TO OTHER AVAILABLE SOURCES OF CASE MANAGEMENT IF THE PROVIDER IS UNABLE TO CONTINUE PROVIDING SERVICES, IF THE AGREEMENT BETWEEN THE PROVIDER, THE PROGRAM AND THE DEPARTMENT IS NOT RENEWED, OR IF THE AGREEMENT IS TERMINATED;

(K) INCLUDE A COPY OF THE FORMS WHICH WILL BE UTILIZED IN COMPLETING ASSESSMENTS AND PREPARING CASE MANAGEMENT PLANS; AND

(L) CONTAIN ASSURANCES THAT AN ANNUAL EVALUATION OF THE EFFECTIVENESS OF CASE MANAGEMENT SERVICES WILL BE COMPLETED.

13. PROVIDER AGREEMENT. UPON APPROVAL OF A SUBMITTED PROPOSAL, A PROVIDER AGREEMENT WILL BE ESTABLISHED BETWEEN THE PROVIDER OF SERVICE AND THE PROGRAM, IN CONSULTATION WITH THE DEPARTMENT. SUCH PROVIDER AGREEMENTS MUST INCLUDE A COPY OF:

(A) THE PROVIDER'S PROPOSAL;

(B) THE REFERRAL AGREEMENT OR MEMORANDUM OF UNDERSTANDING BETWEEN THE PROVIDER OF SERVICE AND THE PROGRAM, IF DEEMED NECESSARY;

(C) A WORK PLAN OUTLINING THE CASE MANAGEMENT PROCESS AS IT APPLIES TO THE ELIGIBLE IMPAIRED PERSON; AND

(D) THE FORMS TO BE UTILIZED IN THE PROVISION OF CASE MANAGEMENT SERVICES.

14. AGREEMENT PERIOD. A PROVIDER AGREEMENT SHALL NOT REMAIN IN EFFECT FOR A PERIOD EXCEEDING TWELVE MONTHS. THIS PROVISION MAY BE WAIVED AT THE DISCRETION OF THE PROGRAM AND THE DEPARTMENT IF THE PROVISION OF SERVICE TO THE ELIGIBLE IMPAIRED PERSON FOR A LONGER PERIOD OF TIME IS JUSTIFIED.

(A) ANY PROVIDER AGREEMENT WHICH IS NOT BEING PROPERLY FULFILLED SHALL BE TERMINATED IN ACCORDANCE WITH THE TERMS OF THE AGREEMENT.

(B) AGREEMENTS TO BE RENEWED MUST BE RENEGOTIATED IN A TIMELY MANNER.

15. ANNUAL EVALUATION. AN ANNUAL EVALUATION OF EACH CASE MANAGEMENT PROGRAM SHALL BE PERFORMED BY THE PROVIDER AND SHALL BE TRANSMITTED TO THE PROGRAM AND THE DEPARTMENT AS REQUIRED BY THE PROVIDER AGREEMENT. THE ANNUAL EVALUATION MUST BE RECEIVED BY THE DEPARTMENT AT LEAST NINETY DAYS PRECEDING THE ANNUAL ANNIVERSARY OF THE EFFECTIVE DATE OF EACH PROVIDER AGREEMENT. THE ANNUAL EVALUATION SHALL:

(A) RESTATE THE GOALS AND OBJECTIVES OF THE CASE MANAGEMENT SERVICES THAT HAVE BEEN PROVIDED, AS LISTED IN THE APPROVED PROVIDER PROPOSAL;

(B) RESTATE THE SCOPE OF CASE MANAGEMENT PROVIDED;

(C) USING EVALUATION HYPOTHESES, DEMONSTRATE THE EXTENT TO WHICH THE PROVIDER HAS ACHIEVED THE GOALS AND OBJECTIVES LISTED IN THE APPROVED PROVIDER PROPOSAL;

(D) SET FORTH THE TYPES AND SOURCES OF DATA COLLECTED AND USED IN THE EVALUATION; AND

(E) RECOMMEND ANY CASE MANAGEMENT SERVICE CHANGES BASED UPON THE CONCLUSIONS OF THE EVALUATION.

