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

7699--A

2011-2012 Regular Sessions

I N A S S E M B L Y

May 16, 2011

Introduced by M. of A. CASTRO -- read once and referred to the Committee on Health -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health law, in relation to providing quality out-patient specialty care for patients of academic medical centers regardless of source of payment or insurance type, and providing improved notification to patients regarding their rights to financial assistance at hospitals; and to amend the social services law, in relation to improving access to specialty care for medical assistance recipients

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

Section 1. Legislative intent. The legislature hereby finds that private academic medical centers operate a two-tiered system of out-patient specialty care, in which patients are sorted into the medical centers' faculty practices or clinics depending upon their source of payment or insurance status. Within this two-tiered system of out-patient specialty care, privately insured patients are treated at faculty practices while Medicaid and uninsured patients are treated at the hospital-based clinics, even if both types of patients are seeking care for the same problem.

Once separated into different systems of care, the Medicaid and uninsured patients are not given access to the same services as privately insured patients. For example, privately insured patients are able to see highly experienced faculty physicians to whom they have twenty-four hour access, resulting in continuity of care and good care coordination. Medicaid or uninsured patients, by contrast, only have access to rotating student doctors, who are less able to provide the continuity of care or care coordination that is so critical for patients who suffer from chronic or serious medical conditions. Furthermore, these student doctors often lack adequate supervision from attending physicians, who

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

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are not required by the academic medical centers to spend sufficient time supervising residents and caring for patients in the clinics. In cases of emergency, Medicaid and uninsured patients only have access to the hospital's emergency room, and not to a 24-hour call service as the privately insured patients do, which contributes to emergency room overcrowding as well as higher health care costs.

The legislature further finds that the difference in access to care experienced by patients based on their insurance status contributes to disparities in racial and ethnic disparities in health outcomes, particularly since blacks and Hispanics are disproportionately represented among Medicaid beneficiaries and the uninsured. In addition, the system is economically wasteful, as it allows two systems of care to operate within one facility and it causes Medicaid and other state dollars to be spent on inferior care. Finally, the system runs counter to current state health policy, which is increasingly focused on patient-centered medical homes and similar innovative strategies to achieve care coordination for Medicaid beneficiaries and cost reduction for the state's health care system.

It is therefore the intent of the legislature to eliminate this separate and unequal system of care by requiring private academic teaching hospitals to care for all patients, regardless of insurance type or source of payment, in the same place and at the same time. The legislature seeks to ensure that academic medical centers, which receive millions of dollars every year through the Medicaid program and the state's indigent care pool, do not limit access to care and services to patients in whose name those funds are given.

In addition, the legislature seeks to ensure that all patients are made aware of hospital financial assistance policies through the hospital's website and patient referral line. Lastly, the legislature seeks to require that New York state general hospitals make reasonable efforts to negotiate with Medicaid managed care plans in their social services districts to ensure that all medical service providers employed by the general hospitals are credentialed by available plans.

S 2. The public health law is amended by adding a new section 2805-u to read as follows:

S 2805-U. PROHIBITION AGAINST PATIENT STEERING BASED ON SOURCE OF PAYMENT AND INTEGRATION OF OUT-PATIENT CARE. 1. NO GENERAL HOSPITAL SHALL REFER, STEER, OR OTHERWISE DIRECT ANY PATIENT SEEKING SPECIALTY OUT-PATIENT HOSPITAL SERVICES TO PRIVATE PHYSICIAN PRACTICES THAT ARE NOT LICENSED PURSUANT TO THIS ARTICLE, INCLUDING BUT NOT LIMITED TO UNIVERSITY FACULTY PRACTICE CORPORATIONS AS DEFINED IN SECTION FOURTEEN HUNDRED TWELVE OF THE NOT-FOR-PROFIT CORPORATION LAW, IF THE PATIENT'S INSURANCE IS ACCEPTED BY THE GENERAL HOSPITAL AND APPROPRIATELY CREDENTIALED PHYSICIANS ARE AVAILABLE TO TREAT THE PATIENT IN THE APPROPRIATE OUT-PATIENT CLINIC OWNED AND OPERATED BY THE GENERAL HOSPITAL. THE PROVISIONS OF THIS SECTION SHALL APPLY REGARDLESS OF WHETHER THE PATIENT CONTACTS THE GENERAL HOSPITAL VIA A TELEPHONE-OR INTERNET-BASED PHYSICIAN REFERRAL SERVICE, AS A WALK-IN, OR THROUGH THE PATIENT'S PRIMARY CARE PHYSICIAN.

2. EVERY GENERAL HOSPITAL SHALL ENSURE THAT ALL PATIENTS, REGARDLESS OF INSURANCE STATUS, SEEKING SPECIALTY OUT-PATIENT CARE RECEIVE TREATMENT FROM AN INTEGRATED TEAM OF MEDICAL PROFESSIONALS, CONSISTING OF ATTENDING PHYSICIANS AND RESIDENTS, WHO RECEIVE ROUTINE ON-SITE SUPERVISION FROM ATTENDING PHYSICIANS. FURTHERMORE, SUCH HOSPITALS SHALL ENSURE THAT ALL PATIENTS SEEN IN THE CLINIC SETTING SHALL HAVE DIRECT

ACCESS TO THE ATTENDING PHYSICIANS SUPERVISING THEIR TREATMENT DURING WEEKEND AND EVENING HOURS AND EMERGENCIES.

3. THE PROVISIONS OF THIS SECTION SHALL NOT APPLY TO THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION, ESTABLISHED PURSUANT TO CHAPTER ONE THOUSAND SIXTEEN OF THE LAWS OF NINETEEN SIXTY-NINE, AS AMENDED.

