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

6228--A

I N S E N A T E

January 13, 2012

Introduced by Sens. HANNON, GOLDEN, JOHNSON, LARKIN, MARTINS, McDONALD, RANZENHOFER -- read twice and ordered printed, and when printed to be committed to the Committee on Health -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the public health, in relation to accountable care organizations

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

Section 1. Article 29-E of the public health law, as added by section 66 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

ARTICLE 29-E

ACCOUNTABLE CARE ORGANIZATIONS [DEMONSTRATION PROGRAM]

Section 2999-n. Accountable care organizations; findings; purpose.
2999-o. Definitions.
2999-p. Establishment of [ACO demonstration program] ACOS.
2999-q. Accountable care organizations; requirements.
2999-r. Other laws.

S 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.

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

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S 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. "ACO PARTICIPANT" OR "PARTICIPANT" MEANS A HEALTH CARE PROVIDER THAT IS ONE OF THE HEALTH CARE PROVIDERS THAT COMPRISE THE ACO.

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

[3.] 4. "CMS" MEANS THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES.

5. "CMS REGULATIONS" MEANS APPLICABLE FEDERAL LAWS AND CMS REGULATIONS AND POLICIES.

6. "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.] 7. "MEDICARE-ONLY ACO" MEANS AN ACO ISSUED A CERTIFICATE OF AUTHORITY UNDER SUBDIVISION FOUR OF SECTION TWENTY-NINE HUNDRED NINETY-NINE-P OF THIS ARTICLE.

8. "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.] 9. "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."]

S 2999-p. Establishment of [ACO demonstration program] ACOS. 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] PROMOTE AND REGULATE THE USE 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] MADE 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] SIXTEEN.

4. (A) NOTWITHSTANDING SUBDIVISION THREE OF THIS SECTION, THE COMMISSIONER SHALL ISSUE A CERTIFICATE OF AUTHORITY AS A MEDICARE-ONLY ACO TO AN ENTITY AUTHORIZED BY CMS TO BE AN ACCOUNTABLE CARE ORGANIZATION UNDER THE MEDICARE PROGRAM, UPON RECEIVING AN APPLICATION TO BE A MEDICARE-ONLY ACO FROM THE ENTITY DOCUMENTING ITS STATUS UNDER THIS SUBDIVISION. A CERTIFICATE OF AUTHORITY UNDER THIS SUBDIVISION SHALL ONLY APPLY TO THE MEDICARE-ONLY ACO'S ACTIONS IN RELATION TO MEDICARE BENEFICIARIES UNDER ITS AUTHORIZATION FROM CMS.

(B) TO THE EXTENT CONSISTENT WITH CMS REGULATIONS, A MEDICARE-ONLY ACO SHALL BE SUBJECT TO:

(I) SUBDIVISIONS ONE, TWO AND THREE OF SECTION TWENTY-NINE HUNDRED NINETY-NINE-R OF THIS ARTICLE, WITHOUT REGARD TO WHETHER THE COMMISSIONER HAS MADE REGULATIONS UNDER THIS ARTICLE; AND

(II) OTHER PROVISIONS OF THIS ARTICLE TO THE EXTENT SPECIFICALLY PROVIDED BY THE COMMISSIONER IN REGULATIONS CONSISTENT WITH THIS ARTICLE.

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

[5.] 6. 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.

S 2999-q. Accountable care organizations; requirements. 1. The commissioner shall [promulgate] MAKE 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] ACOS UNDER THIS ARTICLE. In [promulgating] MAKING 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. SUCH REGULATIONS SHALL BE CONSISTENT, TO THE EXTENT PRACTICAL AND CONSISTENT WITH THIS ARTICLE, WITH CMS REGULATIONS FOR ACCOUNTABLE CARE ORGANIZATIONS UNDER THE MEDICARE PROGRAM.

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 THAT REASONABLY AND EQUITABLY REPRESENTS THE ACO'S PARTICIPANTS AND THE ACO'S PATIENTS, 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] INCLUDING WHERE PRACTICABLE ELEVATING THE SERVICES OF PRIMARY CARE HEALTH CARE PROVIDERS TO MEET PATIENT-CENTERED MEDICAL HOME STANDARDS, COORDINATING SERVICES FOR COMPLEX HIGH-NEED PATIENTS, AND PROVIDING 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 (WHICH MAY INCLUDE MEDICAL HOME 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, AND PROCEDURES FOR REVIEWING AND APPEALING PATIENT CARE DECISIONS;

(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 AND INTEGRATED, EFFICIENT AND EFFECTIVE HEALTH CARE SERVICES;

(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, INCLUDING SIMILAR METRICS AS THE COMMISSIONER PUBLISHES FOR OTHER ORGANIZATIONS SUCH AS MEDICAID MANAGED CARE PROVIDERS UNDER SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW AND HEALTH HOMES UNDER SECTION THREE HUNDRED SIXTY-FIVE-L OF THE SOCIAL SERVICES LAW;

(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] ACOS;

(n) Protection of patient rights as appropriate;

(o) The impact of the establishment and operation of an ACO [on], INCLUDING PROVIDING THAT IT SHALL NOT DIMINISH access to any health care service FOR THE POPULATION SERVED AND 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) THE ACO SHALL PROVIDE FOR MEANINGFUL PARTICIPATION IN THE COMPOSITION AND CONTROL OF THE ACO'S GOVERNING BODY FOR ACO PARTICIPANTS OR THEIR DESIGNATED REPRESENTATIVES.