16. MONITORING OF PROGRAM PERFORMANCE AND PROVIDER AGREEMENTS. TO ASSURE THAT THE QUALITY OF SERVICES PROVIDED IS IN ACCORDANCE WITH THE REQUIREMENTS OF THIS SECTION, THE FOLLOWING PERFORMANCE MONITORING IS REQUIRED:

(A) THE PROGRAM PERFORMANCE OF ANY STATE AGENCY ESTABLISHING AN AGREEMENT WITH THE DEPARTMENT FOR THE PROVISION OF CASE MANAGEMENT SERVICES SHALL BE MONITORED BY THE PROGRAM AND THE DEPARTMENT.

(B) THE PROGRAM PERFORMANCE OF ANY OTHER ENTITIES ENTERING INTO AN AGREEMENT WITH THE DEPARTMENT SHALL BE MONITORED BY THE PROGRAM AND THE DEPARTMENT.

(C) PROGRAM PERFORMANCE MONITORING INCLUDES ON-SITE VISITS, AT SIX MONTH INTERVALS, TO PROVIDERS OF CASE MANAGEMENT SERVICES. THE SIX-MONTH ON-SITE MONITORING REQUIREMENT MAY BE WAIVED BY THE DEPARTMENT TO PERMIT ANNUAL ON-SITE MONITORING OF PROVIDERS WHEN, AFTER TWO YEARS OF OPERATION, NO SIGNIFICANT DEFICIENCIES HAVE BEEN IDENTIFIED IN REPORTS PREPARED. IN ORDER FOR THE DEPARTMENT TO GRANT A WAIVER, THE APPROPRIATE PROVIDER SHALL SUBMIT TO THE DEPARTMENT A WRITTEN REQUEST FOR A WAIVER AND COPIES OF THE FOUR MOST RECENT MONITORING REPORTS PREPARED. UPON RECEIPT OF SUCH REQUEST AND REPORTS, THE DEPARTMENT WILL DETERMINE WHETHER THERE ARE SIGNIFICANT OPERATIONAL DEFICIENCIES IDENTIFIED IN THE MONITORING REPORTS. IF NO SIGNIFICANT DEFICIENCIES ARE IDENTIFIED, THE WAIVER SHALL BE GRANTED AND DEEMED IN FULL FORCE AND EFFECT.

(D) REPORTS, BASED UPON MONITORING BY A SOCIAL SERVICES DISTRICT OR BY A STATE AGENCY, AND ANY OTHER EVALUATIONS REQUIRED BY A PROVIDER AGREEMENT SHALL BE FORWARDED TO THE PROGRAM AND THE DEPARTMENT COMMENCING WITH THE SIXTH MONTH FOLLOWING THE EFFECTIVE DATE OF EACH PROVIDER AGREEMENT AND ANNUALLY THEREAFTER AND MUST BE RECEIVED BY THE PROGRAM AND THE DEPARTMENT NO LATER THAN NINETY DAYS PRIOR TO THE ANNIVERSARY OF THE PROVIDER AGREEMENT.

(E) THE DEPARTMENT SHALL MONITOR THE PERFORMANCE OF ALL PROVIDER AGREEMENTS.

(F) PROVIDER AGREEMENTS SHALL BE REVIEWED BY THE DEPARTMENT AT LEAST ANNUALLY TO VERIFY CONFORMITY WITH THE TERMS OF SUCH AGREEMENTS. SUCH MONITORING MAY INCLUDE:

(I) THE REVIEW OF PERIODIC REPORTS, INCLUDING THOSE PROGRAM PERFORMANCE REPORTS PURSUANT TO THIS SUBDIVISION;

(II) ANY OTHER EVALUATIONS OR INFORMATION REQUIRED BY THE DEPARTMENT OR REQUIRED BY THE PROVIDER AGREEMENT; AND

(III) ON-SITE VISITS TO PROVIDERS OF SERVICE.

