S T A T E O F N E W Y O R K

6261

2011-2012 Regular Sessions

I N A S S E M B L Y

March 11, 2011

Introduced by M. of A. GOTTFRIED -- read once and referred to the Committee on Health

AN ACT to amend the public health law, the social services law, the public authorities law, and chapter 57 of the laws of 2008 amending the public health law relating to medical home demonstration programs, in relation to accountable care organizations and medical home multi-payor programs

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. The public health law is amended by adding a new article 44-A to read as follows:

ARTICLE 44-A

ACCOUNTABLE CARE ORGANIZATIONS

SECTION 4420. ACCOUNTABLE CARE ORGANIZATIONS; FINDINGS; PURPOSE.
4421. DEFINITIONS.
4422. ESTABLISHMENT OF ACCOUNTABLE CARE ORGANIZATIONS.
4423. CERTIFICATE OF AUTHORITY.

S 4420. ACCOUNTABLE CARE ORGANIZATIONS; FINDINGS; PURPOSE. THE LEGISLATURE INTENDS TO FACILITATE THE ABILITY OF ACCOUNTABLE CARE ORGANIZATIONS TO ASSUME A LARGER ROLE IN DELIVERING A FULL 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 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

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

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ACCOUNTABLE CARE ORGANIZATIONS AND PROTECT THE PUBLIC INTEREST AND THE INTERESTS OF PATIENTS AND HEALTH CARE PROVIDERS.

S 4421. DEFINITIONS. AS USED IN THIS ARTICLE, THE FOLLOWING TERMS SHALL HAVE THE FOLLOWING MEANINGS, UNLESS THE CONTEXT CLEARLY REQUIRES OTHERWISE:

1. "ACCOUNTABLE CARE ORGANIZATION" AND "ACO" MEAN AN ACCOUNTABLE CARE ORGANIZATION 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" MEANS 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; IT MAY ALSO INCLUDE 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, AND SHALL APPLY TO ANY HEALTH CARE PROVIDER ACTING WITHIN HIS, HER, OR ITS LAWFUL SCOPE OF PRACTICE.

5. "THIRD-PARTY HEALTH CARE PAYER" INCLUDES, IN ADDITION TO ITS ORDINARY MEANINGS, 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.

S 4422. ESTABLISHMENT OF ACCOUNTABLE CARE ORGANIZATIONS. 1. AN ACCOUNTABLE CARE ORGANIZATION IS A NOT-FOR-PROFIT OR GOVERNMENTAL ENTITY WHICH (A) IS AN ORGANIZATION OF 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. AN ACO SHALL:

(A) HAVE A GOVERNANCE SYSTEM THAT REASONABLY, EQUITABLY AND DEMOCRATICALLY REPRESENTS THE ACO'S PARTICIPATING HEALTH CARE PROVIDERS, EMPLOYEES OF PARTICIPATING HEALTH CARE PROVIDERS, THE ACO'S ENROLLEES AND PATIENTS, AND THE GENERAL PUBLIC.

(B) DEFINE THE POPULATION PROPOSED TO BE SERVED BY THE ACO, WHICH MAY INCLUDE REFERENCE TO A GEOGRAPHICAL AREA AND PATIENT CHARACTERISTICS.

(C) INCLUDE AN ADEQUATE NETWORK OF PARTICIPATING HEALTH CARE PROVIDERS TO PROVIDE THE HEALTH CARE FOR WHICH THE ACO IS ACCOUNTABLE, INCLUDING PRIMARY CARE HEALTH CARE PROVIDERS, AND AT LEAST ONE FEDERALLY-QUALIFIED HEALTH CENTER (PROVIDED THAT THE COMMISSIONER MAY WAIVE THIS REQUIREMENT IF THERE IS NO FEDERALLY-QUALIFIED HEALTH CENTER SERVING THE AREA SERVED BY THE ACO).