S 3. Paragraph (c) of subdivision 9-a of section 2807-k of the public health law, as added by section 39-a of part A of chapter 57 of the laws of 2006, is amended to read as follows:

(c) Such policies and procedures shall be clear, understandable, in writing and publicly available in summary form and each general hospital participating in the pool shall ensure that every patient is made aware of the existence of such policies and procedures and is provided, in a timely manner, with a summary of such policies and procedures upon request. Any summary provided to patients shall, at a minimum, include specific information as to income levels used to determine eligibility for assistance, a description of the primary service area of the hospital and the means of applying for assistance. For general hospitals with twenty-four hour emergency departments, such policies and procedures shall require the notification of patients during the intake and registration process, through the conspicuous posting of language-appropriate information in the general hospital, NOTIFICATION ON WEBSITES AND THROUGH THE GENERAL HOSPITAL'S PATIENT REFERRAL LINE, and information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. For specialty hospitals without twenty-four hour emergency departments, such notification shall take place through written materials provided to patients during the intake and registration process prior to the provision of any health care services or procedures, NOTIFICATION ON WEBSITES AND THROUGH THE SPECIALTY HOSPITAL'S PATIENT REFERRAL LINE, and through information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. Application materials shall include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility pursuant to the hospital's financial assistance policy, the patient may disregard any bills until the hospital has rendered a decision on the application in accordance with this paragraph.

S 4. Paragraph (a) of subdivision 4 of section 364-j of the social services law, as amended by section 14 of part C of chapter 58 of the laws of 2004, clause (E) of subparagraph (iii) as added and clause (F) of subparagraph (iii) as relettered by chapter 37 of the laws of 2010, is amended to read as follows:

(a) (i) a managed care provider shall arrange for access to and enrollment of primary care practitioners and other medical services providers. Each managed care provider shall possess the expertise and sufficient resources to assure the delivery of quality medical care to participants in an appropriate and timely manner and may include physicians, nurse practitioners, county health departments, providers of comprehensive health service plans licensed pursuant to article forty-four of the public health law, and hospitals and diagnostic and treatment centers licensed pursuant to article twenty-eight of the public health law or otherwise authorized by law to offer comprehensive health services or facilities licensed pursuant to articles sixteen, thirty-one and thirty-two of the mental hygiene law.

(ii) provided, however, if a major public hospital, as defined in the public health law, is designated by the commissioner of health as a

managed care provider in a social services district the commissioner of health shall designate at least one other managed care provider which is not a major public hospital or facility operated by a major public hospital; and

(iii) under a managed care program, not all managed care providers must be required to provide the same set of medical assistance services. The managed care program shall establish procedures through which participants will be assured access to all medical assistance services to which they are otherwise entitled, other than through the managed care provider, where:

(A) the service is not reasonably available directly or indirectly from the managed care provider,

(B) it is necessary because of emergency or geographic unavailability, or

(C) the services provided are family planning services; or

(D) the services are dental services and are provided by a diagnostic and treatment center licensed under article twenty-eight of the public health law which is affiliated with an academic dental center and which has been granted an operating certificate pursuant to article twenty-eight of the public health law to provide such dental services. Any diagnostic and treatment center providing dental services pursuant to this clause shall prior to June first of each year report to the governor, temporary president of the senate and speaker of the assembly on the following: the total number of visits made by medical assistance recipients during the immediately preceding calendar year; the number of visits made by medical assistance recipients during the immediately preceding calendar year by recipients who were enrolled in managed care programs; the number of visits made by medical assistance recipients during the immediately preceding calendar year by recipients who were enrolled in managed care programs that provide dental benefits as a covered service; and the number of visits made by the uninsured during the immediately preceding calendar year; or

(E) the services are optometric services, as defined in article one hundred forty-three of the education law, and are provided by a diagnostic and treatment center licensed under article twenty-eight of the public health law which is affiliated with the college of optometry of the state university of New York and which has been granted an operating certificate pursuant to article twenty-eight of the public health law to provide such optometric services. Any diagnostic and treatment center providing optometric services pursuant to this clause shall prior to June first of each year report to the governor, temporary president of the senate and speaker of the assembly on the following: the total number of visits made by medical assistance recipients during the immediately preceding calendar year; the number of visits made by medical assistance recipients during the immediately preceding calendar year by recipients who were enrolled in managed care programs; the number of visits made by medical assistance recipients during the immediately preceding calendar year by recipients who were enrolled in managed care programs that provide optometric benefits as a covered service; and the number of visits made by the uninsured during the immediately preceding calendar year; or

(F) other services as defined by the commissioner of health; AND

(IV) EVERY GENERAL HOSPITAL, AS DEFINED BY SECTION TWENTY-EIGHT HUNDRED ONE OF THE PUBLIC HEALTH LAW, MUST USE BEST EFFORTS TO NEGOTIATE WITH MANAGED CARE PROVIDERS LICENSED TO OPERATE IN THE SOCIAL SERVICES DISTRICT IN WHICH SUCH GENERAL HOSPITAL IS LOCATED TO CREDENTIAL ALL

MEDICAL SERVICES PROVIDERS EMPLOYED BY SUCH GENERAL HOSPITAL. EACH GENERAL HOSPITAL SUBJECT TO THIS SUBSECTION MUST SUBMIT AN ANNUAL REPORT TO THE DEPARTMENT DESCRIBING THE GENERAL HOSPITAL'S STRATEGIC PLAN TO MEET THE REQUIREMENTS OF THIS SUBSECTION AND THE EFFORTS MADE TO FULFILL THE STRATEGIC PLAN.

S 5. This act shall take effect on the two hundred seventieth day after it shall have become a law, provided however, that the amendments to subdivision 4 of 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, provided further, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for implementation of this act on its effective date is authorized to be made on or before such effective date.