(G) AUTHORIZATION FOR CASE MANAGEMENT SERVICES. AUTHORIZATION BY A PROVIDER CONTRACTED WITH THE PROGRAM, IN CONSULTATION WITH THE COMMISSIONER IS REQUIRED PRIOR TO THE PROVISION OF CASE MANAGEMENT SERVICES.

(H) THE PROVISIONS OF THIS SECTION APPLY TO CASE MANAGEMENT SERVICES PROVIDED ON OR AFTER JANUARY FIRST, TWO THOUSAND ELEVEN.

S 4926. DETERMINATION OF ELIGIBILITY. 1. IN ORDER TO DETERMINE ELIGIBILITY FOR CARE UNDER THE PROGRAM, THE MEDICAL RECORDS OF THE IMPAIRED NEWBORN OR CHILD SHALL BE REVIEWED AND THE PERSON PHYSICALLY SEEN AND EVALUATED IF DEEMED NECESSARY, BY A PHYSICIAN EXPERT ASSIGNED TO THE CLAIM BY THE PROGRAM.

2. WITHIN ONE HUNDRED EIGHTY DAYS OF RECEIVING THE CLAIM AND ALL NECESSARY ACCOMPANYING DOCUMENTATION AND RECORDS SET FORTH IN SUBDIVISION ONE OF THIS SECTION, THE PHYSICIAN EXPERT SHALL DETERMINE WHETHER:

(A) THE IMPAIRED NEWBORN OR CHILD IS ELIGIBLE FOR THE PROGRAM, AND

(B) IF SO, THE COMPENSATION TO BE PROVIDED.

3. A COPY OF THE DETERMINATION SHALL BE MAILED PROMPTLY TO THE CLAIMANT AND, UPON REQUEST, TO ANY HEALTH CARE PROVIDER NAMED IN THE PETITION.

S 4927. APPEALS OF DETERMINATION OF ELIGIBILITY. 1. IF REQUESTED BY THE CLAIMANT OR HEALTH CARE PROVIDER, THE PROGRAM MAY CONVENE A PANEL OF THREE PHYSICIAN EXPERTS TO REVIEW APPEALS OF DETERMINATION BY A PHYSICIAN EXPERT PURSUANT TO SECTION FORTY-NINE HUNDRED TWENTY-SIX OF THIS ARTICLE THAT THE CLAIMANT IS INELIGIBLE FOR THE PROGRAM. THE REVIEW OF AN APPEAL SHALL BE COMMENCED NOT LATER THAN ONE HUNDRED TWENTY DAYS AFTER THE DETERMINATION OF INELIGIBILITY IS PROVIDED TO THE CLAIMANT PURSUANT TO SECTION FORTY-NINE HUNDRED TWENTY-SIX OF THIS ARTICLE.

2. THE PROGRAM SHALL PROVIDE NOTICE OF THE DATE, TIME AND PLACE OF SUCH REVIEW TO THE CLAIMANT AND TO ANY PERSON WHO REQUESTS NOTICE. A CLAIMANT MAY PRESENT INFORMATION FOR THIS REVIEW.

3. THE PROGRAM MAY REQUIRE THE CLAIMANT AND ANY HEALTH CARE PROVIDER WHO PROVIDED PRENATAL, DELIVERY, POSTPARTUM, NEONATAL OR PEDIATRIC CARE TO THE IMPAIRED PERSON TO SPEAK AT THE APPEAL, PROVIDED THAT ANY SUCH PERSON SHALL HAVE THE RIGHT TO BE REPRESENTED BY COUNSEL.

4. THE PHYSICIAN EXPERT APPEAL PANEL SHALL PROVIDE ITS WRITTEN DETERMINATION TO THE PROGRAM WITHIN THIRTY DAYS OF THE HEARING. THE DECISION SHALL BE DEEMED BINDING WHEN AT LEAST TWO OF THE THREE MEMBERS AGREE.