(D) HAVE DEFINED MECHANISMS FOR PROVIDING, MANAGING, AND COORDINATING HIGH QUALITY HEALTH CARE FOR THE ACO'S PATIENTS, INCLUDING: ELEVATING THE SERVICES OF PRIMARY CARE HEALTH CARE PROVIDERS TO MEET PATIENT-CENTERED MEDICAL HOME STANDARDS; COORDINATING INTENSIVE SERVICES FOR COMPLEX HIGH-NEED PATIENTS; PROVIDING ACCESS TO HEALTH CARE PROVIDERS THAT ARE NOT PARTICIPANTS IN THE ACO; AND PROVIDING ACCESS TO THE FULL RANGE OF REPRODUCTIVE HEALTH CARE FOR THE POPULATION SERVED.

(E) HAVE DEFINED MECHANISMS FOR RECEIVING AND DISTRIBUTING PAYMENTS TO THE ACO'S PARTICIPATING HEALTH CARE PROVIDERS, INCLUDING INCENTIVE PAYMENTS (WHICH MAY INCLUDE MEDICAL HOME PAYMENTS) AND PAYMENTS FOR HEALTH CARE SERVICES FROM THIRD-PARTY HEALTH CARE PAYERS AND PATIENTS. AN ACO MAY INCLUDE MECHANISMS FOR POOLING PAYMENTS RECEIVED BY PARTICIPATING HEALTH CARE PROVIDERS FROM THIRD-PARTY PAYERS AND PATIENTS.

(F) HAVE REASONABLE 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 DO NOT DISCRIMINATE ON OTHER GROUNDS.

(G) HAVE A LEADERSHIP AND MANAGEMENT STRUCTURE THAT INCLUDES CLINICAL AND ADMINISTRATIVE SYSTEMS AND CLINICAL PARTICIPATION.

(H) HAVE APPROPRIATE QUALITY ASSURANCE MECHANISMS, GRIEVANCE PROCEDURES FOR HEALTH CARE PROVIDERS AND PATIENTS, AND PROCEDURES FOR REVIEWING AND APPEALING PATIENT CARE DECISIONS.

(I) PROVIDE SATISFACTORY EVIDENCE OF THE CHARACTER AND COMPETENCE OF THE ACO.

(J) HAVE THE ABILITY TO OPERATE ON A FISCALLY SOUND AND FINANCIALLY RESPONSIBLE BASIS, INCLUDING REASONABLE CAPITALIZATION AND RESERVES, AND CONSIDERING THE PAYMENT ARRANGEMENTS ENTERED INTO BY THE ACO.

(K) IN ITS APPLICATION AND FROM TIME TO TIME, AS REQUIRED BY THE COMMISSIONER, PROVIDE THE COMMISSIONER WITH INFORMATION AND DATA RELATING TO:

(I) THE ACO'S PARTICIPATING HEALTH CARE PROVIDERS, INCLUDING INDIVIDUAL HEALTH CARE PRACTITIONERS AFFILIATED WITH SUCH HEALTH CARE PROVIDER WHO PROVIDE HEALTH CARE TO THE HEALTH CARE PROVIDER'S PATIENTS.

(II) DATA, INCLUDING ENCOUNTER DATA, RELATING TO THE NATURE, OUTCOME, AND QUALITY OF, AND PAYMENT FOR, HEALTH CARE PROVIDED BY THE PARTICIPATING HEALTH CARE PROVIDER TO THE PARTICIPATING PATIENT.

(L) HAVE MECHANISMS TO PROMOTE EVIDENCE-BASED HEALTH CARE, PATIENT ENGAGEMENT, COORDINATION OF CARE, ELECTRONIC HEALTH RECORDS, AND OTHER ENABLING TECHNOLOGIES.

3. THE COMMISSIONER, IN CONSULTATION WITH HEALTH CARE PROVIDERS, THIRD-PARTY HEALTH CARE PAYERS, ADVOCATES REPRESENTING PATIENTS, THE SUPERINTENDENT OF INSURANCE, AND OTHER APPROPRIATE PARTIES, SHALL:

(A) ESTABLISH APPROPRIATE REQUIREMENTS FOR ACOS TO PROMOTE COMPLIANCE WITH THE PURPOSES OF THIS ARTICLE.