(B) THE ACO GOVERNING BODY SHALL INCLUDE AT LEAST ONE REPRESENTATIVE OF EACH OF THE FOLLOWING GROUPS: (I) RECIPIENTS OF MEDICAID, FAMILY HEALTH PLUS, OR CHILD HEALTH PLUS; (II) PERSONS WITH OTHER HEALTH COVERAGE; AND (III) PERSONS WHO DO NOT HAVE HEALTH COVERAGE. SUCH REPRESENTATIVES SHALL HAVE NO CONFLICT OF INTEREST WITH THE ACO AND NO IMMEDIATE FAMILY MEMBER WITH A CONFLICT OF INTEREST WITH THE ACO.

(C) AT LEAST SEVENTY-FIVE PERCENT CONTROL OF THE ACO'S GOVERNING BODY SHALL BE HELD BY ACO PARTICIPANTS.

(D) MEMBERS OF THE ACO GOVERNING BODY SHALL HAVE A FIDUCIARY RELATIONSHIP WITH THE ACO AND SHALL BE SUBJECT TO CONFLICT OF INTEREST REQUIREMENTS ADOPTED BY THE ACO AND IN REGULATIONS OF THE COMMISSIONER.

(E) THE ACO'S FINANCES, INCLUDING DIVIDENDS AND OTHER RETURN ON CAPITAL, DEBT STRUCTURE, EXECUTIVE COMPENSATION, AND ACO PARTICIPANT COMPENSATION, SHALL BE ARRANGED AND CONDUCTED TO MAXIMIZE THE ACHIEVEMENT OF THE PURPOSES OF THIS ARTICLE.

4. (A) AN ACO SHALL USE ITS BEST EFFORTS TO INCLUDE AMONG ITS PARTICIPANTS, ON REASONABLE TERMS AND CONDITIONS, ANY FEDERALLY-QUALIFIED HEALTH CENTER THAT IS WILLING TO BE A PARTICIPANT AND THAT SERVES THE AREA AND POPULATION SERVED BY THE ACO.

(B) 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 PERSON WITH RESPECT TO ENROLLING OR PARTICIPATING IN THE ACO.

(C) 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.

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

(E) AN ACO MAY NOT LIMIT OR RESTRICT BENEFICIARIES TO USE OF PROVIDERS CONTRACTED OR AFFILIATED WITH THE ACO. AN ACO MAY NOT REQUIRE A PATIENT TO OBTAIN THE PRIOR APPROVAL, FROM A PRIMARY CARE GATEKEEPER OR OTHERWISE, BEFORE UTILIZING THE SERVICES OF OTHER PROVIDERS. AN ACO MAY NOT MAKE ADVERSE DETERMINATIONS AS DEFINED IN ARTICLE FORTY-NINE OF THIS CHAPTER.

5. AN ACO MAY PROVIDE CARE COORDINATION FOR ITS PARTICIPATING PATIENTS, WHICH (A) SHALL INCLUDE BUT NOT BE LIMITED TO MANAGING, REFERRING TO, LOCATING, COORDINATING, AND MONITORING HEALTH CARE SERVICES FOR THE MEMBER TO ASSURE THAT ALL MEDICALLY NECESSARY HEALTH CARE SERVICES ARE MADE AVAILABLE TO AND ARE EFFECTIVELY USED BY THE MEMBER IN A TIMELY MANNER, CONSISTENT WITH PATIENT AUTONOMY; AND (B) IS NOT A REQUIREMENT FOR PRIOR AUTHORIZATION FOR HEALTH CARE SERVICES, AND REFERRAL SHALL NOT BE REQUIRED FOR A MEMBER TO RECEIVE A HEALTH CARE SERVICE.

6. (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.] (C) AN ACO MAY CONTRACT WITH A THIRD-PARTY HEALTH CARE PAYER TO SERVE AS ALL OR PART OF THE THIRD-PARTY HEALTH CARE PAYER'S PROVIDER NETWORK OR CARE COORDINATION AGENT, PROVIDED IN THAT CASE THE ACO SHALL BE SUBJECT TO ALL PROVISIONS OF THIS CHAPTER OR THE INSURANCE LAW WHICH ARE APPLICABLE TO THE PROVIDER NETWORK OF THE THIRD-PARTY HEALTH CARE PAYER.

7. 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.

S 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] SHALL 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] SHALL 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.

4. 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, INCLUDING DRAFTS, SUBMITTED TO THE FEDERAL GOVERNMENT 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.

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

(A) CONSUMER ASSISTANCE TO PATIENTS SERVED BY 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; AND

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

S 2. The commissioner of health shall convene a workgroup to develop a proposal whereby an ACO may serve, in place of a managed care plan: (a) Medicaid enrollees otherwise required to participate in managed care, care management, or care coordination under section 364-j of the social services law, section 4403-f of the public health law, or other law; and (b) enrollees in family health plus under section 369-ee or section 369-ff of the social services law and the child health insurance plan under title 1-A of article 25 of the public health law. The workgroup shall include, but not be limited to, representatives of: accountable care organizations or entities seeking to form an accountable care organization under article 29-E of the public health law; health care providers serving Medicaid enrollees; Medicaid, family health plus, and child health insurance plan enrollees; and the senate and the assembly. The workgroup shall report its recommendations for regulatory or statutory actions to the governor, the commissioner of health, and the legislature.

S 3. Section 2818 of the public health law is amended by adding a new subdivision 7 to read as follows:

7. 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, THE COMMISSIONER MAY ALLOCATE AND DISTRIBUTE, WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, GRANTS TO ACCOUNTABLE CARE ORGANIZATIONS UNDER ARTICLE TWENTY-NINE-E 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 TWENTY-NINE-E OF THIS CHAPTER IN THE AREA TO BE SERVED.

S 4. This act shall take effect immediately.