5. SUCH REPORT SHALL INDICATE WHETHER THE NEWBORN OR CHILD IS ELIGIBLE FOR THE PROGRAM, AND IF SO, THE LEVEL OF COMPENSATION TO BE PROVIDED SHALL BE COMMUNICATED TO THE PROGRAM AND THE DEPARTMENT.

S 4928. COMPENSATION. 1. (A) COMPENSATION PROVIDED PURSUANT TO THIS ARTICLE SHALL COVER, TO THE EXTENT NOT EXCLUDED IN SUBDIVISION TWO OF THIS SECTION, MEDICALLY-NECESSARY AND REASONABLE EXPENSES RELATED TO THE IMPAIRMENT FOR MEDICAL AND HOSPITAL CARE, SERVICES AND SUPPLIES, REHABILITATIVE AND REMEDIAL CARE, RESIDENTIAL AND CUSTODIAL CARE AND SERVICES, DRUGS, SPECIAL EQUIPMENT, AND HEALTH INSURANCE CO-PAYMENTS AND DEDUCTIBLES, SUBJECT TO ELIGIBILITY IN SECTION FORTY-NINE HUNDRED TWENTY-SIX OF THIS ARTICLE.

(B) COMPENSATION PROVIDED PURSUANT TO THIS ARTICLE ALSO MAY INCLUDE, TO THE EXTENT NOT EXCLUDED IN SUBDIVISION TWO OF THIS SECTION, AND AS APPROVED BY THE CASE MANAGER, REASONABLE EXPENSES FOR: ADDITIONAL MEDICAL CARE, SERVICES AND SUPPLIES; CARE BY OTHER PROFESSIONALS, SUCH AS SOCIAL WORKERS, COUNSELORS, MENTAL HEALTH PROFESSIONALS, HOME HEALTH CARE WORKERS, CUSTODIANS AND MEDICAL PROFESSIONALS; APPROPRIATE MODIFI-

CATIONS TO HOUSING TO ASSURE THAT THE IMPAIRED NEWBORN RESIDES IN A SUITABLE ENVIRONMENT; EDUCATIONAL AND VOCATIONAL TRAINING; AND TRANSPORTATION, SUBJECT TO SUBDIVISIONS TWO AND THREE OF THIS SECTION.

(C) COMPENSATION PROVIDED PURSUANT TO THIS ARTICLE MAY INCLUDE REASONABLE EXPENSES INCURRED IN CONNECTION WITH THE FILING OF THE INITIAL CLAIM INCLUDING REASONABLE ATTORNEY'S FEES AS DETERMINED IN REGULATION.

2. COMPENSATION SHALL EXCLUDE CARE, SERVICES OR ITEMS, OR REIMBURSEMENT, WHICH THE IMPAIRED PERSON HAS RECEIVED OR IS ENTITLED TO RECEIVE FROM:

(A) ANY COMMERCIAL OR SELF-INSURING ENTITY, CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW, PREPAID HEALTH PLAN OR HEALTH MAINTENANCE ORGANIZATION;

(B) ANY FEDERAL, STATE OR LOCAL GOVERNMENT PROGRAM, EXCEPT TO THE EXTENT SUCH EXCLUSION MAY BE PROHIBITED BY FEDERAL LAW AND EXCEPT AS PROVIDED IN SUBDIVISION FIVE OF THIS SECTION, PROVIDED, HOWEVER, THAT COMPENSATION MAY INCLUDE CARE, SERVICES OR ITEMS, OR REIMBURSEMENT, WHICH ARE IN SUPPLEMENTATION OF ANY CARE, SERVICES OR ITEMS, OR REIMBURSEMENT, WHICH THE NEWBORN HAS RECEIVED, OR IS ENTITLED TO RECEIVE FROM ANY SUCH GOVERNMENT PROGRAM TO THE EXTENT PERMITTED UNDER SUCH PROGRAM; AND

(C) ANY PERSON AS A RESULT OF OR IN SETTLEMENT OF A CIVIL ACTION OR PROSPECTIVE CIVIL ACTION BY OR ON BEHALF OF THE IMPAIRED PERSON RELATING TO THE IMPAIRMENT, INCLUDING AN ACTION DESCRIBED IN THIS SECTION.