(B) ESTABLISH APPROPRIATE PERFORMANCE STANDARDS FOR, AND MEASURES TO ASSESS, THE QUALITY OF CARE PROVIDED BY AN ACO, SUCH AS MEASURES OF:

(I) CLINICAL PROCESSES AND OUTCOMES;

(II) PATIENT AND, WHERE PRACTICABLE, CAREGIVER EXPERIENCE OF CARE;

(III) UTILIZATION, SUCH AS RATES OF HOSPITAL ADMISSION FOR AMBULATORY CARE SENSITIVE CONDITIONS, EMERGENCY ROOM USE, AND HOSPITAL RE-ADMISSIONS.

(C) PROVIDE FOR PUBLIC DISCLOSURE, ON THE DEPARTMENT'S WEBSITE, OF STATISTICAL DATA RELATING TO THE QUALITY OF SERVICES, PERFORMANCE, AND OTHER CHARACTERISTICS OF ACOS, WHICH IS APPROPRIATELY ADJUSTED FOR CASE MIX AND EXCLUDES ANY INDIVIDUAL PATIENT IDENTIFYING INFORMATION.

(D) MAKE REGULATIONS, SET STANDARDS, AND TAKE OTHER ACTIONS TO PROMOTE THE ABILITY OF AN ACO TO PARTICIPATE IN APPLICABLE FEDERAL PROGRAMS FOR ACCOUNTABLE CARE ORGANIZATIONS.

4. (A) IN ORDER TO PROMOTE IMPROVED QUALITY AND EFFICIENCY OF, AND ACCESS TO, HEALTH CARE SERVICES AND PROMOTE IMPROVED CLINICAL OUTCOMES, IT SHALL BE THE POLICY OF THE STATE RELATING TO ACOS TO 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 SUCH ARRANGEMENTS MIGHT BE ANTI-COMPETITIVE WITHIN THE MEANING AND INTENT OF THE FEDERAL OR STATE ANTITRUST LAWS, THE INTENT OF THE STATE IS TO SUPPLANT COMPETITION WITH SUCH ARRANGEMENTS AND WITH REGULATION UNDER THIS ARTICLE, TO THE EXTENT NECESSARY TO ACCOMPLISH THE PURPOSES OF THIS ARTICLE RELATING TO ACOS, AND PROVIDE STATE ACTION IMMUNITY UNDER THE STATE AND FEDERAL ANTITRUST LAWS WITH RESPECT TO THE PLANNING, IMPLEMENTATION AND OPERATION OF ACOS AND THIRD-PARTY HEALTH CARE PAYERS AND HEALTH CARE PROVIDERS. THE COMMISSIONER SHALL PROVIDE REASONABLE AND APPROPRIATE STATE SUPERVISION NECESSARY TO PROMOTE STATE ACTION IMMUNITY UNDER THE 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.

(B) TO THE EXTENT THE FORMATION OR OPERATION OF AN ACO OR ITS ARRANGEMENTS WITH THIRD-PARTY HEALTH CARE PAYERS OR HEALTH CARE PROVIDERS MAY VIOLATE THE FEDERAL CIVIL MONETARY PAYMENT LAWS, OR FEDERAL OR STATE ANTI-KICKBACK, PATIENT REFERRAL, OR FEE-SPLITTING LAWS, THE COMMISSIONER SHALL PROVIDE REASONABLE AND APPROPRIATE REGULATION, SUPERVISION, AND WAIVERS UNDER THOSE STATUTES AND THEIR REGULATIONS TO ENABLE SUCH FORMATION, OPERATION OR ARRANGEMENTS TO PROCEED AND TO MAKE SURE THAT THEY DO SO CONSISTENTLY WITH THE PURPOSES OF THIS ARTICLE.

(C) 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.

5. (A) AN ACO (I) SHALL BE DEEMED TO BE A HEALTH PLAN, SOLELY FOR PURPOSES OF ARTICLE FORTY-NINE OF THIS CHAPTER, EXCEPT WHERE THE FUNCTIONS OF A HEALTH PLAN UNDER THAT ARTICLE ARE THE RESPONSIBILITY OF A THIRD-PARTY HEALTH CARE PAYER, AND (II) SHALL BE DEEMED TO BE A MANAGED CARE PRODUCT, SOLELY FOR PURPOSES OF ARTICLE FORTY-EIGHT OF THE INSURANCE LAW, EXCEPT WHERE THE FUNCTIONS OF A MANAGED CARE PRODUCT UNDER THAT ARTICLE ARE THE RESPONSIBILITY OF A THIRD-PARTY HEALTH CARE PAYER.

