Accountable Care Organizations Demonstration Program

Chapter ___, Laws of 2011, Part H, § 66 (A.4009-D, S.2809-D)

Public Health Law

ARTICLE 29-E

ACCOUNTABLE CARE ORGANIZATIONS DEMONSTRATION PROGRAM

§ 2999-n. Accountable care organizations; findings; purpose. The legislature intends to test the ability of accountable care organizations to assume a role in delivering an array of health care services, from primary and preventive care through acute inpatient hospital and post-hospital care. The legislature finds that the formation and operation of accountable care organizations under this article, and subject to appropriate regulation, can be consistent with the purposes of federal and state anti-trust, anti-referral, and other statutes, including reducing over-utilization and expenditures. The legislature finds that the development of accountable care organizations under this article will reduce health care costs, promote effective allocation of health care resources, and enhance the quality and accessibility of health care. The legislature finds that this article is necessary to promote the formation of accountable care organizations and protect the public interest and the interests of patients and health care providers.

§ 2999-o. Definitions. As used in this article, the following terms shall have the following meanings, unless the context clearly requires otherwise:

1. "Accountable care organization" or "ACO" means an organization of clinically integrated health care providers certified by the commissioner under this article.

2. "Certificate of authority" or "certificate" means a certificate of authority issued by the commissioner under this article.

3. "Health care provider" includes but is not limited to an entity licensed or certified under article twenty-eight or thirty-six of this chapter; an entity licensed or certified under article sixteen, thirty-one or thirty-two of the mental hygiene law; or a health care practitioner licensed

or certified under title eight of the education law or a lawful combination of such health care practitioners; and may also include, to the extent provided by regulation of the commissioner, other entities that provide technical assistance, information systems and services, care coordination and other services to health care providers and patients participating in an ACO.

4. "Primary care" means the health care fields of family practice, general pediatrics, primary care internal medicine, primary care obstetrics, or primary care gynecology, without regard to board certification, provided by a health care provider acting within his, her, or its lawful scope of practice.

5. "Third-party health care payer" has its ordinary meanings and may include any entities provided for by regulation of the commissioner, which may include an entity such as a pharmacy benefits manager, fiscal administrator, or administrative services provider that participates in the administration of a third-party health care payer system.

6. Any references to the "department of financial services" and the "superintendent of financial services" in this article shall mean, prior to October third, two thousand eleven, respectively, the "department of insurance" and the "superintendent of insurance."

§ 2999-p. Establishment of ACO demonstration program. 1. An accountable care organization: (a) is an organization of clinically integrated health care providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population; with a mechanism for shared governance; the ability to negotiate, receive, and distribute payments; and accountability for the quality, cost, and delivery of health care to the ACO's patients; in accordance with this article; and (b) has been issued a certificate of authority by the commissioner under this article.

2. The commissioner shall establish a demonstration program within the department to test the ability of ACOs to deliver an array of health care services for the purpose of improving the quality, coordination and accountability of services provided to patients in New York.

3. The commissioner may issue a certificate of authority to an entity that meets conditions for ACO certification as set forth in regulations promulgated by the commissioner pursuant to section twenty-nine hundred ninety-nine-q of this article. The commissioner shall not issue more than seven certificates under this article, and shall not issue any new certificate under this article after December thirty-first, two thousand fifteen.

4. The commissioner may limit, suspend, or terminate a certificate of authority if an ACO is not operating in accordance with this article.

5. The commissioner is authorized to seek federal approvals and waivers to implement this article, including but not limited to those approvals or waivers necessary to obtain federal financial participation.

§ 2999-q. Accountable care organizations; requirements. 1. The commissioner shall promulgate regulations establishing criteria for certificates of authority, quality standards for ACOs, reporting requirements and other matters deemed to be appropriate and necessary in the operation and evaluation of the demonstration program. In promulgating such regulations, the commissioner shall consult with the superintendent of financial services, health care providers, third-party health care payers, advocates representing patients, and other appropriate parties.

