26:2H-12.80 to 26:2H-12.83

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2017 **CHAPTER:** 46

NJSA: 26:2H-12.80 to 26:2H-12.83 (Permits hospitals to establish system for making performance-based incentive payments to physicians)

BILL NO: S913 (Substituted for A3404)

SPONSOR(S) Codey and others

DATE INTRODUCED: 2-4-2016

COMMITTEE: **ASSEMBLY:** ---

SENATE: Health, Human Services & Senior Citizens

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** 3-16-2017

SENATE: 12-19-2016

DATE OF APPROVAL: 5-1-2017

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (First Reprint enacted) Yes

S913

SPONSOR'S STATEMENT: (Begins on page 5 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

A3404

SPONSOR'S STATEMENT: (Begins on page 5 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: No

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

(continued)

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: No

RWH/JA

(CORRECTED COPY)
P.L.2017, CHAPTER 46, ***approved May 1, 2017***
Senate, No. 913 ***(First Reprint)***

AN ACT concerning performance-based incentive payments for physicians, amending P.L.1989, c.19, and supplementing Title 26 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 1 of P.L.1989, c.19 (C.45:9-22.4) is amended to read as follows:

For the purposes of this act:

"Health care service" means a business entity which provides on an inpatient or outpatient basis: testing for or diagnosis or treatment of human disease or dysfunction; or dispensing of drugs or medical devices for the treatment of human disease or dysfunction. Health care service includes, but is not limited to, a bioanalytical laboratory, pharmacy, home health care agency, rehabilitation facility, nursing home, hospital, or a facility which provides radiological or other diagnostic imagery services, physical therapy, ambulatory surgery, or ophthalmic services.

"Hospital and physician incentive plan" means a compensation arrangement established pursuant to sections 2 through 4 of P.L. , c. (C.) (pending before the legislature as this bill) between a general acute care hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) and a physician or physician group.

"Immediate family" means the practitioner's spouse and children, the practitioner's siblings and parents, the practitioner's spouse's siblings and parents, and the spouses of the practitioner's children.

"Practitioner" means a physician, chiropractor, or podiatrist licensed pursuant to Title 45 of the Revised Statutes.

"Significant beneficial interest" means any financial interest; but does not include ownership of a building wherein the space is leased to a person at the prevailing rate under a straight lease agreement, payments made by a hospital to a physician pursuant to a hospital and physician incentive plan, or any interest held in publicly traded securities.

(cf: P.L.1991, c.187, s.83)

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate SHH committee amendments adopted November 3, 2016.

2. (New section) a. A hospital may establish a hospital and physician incentive plan, which shall meet the requirements set forth in sections 2, 3, and 4 of this act.

b. A hospital that establishes a hospital and physician incentive plan shall contract, directly or indirectly, with an independent third party to administer the plan, including applying the plan's incentive methodology and calculating direct payments of incentives from the hospital to physicians, which shall be based on the physician's performance in meeting the hospital's institutional and specialty-specific goals as determined using an incentive payment methodology that meets the requirements set forth in section 4 of this act.

c. A hospital that establishes a hospital and physician incentive plan shall establish a hospital steering committee, which shall meet the requirements set forth in section 4 of this act.

d. If a hospital and physician incentive plan includes multiple hospital participants, the plan shall utilize a facilitator-convener to provide for efficient implementation and operation of the plan. For each hospital, the facilitator-convener shall coordinate with the independent third party administering the plan and with the hospital steering committee to facilitate plan administration, disseminate information concerning best practices, and serve as the point of contact for the Department of Health.