(B) WHERE AN ACO CONTRACTS WITH AN ENROLLEE OR PATIENT TO PROVIDE HEALTH CARE SERVICES TO THAT PERSON, WHERE PAYMENT FOR THOSE SERVICES IS NOT PRIMARILY THE RESPONSIBILITY OF A THIRD-PARTY HEALTH CARE PAYER, NOTHING IN THIS ARTICLE SHALL PRECLUDE THE ACO FROM BEING DEEMED TO BE A HEALTH MAINTENANCE ORGANIZATION SUBJECT TO ARTICLE FORTY-FOUR OF THIS CHAPTER OR ENGAGED IN THE BUSINESS OF INSURANCE AND SUBJECT TO APPLICABLE PROVISIONS OF THE INSURANCE LAW, INCLUDING ARTICLE FORTY-EIGHT OF THE INSURANCE LAW.

6. (A) (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. 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. AN ACO MAY INCLUDE MECHANISMS FOR POOLING PAYMENTS RECEIVED BY PARTICIPATING HEALTH CARE PROVIDERS FROM THIRD-PARTY PAYERS AND PATIENTS.

(II) THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF INSURANCE, MAY AUTHORIZE A THIRD-PARTY HEALTH CARE PAYER TO PARTICIPATE IN PAYMENT METHODOLOGIES WITH AN ACO UNDER THIS PARAGRAPH, 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.

(III) NO THIRD-PARTY HEALTH CARE PAYER SHALL:

(A) IMPOSE ANY DEDUCTIBLE, CO-PAYMENT OR OTHER FORM OF CO-INSURANCE ON ANY ENROLLEE OR PATIENT IN CONNECTION WITH THE ENROLLEE OR PATIENT PARTICIPATING IN AN ACO THAT IS HIGHER THAN IT WOULD OTHERWISE IMPOSE; OR

(B) MAKE ANY DISTINCTION OR DISCRIMINATION AGAINST ANY ENROLLEE OR PATIENT IN CONNECTION WITH THE ENROLLEE OR PATIENT PARTICIPATING IN AN ACO, OR IMPOSE ANY RESTRICTION ON WHICH OF ITS ENROLLEES OR PATIENTS MAY PARTICIPATE IN AN ACO; PROVIDED THAT

(C) THIS SUBDIVISION SHALL NOT BE CONSTRUED TO BAR A THIRD-PARTY HEALTH CARE PAYER FROM PROVIDING INCENTIVES FOR ENROLLEES OR PATIENTS TO PARTICIPATE IN AN ACO; AND

(D) ENROLLEE, PATIENT, AND HEALTH CARE PROVIDER PARTICIPATION IN AN ACO SHALL BE ON A VOLUNTARY BASIS.

(B) WITH RESPECT TO ARRANGEMENTS INVOLVING PUBLIC HEALTH COVERAGE AND AN ACO, THE COMMISSIONER:

(I) SHALL SEEK TO PROMOTE THE ESTABLISHMENT OF ACOS;

(II) MAY PROMOTE USE OF RISK-ADJUSTMENT AND STOP-LOSS METHODOLOGIES; AND

(III) MAY ESTABLISH PAYMENT METHODOLOGIES, INCLUDING FOR MEDICAID FEE-FOR-SERVICE AND MEDICAID MANAGED CARE.

(C) AN ACO MAY SEEK TO FOCUS ON PROVIDING HEALTH CARE SERVICES TO PATIENTS WITH ONE OR MORE CHRONIC CONDITIONS OR SPECIAL NEEDS. HOWEVER, AN ACO MAY NOT OTHERWISE, ON THE BASIS OF A PERSON'S MEDICAL OR DEMOGRAPHIC CHARACTERISTICS, DISCRIMINATE FOR OR AGAINST OR DISCOURAGE OR ENCOURAGE ANY PERSON OR PERSONS WITH RESPECT TO ENROLLING OR PARTICIPATING IN THE ACO.

