

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:

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

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

1 supervising residents and caring for patients in the clinics. In cases of emergency,
2 Medicaid and uninsured patients only have access to the hospital's emergency room, and
3 not to a 24-hour call service as the privately insured patients do, which contributes to
4 emergency room overcrowding as well as higher health care costs.

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

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

22 In addition, the legislature seeks to ensure that all patients are made aware of
23 hospital financial assistance policies through the hospital's website and patient referral

1 line. Lastly, the legislature seeks to require that New York state general hospitals make
2 reasonable efforts to negotiate with Medicaid managed care plans in their social services
3 districts to ensure that all medical service providers employed by the general hospitals are
4 credentialed by available plans.

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

7 §2805-u. Prohibition Against Patient Steering Based on Source of Payment and
8 Integration of Out-patient Care.

9 1. No general hospital shall refer, steer, or otherwise direct any patient seeking
10 specialty out-patient hospital services to private physician practices that are not licensed
11 pursuant to this Article, including but not limited to university faculty practice
12 corporations as defined in section fourteen hundred twelve of the not-for-profit
13 corporation law, if the patient's insurance is accepted by the general hospital and
14 appropriately credentialed physicians are available to treat the patient in the appropriate
15 out-patient clinic owned and operated by the general hospital. The provisions of this
16 section shall apply regardless of whether the patient contacts the general hospital via a
17 telephone- or internet-based physician referral service, as a walk-in, or through the
18 patient's primary care physician.

19 2. Every general hospital shall ensure that all patients, regardless of insurance
20 status, seeking specialty out-patient care receive treatment from an integrated team of
21 medical professionals, consisting of attending physicians and residents, who receive
22 routine on-site supervision from attending physicians. Furthermore, such hospitals shall
23 ensure that all patients seen in the clinic setting shall have direct access to the attending

1 physicians supervising their treatment during weekend and evening hours and
2 emergencies.

3 3. The provisions of this sub-section shall not apply to the New York City Health
4 and Hospitals Corporation, established pursuant to chapter one thousand sixteen of the
5 laws of nineteen hundred sixty nine as amended.

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

9 (c) Such policies and procedures shall be clear, understandable, in writing and
10 publicly available in summary form and each general hospital participating in the pool
11 shall ensure that every patient is made aware of the existence of such policies and
12 procedures and is provided, in a timely manner, with a summary of such policies and
13 procedures upon request. Any summary provided to patients shall, at a minimum, include
14 specific information as to income levels used to determine eligibility for assistance, a
15 description of the primary service area of the hospital and the means of applying for
16 assistance. For general hospitals with twenty-four hour emergency departments, such
17 policies and procedures shall require the notification of patients during the intake and
18 registration process, through the conspicuous posting of language-appropriate
19 information in the general hospital, **notification on websites and through the general**
20 **hospital's patient referral line,** and information on bills and statements sent to patients,
21 that financial aid may be available to qualified patients and how to obtain further
22 information. For specialty hospitals without twenty-four hour emergency departments,
23 such notification shall take place through written materials provided to patients during the

1 intake and registration process prior to the provision of any health care services or
2 procedures, **notification on websites and through the specialty hospital's patient**
3 **referral line,** and through information on bills and statements sent to patients, that
4 financial aid may be available to qualified patients and how to obtain further information.
5 Application materials shall include a notice to patients that upon submission of a
6 completed application, including any information or documentation needed to determine
7 the patient's eligibility pursuant to the hospital's financial assistance policy, the patient
8 may disregard any bills until the hospital has rendered a decision on the application in
9 accordance with this paragraph.

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

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

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(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

1 visits made by medical assistance recipients during the immediately preceding calendar
2 year by recipients who were enrolled in managed care programs; the number of visits
3 made by medical assistance recipients during the immediately preceding calendar year by
4 recipients who were enrolled in managed care programs that provide dental benefits as a
5 covered service; and the number of visits made by the uninsured during the immediately
6 preceding calendar year; or

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

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

1 (iv) Every general hospital, as defined by section twenty-eight hundred one of the
2 public health law, must use best efforts to negotiate with managed care providers licensed
3 to operate in the social service district in which such general hospital is located to
4 credential all medical services providers employed by such general hospital. Each
5 general hospital subject to this subsection must submit an annual report to the department
6 describing the general hospital's strategic plan to meet the requirements of this subsection
7 and the efforts made to fulfill the strategic plan.

8 § 5. This law shall take effect on the two hundred seventieth day after it shall
9 become law, provided however, that the amendments to subdivision 4 of section 364-j of
10 the social services law, made by section four of this act shall not affect the repeal of such
11 section and shall be deemed repealed therewith, provided further, that effective
12 immediately, the addition, amendment and/or repeal of any rule or regulation necessary
13 for implementation of this act on its effective date are authorized and directed to be made
14 and computed on or before such effective date.