2. Such regulations may, and shall as necessary for purposes of this article, address matters including but not limited to:

(a) The governance, leadership and management structure of the ACO, including the manner in which clinical and administrative systems and clinical participation will be managed;

(b) Definition of the population proposed to be served by the ACO, which may include reference to a geographical area and patient characteristics;

(c) The character, competence and fiscal responsibility and soundness of an ACO and its principals, if and to the extent deemed appropriate by the commissioner;

(d) The adequacy of an ACO's network of participating health care providers, including primary care health care providers;

(e) Mechanisms by which an ACO will provide, manage, and coordinate quality health care for its patients and provide access to health care providers that are not participants in the ACO;

(f) Mechanisms by which the ACO shall receive and distribute payments to its participating health care providers, which may include incentive payments or mechanisms for pooling payments received by participating health care providers from third-party payers and patients;

(g) Mechanisms and criteria for accepting health care providers to participate in the ACO that are related to the needs of the patient population to be served and needs and purposes of the ACO, and preventing unreasonable discrimination;

(h) Mechanisms for quality assurance and grievance procedures for patients or health care providers where appropriate;

(i) Mechanisms that promote evidence-based health care, patient engagement, coordination of care, electronic health records, including participation in health information exchanges, and other enabling technologies;

(j) Performance standards for, and measures to assess, the quality and utilization of care provided by an ACO;

(k) Appropriate requirements for ACOs to promote compliance with the purposes of this article;

(l) Posting on the department's website information about ACOs that would be useful to health care providers and patients;

(m) Requirements for the submission of information and data by ACOs and their participating and affiliated health care providers as necessary for the evaluation of the success of the demonstration program;

(n) Protection of patient rights as appropriate;

(o) The impact of the establishment and operation of an ACO on access to any health care service in the area served; and

(p) Establishment of standards, as appropriate, to promote the ability of an ACO to participate in applicable federal programs for ACOs.

3. (a) Subject to regulations of the commissioner: (i) an ACO may enter into arrangements with one or more third-party health care payers to establish payment methodologies for health care services for the third-party health care payer's enrollees provided by the ACO or for which the ACO is responsible, such as full or partial capitation or other arrangements; (ii) such arrangements may include provision for the ACO to receive and distribute payments to the ACO's participating health care providers, including incentive payments and payments for health care services from third-party health care payers and patients; and (iii) an ACO may include mechanisms for pooling payments received by participating health care providers from third-party payers and patients.

(b) Subject to regulations of the commissioner, the commissioner, in consultation with the superintendent of financial services, may authorize a third-party health care payer to participate in payment methodologies with an ACO under this subdivision, notwithstanding any contrary provision of this chapter, the insurance law, the social services law, or the elder law, on finding that the payment methodology is consistent with the purposes of this article.

4. The provision of health care services directly or indirectly by an ACO through health care providers shall not be considered the practice of a profession under title eight of the education law by the ACO.

§ 2999-r. Other laws. 1. (a) It is the policy of the state to permit and encourage cooperative, collaborative and integrative arrangements among third-party health care payers and health care providers who might otherwise be competitors under the active supervision of the commissioner. To the extent that it is necessary to accomplish the purposes of this article, competition may be

supplanted and the state may provide state action immunity under state and federal antitrust laws to payors and health care providers.

(b) The commissioner may engage in state supervision to promote state action immunity under state and federal antitrust laws and may inspect, require, or request additional documentation and take other actions under this article to verify and make sure that this article is implemented in accordance with its intent and purpose.

2. With respect to the planning, implementation, and operation of ACOs, the commissioner, by regulation, may specifically delineate safe harbors that exempt ACOs from the application of the following statutes:

(a) article twenty-two of the general business law relating to arrangements and agreements in restraint of trade;

(b) article one hundred thirty-one-A of the education law relating to fee-splitting arrangements; and

(c) title two-D of article two of this chapter relating to health care practitioner referrals.

3. For the purposes of this article, an ACO shall be deemed to be a hospital for purposes of sections twenty-eight hundred five-j, twenty-eight hundred five-k, twenty-eight hundred five-l and twenty-eight hundred five-m of this chapter and subdivisions three and five of section sixty-five hundred twenty-seven of the education law.

Statewide Patient-Centered Medical Homes

Chapter ___, Laws of 2011, Part H, § 35 (A.4009-D, S.4009-D)

Public Health Law

ARTICLE 29-AA

PATIENT CENTERED MEDICAL HOMES

Section 2959-a. Multipayor patient centered medical home program.