3. COMPENSATION SHALL NOT INCLUDE ANY MONETARY AWARD ATTRIBUTABLE TO NON-ECONOMIC DAMAGES OR LOSS OF FUTURE EARNINGS.

4. (A) COMPENSATION MAY BE IN THE FORM OF A DOCUMENTED CASH PAYMENT FOR EXPENSES PREVIOUSLY INCURRED; PERIODIC PAYMENTS MADE FOR EXPENSES AS INCURRED; A HEALTH INSURANCE POLICY; THE PROVISION OF CARE, SERVICES OR ITEMS BY A PROVIDER PURSUANT TO A CONTRACT WITH THE PROGRAM; A CASH PAYMENT TO ESTABLISH, OR TO ADD TO, A TRUST FOR THE BENEFIT OF THE IMPAIRED NEWBORN OR CHILD; PERIODIC PAYMENTS FOR THE SUPPLEMENTAL NEEDS OF THE IMPAIRED NEWBORN WHICH ARE NOT PROVIDED BY GOVERNMENT ENTITLEMENTS, WITH A RECOGNITION OF THE SPECIAL NEEDS OF AN IMPAIRED PERSON WHO, BECAUSE OF THE NATURE OF THE DISABILITIES OF THE IMPAIRED PERSON, MAY BE DEPENDENT ON GOVERNMENT ENTITLEMENTS FOR LIFE; A COMBINATION OF THE FOREGOING; OR SUCH OTHER FORM OF COMPENSATION THAT WILL ENSURE THE PROVISION OF THE CARE, SERVICES AND ITEMS SET FORTH IN SUBDIVISION ONE OF THIS SECTION.

(B) COMPENSATION FOR EXPENSES SHALL BE LIMITED TO REASONABLE REIMBURSEMENT FOR SIMILAR CARE, SERVICES AND ITEMS PROVIDED IN THE SAME COMMUNITY TO OTHER PERSONS WITH IMPAIRMENTS.

5. (A) COMPENSATION FOR THE FOLLOWING PERSONS SHALL BE REDUCED TO THE EXTENT THAT THE MEDICAL ASSISTANCE PROGRAM PROVIDES EQUIVALENT OR BETTER COVERAGE OF MEDICAL CARE, SERVICES AND SUPPLIES THAN WOULD BE PROVIDED AS COMPENSATION BY THE PROGRAM WITHOUT REGARD TO COVERAGE BY THE MEDICAL ASSISTANCE PROGRAM:

(I) ANY IMPAIRED NEWBORN WHO IS DEEMED TO HAVE BEEN FOUND ELIGIBLE FOR MEDICAL ASSISTANCE ON THE DATE OF BIRTH AND TO REMAIN ELIGIBLE FOR SUCH ASSISTANCE FOR A PERIOD OF ONE YEAR, BY REASON OF BEING BORN TO A WOMAN WHO IS ELIGIBLE FOR AND RECEIVING SUCH ASSISTANCE ON THE DATE OF THE IMPAIRED NEWBORN'S BIRTH AND WHO REMAINS OR, IF PREGNANT, WOULD REMAIN ELIGIBLE FOR SUCH ASSISTANCE, AND FOR SO LONG AS SUCH IMPAIRED NEWBORN REMAINS ELIGIBLE FOR SUCH ASSISTANCE; AND

(II) ANY IMPAIRED NEWBORN WHO HAS BEEN INSTITUTIONALIZED NOT LESS THAN THIRTY DAYS AND WHO WOULD BE ELIGIBLE FOR SUPPLEMENTAL SECURITY INCOME

BENEFITS IF NOT INSTITUTIONALIZED AND FOR SO LONG AS SUCH IMPAIRED NEWBORN REMAINS ELIGIBLE FOR MEDICAL ASSISTANCE.

