§ 2805-x. Hospital-home care-physician collaboration program. 1. The purpose of this section shall be to facilitate innovation in hospital, home care agency and physician collaboration in meeting the community's health care needs. It shall provide a framework to support voluntary initiatives in collaboration to improve patient care access and management, patient health outcomes, cost-effectiveness in the use of health care services and community population health. Such collaborative initiatives may also include payors, skilled nursing facilities and other interdisciplinary providers, practitioners and service entities.

2. For purposes of this section:

(a) "Hospital" shall include a general hospital as defined in this article or other inpatient facility for rehabilitation or specialty care within the definition of hospital in this article.

(b) "Home care agency" shall mean a certified home health agency, long term home health care program or licensed home care services agency as defined in article thirty-six of this chapter.

(c) "Payor" shall mean a health plan approved pursuant to article forty-four of this chapter, or article thirty-two or forty-three of the insurance law.

(d) "Practitioner" shall mean any of the health, mental health or health related professions licensed pursuant to title eight of the education law.

3. The commissioner is authorized to provide financing including, but not limited to, grants or positive adjustments in medical assistance rates or premium payments, to the extent of funds available and allocated or appropriated therefor, including funds provided to the state through federal waivers, funds made available through state appropriations and/or funding through section twenty-eight hundred seven-v of this article, as well as waivers of regulations under title ten of the New York codes, rules and regulations, to support the voluntary initiatives and objectives of this section.

4. Hospital-home care-physician collaborative initiatives under this section may include, but shall not be limited to:

(a) Hospital-home care-physician integration initiatives, including

but not limited to:

(i) transitions in care initiatives to help effectively transition patients to post-acute care at home, coordinate follow-up care and address issues critical to care plan success and readmission avoidance;

(ii) clinical pathways for specified conditions, guiding patients' progress and outcome goals, as well as effective health services use;

(iii) application of telehealth/telemedicine services in monitoring and managing patient conditions, and promoting self-care/management, improved outcomes and effective services use;

(iv) facilitation of physician house calls to homebound patients and/or to patients for whom such home visits are determined necessary and effective for patient care management;

(v) additional models for prevention of avoidable hospital readmissions and emergency room visits;

(vi) health home development;

(vii) development and demonstration of new models of integrated or collaborative care and care management not otherwise achievable through existing models; and

(viii) bundled payment demonstrations for hospital-to-post-acute-care for specified conditions or categories of conditions, in particular, conditions predisposed to high prevalence of readmission, including those currently subject to federal/state penalty, and other discharges with extensive post-acute needs;

(b) Recruitment, training and retention of hospital/home care direct care staff and physicians, in geographic or clinical areas of demonstrated need. Such initiatives may include, but are not limited to, the following activities:

(i) outreach and public education about the need and value of service in health occupations;

(ii) training/continuing education and regulatory facilitation for cross-training to maximize flexibility in the utilization of staff, including:

(A) training of hospital nurses in home care;

(B) dual certified nurse aide/home health aide certification; and

(C) dual personal care aide/HHA certification;

(iii) salary/benefit enhancement;

(iv) career ladder development; and

(v) other incentives to practice in shortage areas; and

(c) Hospital - home care - physician collaboratives for the care and management of special needs, high-risk and high-cost patients, including but not limited to best practices, and training and education of direct care practitioners and service employees.

(d) Collaborative programs to address disparities in health care access or treatment, and/or conditions of higher prevalence, in certain populations, where such collaborative programs could provide and manage services in a more effective, person-centered and cost-efficient manner for reduction or elimination of such disparities.

(i) Such programs may target one or more disparate conditions, or areas of under-service, evidenced in defined populations, including but not be limited to:

(A) cardiovascular disease;

(B) hypertension;

(C) diabetes;

(D) chronic kidney disease;

(E) obesity;

(F) asthma;

(G) sickle cell disease;

(H) sepsis;

(I) lupus;

(J) breast, lung, prostate and colorectal cancers;

(K) geographic shortage of primary care, prenatal/obstetric care, specialty medical care, home health care, or culturally and linguistically compatible care;

(L) alcohol, tobacco, or substance abuse;

(M) post-traumatic stress disorder and other conditions more prevalent among veterans of the United States military services;

(N) attracting members of minority populations to the field and practice of medicine; and

(O) such other areas approved by the commissioner.

(ii) Collaborative hospital-home care-physician, and as applicable additional partner, models may include under such disparities programs:

(A) service planning and design;

(B) recruitment of specialty personnel and/or specialty training of professionals or other direct care personnel (including physicians, home

care and hospital staffs), patients and informal caregivers;

(C) continuing medical education and clinical training for physicians, follow-up evaluations, and supporting educational materials;

(D) use of evidenced-based approaches and/or best practices to treatment;

(E) reimbursement of uncovered services;

(F) bundled or other integrated payment methods to support the necessary, coordinated and cost-effective services;

(G) regulatory waivers to facilitate flexibility in provider collaboration and person-centered care;

(H) patient/family peer support and education;

(I) data collection, research and evaluation of efficacy; and/or

(J) other components or innovations satisfactory to the commissioner.

(iii) Nothing contained in this paragraph shall prevent a physician, physicians group, home care agency, or hospital from individually applying for said grant.

(iv) The commissioner shall consult with physicians, home care agencies, hospitals, consumers, statewide associations representative of such participants, and other experts in health care disparities, in developing an application process for grant funding or rate adjustment, and for request of state regulatory waivers, to facilitate implementation of disparities programs under this paragraph.

5. Hospitals and home care agencies which are provided financing or waivers pursuant to this section shall report to the commissioner on the patient, service and cost experiences pursuant to this section, including the extent to which the project goals are achieved. The commissioner shall compile and make such reports available on the department's website.