§ 2959-a. Multipayor patient centered medical home program. 1. (a) The commissioner is authorized to establish medical home multipayor programs (referred to in this section as a "program") whereby enhanced payments are made to primary care clinicians and clinics statewide that are certified as medical homes for the purpose of improving health care outcomes and efficiency through improved access, patient care continuity and coordination of health services.

(b) As used in this section:

(i) "clinic" means a general hospital providing outpatient care or diagnostic and treatment center, licensed under article twenty-eight of this chapter; and

(ii) "primary care clinician" means a physician, nurse practitioner, or midwife acting within his or her lawful scope of practice under title eight of the education law and who is practicing in a primary care specialty.

(iii) "primary care medical home collaborative" means an entity approved by the commissioner which shall include but not be limited to health care providers, which may include but not be limited to hospitals, diagnostic and treatment centers, private practices and independent practice associations, and payors of health care services, which may include but not be limited to employers, health plans and insurers.

2. (a) In order to promote improved quality of, and access to, health care services and promote improved clinical outcomes, it is the policy of the state to encourage cooperative, collaborative and integrative arrangements among payors of health care services and health care services providers who might otherwise be competitors, under the active supervision of the commissioner. It is the intent of the state to supplant competition with such arrangements and regulation only to the extent necessary to accomplish the purposes of this article, and to provide state action immunity under the state and federal antitrust laws to payors of health care services and health care services providers with respect to the planning, implementation and operation of the multipayor patient centered medical home program.

(b) The commissioner or his or her duly authorized representative may engage in appropriate state supervision necessary to promote state action immunity under the state and federal antitrust laws, and may inspect or request additional documentation from payors of health care services and health care services providers to verify that medical homes certified pursuant to this section operate in accordance with its intent and purpose.

3. The commissioner is authorized to participate in, actively supervise, facilitate and approve a primary care medical home collaborative for each program around the state to establish: (a) the boundaries of each program and the providers eligible to participate, provided that the boundaries of programs may overlap; (b) practice standards for each medical home program adopted with consideration of existing standards developed by the National Committee for Quality Assurance ("NCQA"), the Joint Commission of Accreditation of Healthcare Organizations ("JCAHCO" or the "Joint Commission"), American Accreditation Healthcare Commission ("URAC"), American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association; the American Academy of Nurse Practitioners, and the American College of Nurse Practitioners; (c) standards for implementation and use of health information technology, including participation in health information exchanges through the statewide health information network; (d) methodologies by which payors will provide enhanced rates of payment to certified medical homes; (e) requirements for collecting data relating to the providing and paying for health care services under the program and providing of data to the commissioner, payors and health care providers under the program, to promote the effective operation and evaluation of the program, consistent with protection of the confidentiality of individual patient information; and (f) provisions under which the commissioner may terminate the program.

3-a. The commissioner may develop or approve (a) methodologies to pay additional amounts for medical homes that meet specific process or outcome standards established by each multipayor patient centered medical home collaborative; (b) alternative methodologies for payors of health care services to health care providers under the program; (c) provisions for payments to providers that may vary by size or form of organization of the provider, or patient case mix, to accommodate different levels of resources and difficulty to meet the standards of the program; (d) provisions for payments to entities that provide services to health care providers to assist them in meeting medical home standards under the program such as the services of community health workers.

4. The commissioner is authorized to establish an advisory group of state agencies and stakeholders, such as professional organizations and associations, and consumers, to identify legal and/or administrative barriers to the sharing of care management and care coordination services among participating health care services providers and to make recommendations for statutory and/or regulatory changes to address such barriers.

5. Patient, payor and health care services provider participation in the multipayor patient centered medical home program shall be on a voluntary basis.

6. Clinics and primary care clinicians participating in a program are not eligible for additional enhancements or bonuses under the statewide patient centered medical home program established pursuant to section three hundred sixty-four-m of the social services law. The commissioner shall develop or approve a method for determining payment under a program where a provider participates, or a patient is served, in an area where program boundaries overlap.

7. Subject to the availability of funding and federal financial participation, the commissioner is authorized:

(a) To pay enhanced rates of payment under Medicaid fee-for-service, Medicaid managed care, family health plus and child health plus to clinics and clinicians that are certified as patient centered medical homes under this title;

(b) To pay additional amounts for medical homes that meet specific process or outcome standards specified by the commissioner in consultation with each multipayor patient centered medical home collaborative;

(c) To authorize alternative payment methodologies under Medicaid fee-for-service, Medicaid managed care, family health plus and child health plus for health care providers and to serve the purposes of the program, including payments to entities under paragraph (g) of subdivision three of this section; and

(d) To test new models of payment to high volume Medicaid primary care medical home practices that incorporate risk adjusted global payments combined with care management and pay for performance adjustments.