(D) AN ACO SHALL NOT, BY INCENTIVES OR OTHERWISE, DISCOURAGE A HEALTH CARE PROVIDER FROM PROVIDING OR AN ENROLLEE OR PATIENT FROM SEEKING APPROPRIATE HEALTH CARE SERVICES.

(E) AN ACO SHALL NOT DISCRIMINATE AGAINST OR DISADVANTAGE A PATIENT OR PATIENT'S REPRESENTATIVE FOR THE EXERCISE OF PATIENT AUTONOMY.

7. THE COMMISSIONER IS AUTHORIZED TO SEEK FEDERAL GRANTS, APPROVALS, AND WAIVERS TO IMPLEMENT THIS ARTICLE, INCLUDING FEDERAL FINANCIAL PARTICIPATION UNDER PUBLIC HEALTH COVERAGE. THE COMMISSIONER SHALL PROVIDE COPIES OF APPLICATIONS AND OTHER DOCUMENTS SEEKING SUCH FEDERAL GRANTS, APPROVALS, AND WAIVERS TO THE CHAIRS OF THE SENATE FINANCE COMMITTEE, THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE SENATE AND ASSEMBLY HEALTH COMMITTEES SIMULTANEOUSLY WITH THEIR SUBMISSION TO THE FEDERAL GOVERNMENT.

8. THE COMMISSIONER MAY DIRECTLY, OR BY CONTRACT WITH NOT-FOR-PROFIT ORGANIZATIONS, PROVIDE:

(A) CONSUMER ASSISTANCE TO PATIENTS PARTICIPATING IN OR CONSIDERING PARTICIPATING IN AN ACO AS TO MATTERS RELATING TO ACOS;

(B) TECHNICAL AND OTHER ASSISTANCE TO HEALTH CARE PROVIDERS PARTICIPATING IN AN ACO AS TO MATTERS RELATING TO THE ACO;

(C) ASSISTANCE TO ACOS TO PROMOTE THEIR FORMATION AND IMPROVE THEIR OPERATION, INCLUDING ASSISTANCE UNDER SECTION TWENTY-EIGHT HUNDRED EIGHTEEN OF THIS CHAPTER;

(D) INFORMATION SHARING AND OTHER ASSISTANCE AMONG ACOS TO IMPROVE THE OPERATION OF ACOS.

S 4423. CERTIFICATE OF AUTHORITY. 1. THE COMMISSIONER SHALL ISSUE A CERTIFICATE OF AUTHORITY TO AN APPLICANT THAT SATISFIES THE REQUIREMENTS UNDER THIS ARTICLE FOR ESTABLISHMENT OF AN ACO.

2. THE COMMISSIONER MAY LIMIT, SUSPEND, OR TERMINATE A CERTIFICATE OF AUTHORITY IF THE ACO IS NOT OPERATING IN ACCORDANCE WITH THIS ARTICLE.

3. THE COMMISSIONER SHALL ESTABLISH, BY REGULATION, REASONABLE AND APPROPRIATE PROCEDURES UNDER THIS SECTION, CONSISTENT WITH THE STATE ADMINISTRATIVE PROCEDURE ACT.

4. THE COMMISSIONER SHALL NOT APPROVE ANY CERTIFICATE OF AUTHORITY UNDER THIS ARTICLE AFTER DECEMBER THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

S 2. Subdivision 1 of section 2 of the public health law is amended by adding eight new paragraphs (o), (p), (q), (r), (s), (t), (u), and (v) to read as follows:

(O) "MEDICAID" OR "MEDICAL ASSISTANCE" MEANS TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW AND THE PROGRAM THEREUNDER.

(P) "FAMILY HEALTH PLUS" MEANS TITLE ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW AND THE PROGRAM THEREUNDER.

(Q) "CHILD HEALTH PLUS" MEANS TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER AND THE PROGRAM THEREUNDER.

(R) "MEDICAID MANAGED CARE" MEANS MEDICAID PROVIDED UNDER SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW.

(S) "MEDICAID FEE-FOR-SERVICE" MEANS MEDICAID PROVIDED OTHER THAN UNDER MEDICAID MANAGED CARE.

(T) "MEDICARE" MEANS TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND THE PROGRAMS THEREUNDER.