(B) IN DETERMINING THE CONTINUING ELIGIBILITY FOR AND PAYMENT OF MEDICAL ASSISTANCE WITH RESPECT TO SUCH A CHILD, THE AVAILABILITY OF BENEFITS UNDER THE PROGRAM SHALL NOT BE CONSIDERED INCOME OR RESOURCES AVAILABLE TO THE CHILD, NOR A LEGAL LIABILITY OF A THIRD-PARTY.

S 4929. LIMITATION ON PROCESSING OF CLAIMS. ANY CLAIM FOR COMPENSATION FOR AN ELIGIBLE IMPAIRED PERSON BASED ON A PETITION FILED MORE THAN TEN YEARS AFTER THE BIRTH OF THE NEWBORN SHALL BE TIME BARRED.

S 4930. NOTICE TO OBSTETRIC PATIENTS. 1. OBSTETRIC HOSPITALS MAY POST NOTICE OF THIS PROGRAM AT APPROPRIATE LOCATIONS. WRITTEN INFORMATIONAL PAMPHLETS DESCRIBING THE PROGRAM MAY BE PROVIDED AT ANY TIME TO THE PARENTS OR GUARDIANS AND SHALL INCLUDE A CLEAR AND CONCISE EXPLANATION OF THE BENEFITS AVAILABLE TO THE PATIENT UNDER THE PROGRAM, THE AVAILABILITY OF GOVERNMENTAL ASSISTANCE PROGRAMS FOR CHILDREN WITH DISABILITIES AND THE TOLL-FREE TELEPHONE NUMBER OF THE PROGRAM'S CLAIMS ASSISTANCE UNIT.

2. IF A HOSPITAL AT WHICH A PATIENT DELIVERS A CHILD HAS REASON TO BELIEVE THAT A CHILD HAS AN IMPAIRMENT, IT WILL MAKE EVERY ATTEMPT TO NOTIFY THE PROGRAM'S CLAIMS ASSISTANCE UNIT, AND THE EARLY INTERVENTION OFFICIAL APPOINTED PURSUANT TO TITLE II-A OF ARTICLE TWO OF THIS CHAPTER IN THE LOCALITY IN WHICH THE CHILD RESIDES, EACH OF WHICH SHALL OFFER THE LEGALLY RESPONSIBLE PARENTS OR GUARDIANS THE OPPORTUNITY TO DISCUSS BENEFITS, RESOURCES AND SERVICES AVAILABLE, AND ASSIST THE PARENT OR PARENTS IN APPLYING FOR THEM.

S 4931. NEW YORK STATE STANDARD OF CARE ASSESSMENT PROGRAM. 1. THERE IS HEREBY ESTABLISHED WITHIN THE NEUROLOGICAL IMPAIRED PROGRAM OF NEW YORK STATE, THE STANDARD OF CARE ASSESSMENT PROGRAM.

2. NO CIVIL ACTION SHALL BE BROUGHT IN ANY COURT AGAINST ANY EMPLOYEE, PHYSICIAN, NURSE OR OTHER EXPERT ENGAGED BY THE PROGRAM FOR ANY ACT DONE, FAILURE TO ACT, OR STATEMENT OR OPINION MADE, WITHIN THE SCOPE OF HIS OR HER DUTIES AS AN EMPLOYEE OF SUCH PROGRAM.

3. A LIST OF PHYSICIAN ASSESSORS WILL BE ASSEMBLED, MAINTAINED AND CONTRACTED FOR THE PURPOSE OF MAKING DETERMINATIONS OF NEGLIGENCE.

4. PHYSICIANS AND NURSES SHALL BE PAID A FLAT FEE PER CASE FOR THEIR WORK EITHER AS A LEVEL I OR LEVEL II ASSESSOR AS DETERMINED THROUGH REGULATION.

5. THE DECISIONS OF INDIVIDUAL ASSESSORS SHALL BE EXAMINED PERIODICALLY FOR FAIRNESS, QUALITY AND APPROPRIATENESS BY THE STATE AGENCY THAT ADMINISTERS THE PROGRAM OR OTHER AGENCY AS DEEMED BY REGULATION.