8. (a) The commissioner is authorized to contract with one or more entities to assist the state in implementing the provisions of this section. Such entity or entities shall be the same entity or entities chosen to assist in the implementation of the health home provisions of section three hundred sixty-five-l of the social services law. Responsibilities of the contractor shall include but not be limited to: developing recommendations with respect to program policy, reimbursement, system requirements, reporting requirements, evaluation protocols, and provider and patient enrollment; providing technical assistance to potential medical home and health home providers; data collection; data sharing; program evaluation, and preparation of reports.

(b) Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner is authorized to enter into a contract or contracts under paragraph (a) of this subdivision without a request for proposal process, provided, however, that:

(i) The department shall post on its website, for a period of no less than thirty days:

(1) A description of the proposed services to be provided pursuant to the contract or contracts;

(2) The criteria for selection of a contractor or contractors;

(3) The period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(4) The manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(ii) All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner; and

(iii) The commissioner shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.

9. The commissioner may directly, or by contract, provide:

(a) technical assistance to a primary care medical home collaborative in relation to establishing and operating a program;

(b) consumer assistance to patients participating in a program as to matters relating to the program;

(c) technical and other assistance to health care providers participating in a program as to matters relating to the program, including achieving medical home standards;

(d) care coordination provider technical and other assistance to individuals and entities providing care coordination services to health care providers under a program; and

(e) information sharing and other assistance among programs to improve the operation of programs, consistent with applicable laws relating to patient confidentiality.

10. The commissioner shall, to the extent necessary for the purpose of this section, submit the appropriate waivers and other applications, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers or applications necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under Medicaid, family health plus and child health plus or Medicare. Copies of such original waiver and other applications shall be provided to the chairman of the senate finance committee and the chairman of the assembly ways and means committee simultaneously with their submission to the federal government.

11. The Adirondack medical home multipayor demonstration program (including the Adirondack medical home collaborative) previously established under section twenty-nine hundred fifty-nine of this chapter is continued and shall be deemed to be a program under this section.

12. The commissioner shall annually report to the governor and the legislature on the operation of the programs and their effectiveness in achieving the purposes of this section, with particular reference to the quality, cost, and outcomes for enrollees in Medicaid fee-for-service, Medicaid managed care, family health plus and child health plus.

All-Payer Claims Database

Chapter ____, Laws of 2011, Part H, §§ 38 and 38-a (A.4009-D, S.4009-D). Matter underlined is new law being added. Matter in [~~brackets and strike-out~~] is existing law being repealed.

§ 38. Section 2816 of the public health law, as added by chapter 225 of the laws of 2001, paragraph (a) of subdivision 2 as amended by section 19 of part D of chapter 57 of the laws of 2006, is amended to read as follows:

§ 2816. Statewide planning and research cooperative system. 1. (a) The statewide planning and research cooperative system in the department is continued, as provided in and subject to this section, within amounts appropriated for that purpose. The [~~statewide planning and research cooperative~~] system shall be developed and operated by the commissioner in consultation with the council, [~~and shall be comprised of such data elements~~] as may be specified by regulation of the commissioner. Any component or components of the system may be operated under a different name or names, and may be structured as separate systems. In making regulations under this section, subsequent to April first, two thousand eleven, the commissioner shall consult with the superintendent of insurance or the head of any agency that succeeds the insurance department, health care providers, third-party health care payers, and advocates representing patients; protect the confidentiality of patient-identifiable information; promote the accuracy and completeness of reporting; and minimize the burden on institutional and non-institutional health care providers and third-party health care payers.

(b) As used in this section, unless the context clearly requires otherwise:

(i) "Health care" means any services, supplies, equipment, or prescription drugs referred to in subdivision two of this section.

(ii) "Health care provider" includes, in addition to its common meanings, a clinical laboratory, a pharmacy, an entity that is an integrated organization of health care providers, and an accountable care organization of health care providers.

(iii) "System" means the statewide planning and research cooperative system under this section, and any separate system under this subdivision.