(U) "EPIC" MEANS TITLE THREE OF ARTICLE TWO OF THE ELDER LAW AND THE PROGRAM THEREUNDER.

(V) "PUBLIC HEALTH COVERAGE" MEANS MEDICAID, CHILD HEALTH PLUS, FAMILY HEALTH PLUS, MEDICARE (TO THE EXTENT IT IS SUBJECT TO STATE LAW IN THE CONTEXT IN WHICH THE TERM IS USED), AND EPIC.

S 3. Paragraph (b) of subdivision 1 of section 364-j of the social services law, as amended by chapter 649 of the laws of 1996, subparagraphs (i) and (ii) as amended by chapter 433 of the laws of 1997, is amended to read as follows:

(b) "Managed care provider". An entity that provides or arranges for the provision of medical assistance services and supplies to participants directly or indirectly (including by referral), including case management; and:

(i) is authorized to operate under article forty-four of the public health law or article forty-three of the insurance law and provides or arranges, directly or indirectly (including by referral) for covered comprehensive health services on a full capitation basis; [or]

(ii) is authorized as a partially capitated program pursuant to section three hundred sixty-four-f of this title or section forty-four hundred three-e of the public health law or section 1915b of the social security act; OR

(III) IS AN ACCOUNTABLE CARE ORGANIZATION UNDER ARTICLE FORTY-FOUR-A OF THE PUBLIC HEALTH LAW.

S 4. Section 2818 of the public health law is amended by adding a new subdivision 6 to read as follows:

6. NOTWITHSTANDING SUBDIVISIONS ONE AND TWO OF THIS SECTION, SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR ANY OTHER INCONSISTENT PROVISION OF LAW, OF THE FUNDS AVAILABLE FOR EXPENDITURE PURSUANT TO THIS SECTION, TEN MILLION DOLLARS MAY BE ALLOCATED AND DISTRIBUTED BY THE COMMISSIONER WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS FOR GRANTS TO ACCOUNTABLE CARE ORGANIZATIONS UNDER ARTICLE FORTY-FOUR-A OF THIS CHAPTER FOR THE PURPOSE OF PROMOTING THEIR FORMATION AND IMPROVING THEIR OPERATION. CONSIDERATION RELIED UPON BY THE COMMISSIONER IN DETERMINING THE ALLOCATION AND

DISTRIBUTION OF THESE FUNDS SHALL INCLUDE, BUT NOT BE LIMITED TO, THE NEED FOR AND CAPACITY OF THE ACCOUNTABLE CARE ORGANIZATION TO ACCOMPLISH THE PURPOSES OF ARTICLE FORTY-FOUR-A OF THIS CHAPTER IN THE AREA TO BE SERVED.

S 5. The opening paragraph of section 1680-j of the public authorities law, as amended by section 54 of part B of chapter 58 of the laws of 2005, is amended to read as follows:

Notwithstanding any other provision of law to the contrary, the dormitory authority of the state of New York is hereby authorized to issue bonds or notes in one or more series in an aggregate principal amount not to exceed seven hundred fifty million dollars excluding bonds issued to fund one or more debt service reserve funds, to pay costs of issuance of such bonds, and bonds or notes issued to refund or otherwise repay such bonds or notes previously issued, for the purposes of financing project costs authorized under section twenty-eight hundred eighteen of the public health law. Of such seven hundred fifty million dollars, ten million dollars shall be made available to the community health centers capital program established pursuant to section twenty-eight hundred seventeen of the public health law; AND TEN MILLION DOLLARS SHALL BE MADE AVAILABLE TO ACCOUNTABLE CARE ORGANIZATIONS UNDER SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED TWENTY-TWO AND SUBDIVISION SIX OF SECTION TWENTY-EIGHT HUNDRED EIGHTEEN OF THE PUBLIC HEALTH LAW.