6. QUALIFICATIONS OF PHYSICIAN ASSESSORS. (A) PHYSICIANS MAY SERVE AS EITHER A LEVEL I OR LEVEL II ASSESSOR BUT NEVER BOTH IN THE SAME CLAIM.

(B) THE DECISIONS OF INDIVIDUAL ASSESSORS SHALL BE EXAMINED PERIODICALLY FOR FAIRNESS, QUALITY AND APPROPRIATENESS BY THE STATE AGENCY THAT ADMINISTERS THE PROGRAM OR OTHER AGENCY AS DEEMED BY REGULATION.

7. DUTIES OF PHYSICIAN ASSESSORS. THE PHYSICIAN ASSESSORS SHALL PERFORM THE FOLLOWING DUTIES:

(A) WITHIN THIRTY DAYS OF THE NOTICE OF AN ELIGIBILITY DETERMINATION, A LEVEL I STANDARD OF CARE ASSESSMENT SHALL COMMENCE. ALL RELEVANT RECORDS SHALL BE OBTAINED FROM THE INSTITUTION OR INSTITUTIONS WHERE THE CHILD WAS BORN AND RECEIVED ITS NEONATAL CARE.

(B) THE LEVEL I ASSESSMENT SHALL CONCLUDE WITH A DETERMINATION OF:

(I) WHETHER THE STANDARD OF CARE WAS MET BY EACH OF THE HEALTH CARE PROVIDERS WHO PARTICIPATED IN THE OBSTETRICAL CARE AND NEONATAL MANAGEMENT;

(II) WHETHER SYSTEMS FAILURES AT THE SITE OF THE DELIVERY OR NEONATAL CARE CONTRIBUTED ADVERSELY TO THE CHILD'S OUTCOME.

(C) EACH CASE SHALL RECEIVE AN INITIAL ASSESSMENT BY A LEVEL I PANEL CONSISTING OF TWO BOARD CERTIFIED OBSTETRICIANS AND A BOARD CERTIFIED NEONATOLOGIST WHO SHALL DETERMINE WITHIN NINETY DAYS:

(I) WHETHER THE STANDARD OF CARE WAS MET BY EACH OF THE INDIVIDUAL PRACTITIONERS WHO PROVIDED CARE TO THE PATIENT'S MOTHER DURING THE ANTE PARTUM, INTRAPARTUM AND DELIVERY PERIODS AS WELL AS THOSE CARING FOR THE NEONATE DURING THE FIRST TWENTY-EIGHT DAYS OF HIS OR HER BIRTH;

(II) WHETHER SYSTEMS FAILURES AT THE SITE OF THE DELIVERY OR NEONATAL CARE CONTRIBUTED ADVERSELY TO THE CHILD'S OUTCOME.

(D) THE PANEL SHALL LIMIT ITS REVIEW TO THE RECORDS IT HAS BEEN SENT. IF THIS MATERIAL IS DEEMED TO BE INSUFFICIENT TO MAKE A DETERMINATION REGARDING THE STANDARD OF CARE RENDERED, THE CASE SHALL BE REFERRED TO A PANEL OF LEVEL II ASSESSORS.

(E) IF ALL THREE MEMBERS OF THE LEVEL I PANEL ARE UNANIMOUS IN DECIDING THAT THE STANDARD OF CARE WAS MET BY THE INDIVIDUAL PRACTITIONERS AND PARTICIPATING HOSPITALS WHERE THE CARE WAS RENDERED, THE REVIEW PROCESS CONCLUDES.

(F) IF THE LEVEL I PANEL FINDS THAT THE STANDARD OF CARE HAS NOT BEEN MET, OR IS DIVIDED IN THEIR OPINION ON THIS MATTER, THE CASE WILL BE REFERRED TO A SECOND LEVEL OF REVIEW. THE PANEL OF LEVEL II ASSESSORS WILL CONSIST OF THREE SUBSPECIALTY BOARDED PHYSICIANS OR ADVANCED PRACTICE NURSES WHOSE AREA OF EXPERTISE WILL BE DECIDED BY THE LEVEL I SCREENING PANELISTS. THIS SECOND PANEL CANNOT CONTAIN ANY OF THE PHYSICIANS FROM THE LEVEL I PANEL.