3. (New section) a. Except for plans limited to specific clinical specialties or diagnosis related groups, a hospital and physician incentive plan shall apply to all admissions and all inpatient costs related to those admissions in a given program. Plans shall be open to all surgeons and attending physicians of record and may, at the discretion of a participating hospital, include other physicians involved in the provision of inpatient care. A physician shall not be eligible to participate in a plan unless the physician has been on the medical staff of the hospital for at least one year, except that these restrictions shall not apply to hospitalists and physicians who are new to the participating hospital's geographic area. Each plan shall include a mechanism to limit incentives attributable to year-to-year increases in patient volume for physicians on staff with multiple admitting privileges.

b. (1) A hospital and physician incentive plan shall be filed with the Department of Health by the hospital or facilitator-convener prior to the anticipated start date of the plan. The plan shall set forth the physician incentive methodology, institutional and specialty-specific goals, quality and cost performance standards, and any standards, programs, or protocols designed to ensure the plan meets the requirements of this act. Hospitals that have implemented a hospital and physician incentive plan shall submit an annual report to the department setting forth the distributions made to physicians, quality and cost performance

standards, proposed revisions to the plan, if any, and such other information as the department may require.

(2) The department shall review plans submitted pursuant to paragraph (1) of this subsection, and shall notify the hospital if its plan does not meet the requirements of this act. The department shall provide the hospital with a reasonable opportunity to remedy any deficiencies in the plan, and may terminate a plan that continues to fail to meet the requirements of this act.

c. (1) A participating physician may withdraw from a plan upon reasonable notice to the hospital.

(2) A hospital may terminate a plan upon reasonable notice to the department and to physicians participating in the plan.

d. Patients shall be notified of the hospital and physician incentive plan in advance of admission to the hospital.

4. (New section) a. A hospital steering committee shall establish institutional and specialty-specific goals related to patient safety, quality of care, and operational performance, which may incorporate specific patient management tasks, care redesign initiatives, and patient safety and quality of care objectives. In establishing these goals, the committee shall prioritize institution-specific quality commitments and shall condition incentive payments, as well as physician participation, upon the successful response to these goals. In addition, the committee shall ensure that:

(1) no payments may be made for reducing or limiting medically necessary care;

(2) the appropriate course of treatment for each patient is determined, in consultation with the patient or the patient's representative, by the attending physician or surgeon of record;

(3) adequate safeguards are in place to ensure that there are no incentives to avoid difficult or complex medical cases, or to withhold, reduce, or limit quality care;

(4) no incentive payment may be made in any individual case for exceeding best practice standards established under the plan; and

(5) overall payments to individual physicians under a plan shall not exceed 50 percent of the total professional payments for services related to the cases for which that physician receives incentive payments under the plan.

b. The steering committee shall establish an incentive payment methodology, which shall be internally consistent and shall ensure that:

(1) individual physician performance is objectively measured, taking into account the severity of the medical issues presented by an individual patient;

(2) incentive payments objectively correlate with physician performance and are applied in a consistent manner to all physicians participating in the plan;

(3) participating physicians are treated uniformly relative to their respective individual contributions to institutional efficiency and quality of patient care;

(4) performance and best practice standards established under the plan are based primarily on local and regional data;

(5) the methodology recognizes both individual physician performance, including a physician's utilization of inpatient resources compared to the physician's peers, and improvements in individual physician performance, including a physician's utilization of inpatient resources compared with the physician's own performance over time; and

(6) the elements of the methodology are properly balanced to meet the needs of physicians, hospitals, and patients.

c. The steering committee shall adopt a mechanism to protect the financial health of the hospital.

d. At least half of the members of the steering committee shall be physicians.

[1]5. (New section) a. The Department of Health shall review each hospital and physician incentive plan filed with the department at least once every six years to determine whether the plan is operated in compliance with this act and other relevant State and federal laws and regulations, and whether the hospital and physician incentive plan has resulted in a degradation of quality of health care provided to patients attributable to the hospital and physician incentive plan.

b. The department shall have authority to terminate a hospital and physician incentive plan if the department's review finds that the hospital and physician incentive plan fails to comply with State or federal law, or if it results in a degradation of quality of patient care.

c. A hospital and physician incentive plan shall not expire or otherwise be terminated solely as a result of the department's failure to conduct a review required pursuant to subsection a. of this section.[1]

[1][5.] 6.[1] This act shall take effect immediately.

Permits hospitals to establish system for making performance-based incentive payments to physicians.

