*** § 364-f. Primary care case management programs.** 1. The department is authorized to establish primary care case management programs, under the medical assistance program, in accordance with applicable federal law and regulations. Primary care case management programs shall only be authorized in areas of the state where comprehensive health services plans, as defined in section forty-four hundred one of the public health law, are not yet available. Subject to the approval of the director of the budget, the commissioner is authorized to apply for the appropriate waivers under federal law and regulation, and may waive any of the provisions of sections three hundred sixty-five-a, three hundred sixty-six, three hundred sixty-seven-b, three hundred sixty-eight-a and three hundred sixty-four-j of this chapter or any regulation of the department when such action would be necessary to assist in promoting the objectives of this section.

2. (a) A primary care case management program shall provide individuals eligible for medical assistance with the opportunity to select a primary care case manager who shall provide medical assistance services to such eligible individuals, either directly, or through referral.

(b) Primary care case managers shall be limited to qualified, licensed primary care practitioners, as defined in paragraph (f) of subdivision one of section three hundred sixty-four-j of this chapter, who meet standards established by the commissioner for the purposes of this program.

(c) Services that may be covered by the primary care case management program are defined by the commissioner in the benefit package. Covered services may include all medical assistance services defined under section three hundred sixty-five-a of this chapter, except:

(i) services excluded under paragraph (e) of subdivision three of section three hundred sixty-four-j of this chapter shall be excluded under this section;

(ii) services provided by residential health care facilities, long term home health care programs, child care agencies, and entities offering comprehensive health services plans;

(iii) services provided by dentists and optometrists; and

(iv) eyeglasses, emergency care, mental health services and family

planning services.

(d) Case management services provided by primary care case managers shall include, but need not be limited to:

(i) management of the medical and health care of each recipient to assure that all services provided under paragraph (c) of this subdivision and which are found to be necessary, are made available in a timely manner;

(ii) referral to, and coordination, monitoring and follow-up of, appropriate providers for diagnosis and treatment, the need for which has been identified by the primary care case manager but which is not directly available from the primary care case manager, and assisting medical assistance recipients in the prudent selection of medical services;

(iii) arrangements for referral of recipients to appropriate providers; and

(iv) all early periodic screening, diagnosis and treatment services, as well as interperiodic screening and referral, to each participant under the age of twenty-one at regular intervals.

3. (a) Primary care case management programs may be conducted only in accordance with guidelines established by the commissioner. For the purpose of implementing and administering the primary care case management programs, the commissioner may contract with private not-for-profit and public agencies as defined in guidelines established by the commissioner for the management and administration of the primary care case management program.

(b) The primary care case management program must:

(i) assure access to and delivery of high quality, appropriate medical services;

(ii) participate in quality assurance activities as required by the commissioner, as well as other mechanisms designed to protect recipient rights under such program;

(iii) ensure that persons eligible for medical assistance will be provided sufficient information regarding the program to make an informed and voluntary choice whether to participate; and

(iv) provide for adequate safeguards to protect recipients from being misled concerning the program and from being coerced into participating

in the primary care case management program.

4. (a) Individuals eligible to participate in Medicaid managed care, to participate in Medicaid managed care may participate in a primary care case management program, subject to the availability of such a program within the applicable social services district, except for individuals: (i) required by Medicaid managed care to be enrolled in an entity offering a comprehensive health services plan as defined in paragraph (k) of subdivision two of section three hundred sixty-five-a of this chapter; (ii) participating in another medical assistance reimbursed demonstration or pilot project, or (iii) receiving services as an inpatient from a nursing home or intermediate care facility or residential services from a child care agency or services from a long term home health care program.

(b) Individuals choosing to participate in a primary care case management program will be given thirty days from the effective date of enrollment in the program to disenroll without cause. After this thirty day disenrollment period, all individuals participating in the program will be enrolled for a period of twelve months, except that all participants will be permitted to disenroll for good cause, as defined in guidelines established by the commissioner.

5. (a) Primary care case management programs may include provisions for innovative payment mechanisms, including, but not limited to, payment of case management fees, capitation arrangements, and fee-for-service payments.

(b) Any new payment mechanisms and levels of payment implemented under the primary care case management program shall be developed by the commissioner subject to the approval of the director of the budget.

6. Notwithstanding any inconsistent provision of this section, participation in a primary care case management program will not diminish the scope of available medical services to which a recipient is entitled.

7. This section shall be effective if, and as long as, federal financial participation is available therefor.

* NB Expires March 31, 2029