

STATE OF NEW YORK

1197--B

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 -- 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.

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

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1 (3) "Primary care" means integrated, accessible healthcare, provided
2 by clinicians accountable for addressing most of a patient's healthcare
3 needs, developing a sustained partnership with patients, and practicing
4 in the context of family and community.

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

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

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

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

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

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

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

54 (d) Primary care spending. (1) Beginning on April first, two thousand
55 twenty-six, each plan or payor that reports less than twelve and one-
56 half percent of its total expenditures on physical and mental health is

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

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

14 (A) reimbursement;

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

16 (C) upgrading technology, including electronic health record systems
17 and telehealth capabilities;

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

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

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

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

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

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

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

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

1 steps that have been taken to increase their proportion of primary care
2 spending.

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

6 (i) reimbursement;

7 (ii) capacity-building, technical assistance and training;

8 (iii) upgrading technology, including electronic health record systems
9 and telehealth capabilities;

10 (iv) incentive payments, including but not limited to per-member-per-
11 month, value-based-payment arrangements, shared savings, quality-based
12 payments, risk-based payments; and

13 (v) transitioning to value-based-payment arrangements.

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

25 § 3. This act shall take effect immediately.