S 6. The article heading of article 27-L of the public health law, as added by section 16 of part OO of chapter 57 of the laws of 2008, is amended to read as follows:

MEDICAL HOME [DEMONSTRATION] PROGRAMS

S 7. The public health law is amended by adding a new section 2799-t to read as follows:

S 2799-T. MEDICAL HOME MULTIPAYOR PROGRAMS. 1. (A) THE COMMISSIONER IS AUTHORIZED TO ESTABLISH MEDICAL HOME MULTIPAYOR PROGRAMS (REFERRED TO IN THIS SECTION AS A "PROGRAM") AND IN RELATION TO A PROGRAM MAY CERTIFY CERTAIN PRIMARY CARE CLINICIANS AND CLINICS AS MEDICAL HOMES ELIGIBLE FOR ENHANCED PAYMENTS FOR SERVICES PROVIDED TO: RECIPIENTS ELIGIBLE FOR MEDICAID FEE-FOR-SERVICE; ENROLLEES ELIGIBLE FOR AND ENROLLED IN MEDICAID MANAGED CARE; ENROLLEES ELIGIBLE FOR AND ENROLLED IN FAMILY HEALTH PLUS; ENROLLEES ELIGIBLE FOR AND ENROLLED IN CHILD HEALTH PLUS; ENROLLEES AND SUBSCRIBERS OF COMMERCIAL MANAGED CARE PLANS OPERATING UNDER ARTICLE FORTY-FOUR OF THIS CHAPTER OR HEALTH MAINTENANCE ORGANIZATIONS OPERATING UNDER ARTICLE FORTY-THREE OF THE INSURANCE LAW; ENROLLEES AND SUBSCRIBERS OF OTHER COMMERCIAL INSURANCE PRODUCTS; AND EMPLOYEES OF EMPLOYER-SPONSORED SELF-INSURED PLANS. THE PURPOSE OF THE PROGRAMS IS TO IMPROVE 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 A DIAGNOSTIC AND TREATMENT CENTER, LICENSED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER; AND

(II) "PRIMARY CARE CLINICIAN" MEANS A HEALTH CARE PRACTITIONER ACTING WITHIN HIS OR HER LAWFUL SCOPE OF PRACTICE UNDER TITLE EIGHT OF THE EDUCATION LAW WHO IS: (A) A PHYSICIAN OR NURSE PRACTITIONER PRACTICING IN A PRIMARY CARE SPECIALTY; (B) A PHYSICIAN, NURSE PRACTITIONER, OR MIDWIFE PRACTICING PRIMARY GYNECOLOGICAL CARE FOR FEMALE PATIENTS; OR (C) A PHYSICIAN OR NURSE PRACTITIONER PRACTICING IN A NON-PRIMARY CARE SPECIALTY, FOR A PATIENT WHO HAS A CHRONIC CONDITION THAT REQUIRES SPECIALTY CARE, WHERE THE SPECIALIST HEALTH CARE PRACTITIONER REGULARLY AND CONTINUALLY PROVIDES TREATMENT FOR THAT CONDITION TO THE PATIENT;

(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 AND EFFICIENCY OF, AND ACCESS TO, HEALTH CARE SERVICES AND PROMOTE IMPROVED CLINICAL OUTCOMES, IT SHALL BE THE POLICY OF THE STATE RELATING TO THE PROGRAMS TO ENCOURAGE COOPERATIVE, COLLABORATIVE AND INTEGRATIVE ARRANGEMENTS BETWEEN AND AMONG PAYORS OF HEALTH CARE SERVICES AND HEALTH CARE PROVIDERS WHO MIGHT OTHERWISE BE COMPETITORS, UNDER THE ACTIVE SUPERVISION OF THE COMMISSIONER. TO THE EXTENT SUCH ARRANGEMENTS MIGHT BE ANTI-COMPETITIVE WITHIN THE MEANING AND INTENT OF THE FEDERAL ANTITRUST LAWS, THE INTENT OF THE STATE IS TO SUPPLANT COMPETITION WITH SUCH ARRANGEMENTS, AND WITH REGULATION UNDER THIS SECTION TO THE EXTENT NECESSARY TO ACCOMPLISH THE PURPOSES OF THIS SECTION RELATING TO THE PROGRAMS, AND PROVIDE STATE ACTION IMMUNITY UNDER THE STATE AND FEDERAL ANTITRUST LAWS WITH RESPECT TO THE PLANNING, IMPLEMENTATION AND OPERATION OF THE PROGRAMS AND PAYORS OF HEALTH CARE SERVICES AND HEALTH CARE PROVIDERS.