(G) WITHIN THIRTY DAYS OF THE FINDINGS OF THE LEVEL I PANEL, THE LEVEL II PANEL WILL REVIEW THE RECORDS THAT HAVE BEEN SUBMITTED AND NOTIFY THE INVOLVED HEALTH CARE PROVIDERS THAT A LEVEL II ASSESSMENT IS IN PROCESS. THE LEVEL II ASSESSMENT SHALL BE COMPLETED WITHIN ONE HUNDRED TWENTY DAYS. LEVEL II ASSESSORS CAN REQUEST ADDITIONAL RECORDS FOR REVIEW AND/OR INTERVIEW ANY INDIVIDUALS THAT WERE INVOLVED IN THE PATIENT'S OBSTETRICAL OR NEONATAL CARE.

(H) IF TWO OR MORE OF THE LEVEL II PANEL FIND THAT THE STANDARD OF CARE HAS BEEN MET, THE REVIEW PROCESS CONCLUDES.

(I) IF TWO OR MORE OF THE LEVEL II PANEL FIND THAT THE STANDARD OF CARE HAS NOT BEEN MET, THE HEALTH CARE PROVIDERS SHALL BE SENT A REPORT DETAILING THE ACTS OF NEGLIGENCE THAT HAVE BEEN IDENTIFIED.

(J) IF TWO OR MORE OF THE LEVEL II PANEL OF ASSESSORS DECIDE THAT SYSTEMS FAILURES CONTRIBUTED ADVERSELY TO THE CHILD'S OUTCOME THE SENIOR LEADERSHIP OF THE INSTITUTION INVOLVED SHALL BE SENT A REPORT DETAILING THE NEGLIGENT OFFENSES THAT HAVE BEEN IDENTIFIED.

(K) IF TWO OR MORE OF THE LEVEL II PANEL OF ASSESSORS DECIDE THAT FAILURE TO MEET THE STANDARD OF CARE BY ANY OF THE HEALTH CARE PROVIDERS OR HOSPITALS CONSTITUTES NEGLIGENCE THAT CONTRIBUTED TO THE POOR OUTCOME, A REPORT SHALL BE SENT TO THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT AND THE NY PATIENT OCCURRENCE, REPORTING AND TRACKING SYSTEM. ALL STATUTORY AND REGULATORY REQUIREMENTS OF SAID PHYSICIAN AND HOSPITAL REVIEW PROGRAMS SHALL BE AND REMAIN IN EFFECT RELEVANT TO A NEGLIGENCE NOTIFICATION BY THE LEVEL II PANEL.

(L) IN EACH CASE, THE FAMILY SHALL BE NOTIFIED IN WRITING OF THE FINAL DETERMINATIONS OF THE STANDARD OF CARE ASSESSMENTS.

(M) DETAILED SUMMARIES OF THE CASES IN WHICH NEGLIGENCE WAS FOUND TO BE PRESENT SHALL BE KEPT IN A DATABASE. A CASEBOOK SHALL BE CREATED ANNUALLY WHICH SHALL INCLUDE DE-IDENTIFIED SELECTED CASES FROM THAT DATABASE. THE CASES SHALL BE CHOSEN TO ILLUSTRATE SPECIFIC ISSUES, AND

SHALL BE ACCOMPANIED BY COMMENTARY THAT HIGHLIGHTS THOSE ASPECTS OF THE CASE THAT SHOULD HAVE BEEN MANAGED DIFFERENTLY. THIS CASEBOOK SHALL BE CIRCULATED ELECTRONICALLY TO ALL OBSTETRICAL CAREGIVERS THROUGHOUT THE STATE.

S 2. This act shall take effect January 1, 2011; provided, however, that 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 and directed to be made and completed on or before such effective date.