(iv) "Third-party health care payer" includes, but is not limited to, an insurer, organization or corporation licensed or certified pursuant to article thirty-two, forty-three or forty-seven of the insurance law, or article forty-four of the public health law; or an entity such as a pharmacy benefits manager, fiscal administrator, or administrative services provider that participates in the administration of a third-party health care payer system.

(v) "Covered person" is a person covered under a third-party health care payer contract, agreement, or arrangement.

2. [~~Regulations~~] Notwithstanding any provision of law to the contrary, regulations governing the [~~statewide planning and research cooperative~~] system shall include, but not be limited to, the following:

(a) Specification of patient, covered person, claims, and other data elements and format [~~to~~] which shall be reported including data related to:

(i) inpatient hospitalization data from general hospitals;

(ii) ambulatory surgery data from hospital-based ambulatory surgery services and all other ambulatory surgery facilities licensed under this article;

(iii) emergency department data from general hospitals;

(iv) outpatient [~~clinic~~], clinical laboratory, and prescription data, including but not limited to data from or relating to services, supplies, equipment, and prescription drugs provided or ordered by general hospitals and diagnostic and treatment centers licensed under this article, [~~provided, however, that notwithstanding subdivision one of this section the commissioner, in consultation with the health care industry, is authorized to promulgate or adopt any rules or regulations necessary to implement the collection of data pursuant to this subparagraph~~] pharmacies, clinical laboratories, and other health care providers;

(v) covered person and claims data; and

(vi) the data specified in this paragraph shall include the identification of patients transferred, admitted or treated subsequent to a medical, surgical or diagnostic procedure by a licensed health care professional or at a health care site or facility [~~other than those specified in subparagraph (i), (ii), (iii) or (iv) of this paragraph~~].

(b) Standards to assure the protection of patient privacy in data collected [~~and~~], published, released [~~under this section~~], used and accessed under this section, including compliance with applicable federal law.

(c) Standards for the publication [~~and~~], release, and use of and access to data reported in accordance with this section, including fees to be charged.

(d) Provisions requiring specified health care providers and third-party health care payers to report data to the system, with specifications of the data, circumstances, format, time and method of reporting.

(e) Provisions to acquire data relating to health care provided (i) to patients for whom there is no third-party health care payer and (ii) under arrangements that do not involve fee-for-service payment.

(f) Phased-in implementation of the system.

3. The commissioner may provide that the system may participate in or cooperate with a similar system operated by, or receive information from or provide information to, a regional or national entity or another jurisdiction, including making appropriate agreements and applying for approvals, provided that the protections for health care providers, patients, and third-party health care payers in this section are preserved and comparable provisions are included in the other system.

4. The commissioner may provide for access to data in the system by a health care provider relating to a patient being treated by the health care provider, subject to this section and applicable state and federal law.

5. In operating the system, the commissioner shall consider national standards, including but not limited to those approved by the National Uniform Billing Committee (NUBC) or required under national electronic data interchange (EDI) standards for health care transactions. The commissioner shall also consider the use of the Statewide Health Information Network for New York in relation to the system.

6. Notwithstanding any inconsistent provision of law to the contrary, including but not limited to section one hundred two of the executive law, such rules and regulations may describe data elements by reference to information reasonably available to regulated parties, as such material may be amended in the future, even though such material cannot be precisely identified to the extent that it is amended in the future; provided, however, that the commissioner shall precisely identify and publish such data elements.

7. The commissioner may contract with one or more entities to operate any part of the system subject to this section.

8. The commissioner may accept grants and enter into contracts as may be necessary to provide funding for the system.

9. The commissioner shall publish an annual report relating to health care utilization, cost, quality, and safety, including data on health disparities.

§ 38-a. Paragraph (b) of subdivision 18-a of section 206 of the public health law, as added by section 11 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

(b) The commissioner shall make such rules and regulations as may be necessary to implement federal policies and disburse funds as required by the American Recovery and Reinvestment Act of 2009 and to promote the development of a statewide health information network of New York (SHIN-NY) to enable widespread interoperability among disparate health information systems, including electronic health records, personal health records, health care claims and other

administrative data, and public health information systems, while protecting privacy and security. Such rules and regulations shall include, but not be limited to, requirements for organizations covered by 42 U.S.C. 17938 or any other organizations that exchange health information through the SHIN-NY.