(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 TO VERIFY THAT THE PROGRAM IS IMPLEMENTED IN ACCORDANCE WITH ITS INTENT AND PURPOSE.

3. THE COMMISSIONER, FOR PURPOSES OF THE PROGRAM, IS AUTHORIZED TO PARTICIPATE IN, ACTIVELY SUPERVISE, FACILITATE AND APPROVE A PRIMARY CARE MEDICAL HOME COLLABORATIVE FOR A PROGRAM TO ESTABLISH:

(A) THE BOUNDARIES OF THE PROGRAM AND THE HEALTH CARE PROVIDERS ELIGIBLE TO PARTICIPATE; PROVIDED THAT THE BOUNDARIES OF PROGRAMS MAY OVERLAP;

(B) PRACTICE STANDARDS FOR THE MEDICAL HOME ADOPTED WITH CONSIDERATION OF EXISTING STANDARDS DEVELOPED BY NATIONAL ACCREDITING AND PROFESSIONAL ORGANIZATIONS INCLUDING, BUT NOT LIMITED TO, 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;

(C) METHODOLOGIES BY WHICH PAYORS WILL PROVIDE ENHANCED RATES OF PAYMENT TO CERTIFIED MEDICAL HOMES;

(D) METHODOLOGIES TO PAY ADDITIONAL AMOUNTS FOR MEDICAL HOMES THAT MEET SPECIFIC PROCESS OR OUTCOME STANDARDS ESTABLISHED BY THE PRIMARY CARE MEDICAL HOME COLLABORATIVE OF THE PROGRAM;

(E) ALTERNATIVE METHODOLOGIES FOR PAYORS OF HEALTH CARE SERVICES TO HEALTH CARE PROVIDERS UNDER THE PROGRAM;

(F) 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;

(G) PROVISIONS FOR PAYMENTS TO NOT-FOR-PROFIT 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;

(H) 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

(I) PROVISIONS UNDER WHICH THE COMMISSIONER MAY TERMINATE THE PROGRAM.

4. PATIENT AND HEALTH CARE PROVIDER PARTICIPATION IN THE PROGRAM SHALL BE ON A VOLUNTARY BASIS.

5. CLINICS AND PRIMARY CARE CLINICIANS PARTICIPATING IN A PROGRAM ARE NOT ELIGIBLE FOR ADDITIONAL ENHANCEMENTS OR BONUSES UNDER THE STATEWIDE MEDICAL HOME PROGRAM, ESTABLISHED PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-M OF THE SOCIAL SERVICES LAW, FOR SERVICES PROVIDED TO PARTICIPANTS IN MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS OR CHILD HEALTH PLUS.

6. 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 PRIMARY CARE CLINICIANS THAT ARE CERTIFIED AS MEDICAL HOMES UNDER THIS SECTION;

(B) TO PAY ADDITIONAL AMOUNTS FOR MEDICAL HOMES THAT MEET SPECIFIC PROCESS OR OUTCOME STANDARDS SPECIFIED BY THE COMMISSIONER, IN CONSULTATION WITH THE PRIMARY CARE MEDICAL HOME COLLABORATIVE OF THE PROGRAM; AND

(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 NOT-FOR-PROFIT ENTITIES UNDER PARAGRAPH (G) OF SUBDIVISION THREE OF THIS SECTION.

7. THE COMMISSIONER MAY DIRECTLY, OR BY CONTRACT WITH NOT-FOR-PROFIT ORGANIZATIONS, 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.

8. 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.

9. 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.

10. 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.

11. NO PROGRAM SHALL BE APPROVED UNDER THIS SECTION AFTER APRIL FIRST, TWO THOUSAND SIXTEEN.

S 8. Paragraph o of section 21 of part OO of chapter 57 of the laws of 2008 amending the public health law relating to medical home demonstration programs, is amended to read as follows:

o. section 2799-S OF THE PUBLIC HEALTH LAW AS ADDED BY SECTION sixteen of this act shall take effect January 1, 2009 and shall expire and be deemed repealed 3 years after such effective date; and

S 9. This act shall take effect immediately; provided however that the amendments to section 364-j of the social services law made by section three of this act shall not affect the repeal of such section and shall be deemed to repeal therewith.