SENATE, No. 913

STATE OF NEW JERSEY

217th LEGISLATURE

INTRODUCED FEBRUARY 4, 2016

Sponsored by:
Senator RICHARD J. CODEY
District 27 (Essex and Morris)
Senator JOSEPH F. VITALE
District 19 (Middlesex)

SYNOPSIS

Permits hospitals to establish system for making performance-based incentive payments to physicians.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 11/4/2016)

AN ACT concerning performance-based incentive payments for physicians, amending P.L.1989, c.19, and supplementing Title 26 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 1 of P.L.1989, c.19 (C.45:9-22.4) is amended to read as follows:

For the purposes of this act:

"Health care service" means a business entity which provides on an inpatient or outpatient basis: testing for or diagnosis or treatment of human disease or dysfunction; or dispensing of drugs or medical devices for the treatment of human disease or dysfunction. Health care service includes, but is not limited to, a bioanalytical laboratory, pharmacy, home health care agency, rehabilitation facility, nursing home, hospital, or a facility which provides radiological or other diagnostic imagery services, physical therapy, ambulatory surgery, or ophthalmic services.

"Hospital and physician incentive plan" means a compensation arrangement established pursuant to sections 2 through 4 of P.L. , c. (C.) (pending before the legislature as this bill) between a general acute care hospital licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) and a physician or physician group.

"Immediate family" means the practitioner's spouse and children, the practitioner's siblings and parents, the practitioner's spouse's siblings and parents, and the spouses of the practitioner's children.

"Practitioner" means a physician, chiropractor, or podiatrist licensed pursuant to Title 45 of the Revised Statutes.

"Significant beneficial interest" means any financial interest; but does not include ownership of a building wherein the space is leased to a person at the prevailing rate under a straight lease agreement, payments made by a hospital to a physician pursuant to a hospital and physician incentive plan, or any interest held in publicly traded securities.

(cf: P.L.1991, c.187, s.83)

2. (New section) a. A hospital may establish a hospital and physician incentive plan, which shall meet the requirements set forth in sections 2, 3, and 4 of this act.

b. A hospital that establishes a hospital and physician incentive plan shall contract, directly or indirectly, with an independent third party to administer the plan, including applying the plan's incentive methodology and calculating direct payments of incentives from the hospital to physicians, which shall be based on the physician's

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

performance in meeting the hospital's institutional and specialty-specific goals as determined using an incentive payment methodology that meets the requirements set forth in section 4 of this act.

c. A hospital that establishes a hospital and physician incentive plan shall establish a hospital steering committee, which shall meet the requirements set forth in section 4 of this act.

d. If a hospital and physician incentive plan includes multiple hospital participants, the plan shall utilize a facilitator-convener to provide for efficient implementation and operation of the plan. For each hospital, the facilitator-convener shall coordinate with the independent third party administering the plan and with the hospital steering committee to facilitate plan administration, disseminate information concerning best practices, and serve as the point of contact for the Department of Health.

3. (New section) a. Except for plans limited to specific clinical specialties or diagnosis related groups, a hospital and physician incentive plan shall apply to all admissions and all inpatient costs related to those admissions in a given program. Plans shall be open to all surgeons and attending physicians of record and may, at the discretion of a participating hospital, include other physicians involved in the provision of inpatient care. A physician shall not be eligible to participate in a plan unless the physician has been on the medical staff of the hospital for at least one year, except that these restrictions shall not apply to hospitalists and physicians who are new to the participating hospital's geographic area. Each plan shall include a mechanism to limit incentives attributable to year-to-year increases in patient volume for physicians on staff with multiple admitting privileges.

b. (1) A hospital and physician incentive plan shall be filed with the Department of Health by the hospital or facilitator-convener prior to the anticipated start date of the plan. The plan shall set forth the physician incentive methodology, institutional and specialty-specific goals, quality and cost performance standards, and any standards, programs, or protocols designed to ensure the plan meets the requirements of this act. Hospitals that have implemented a hospital and physician incentive plan shall submit an annual report to the department setting forth the distributions made to physicians, quality and cost performance standards, proposed revisions to the plan, if any, and such other information as the department may require.

(2) The department shall review plans submitted pursuant to paragraph (1) of this subsection, and shall notify the hospital if its plan does not meet the requirements of this act. The department shall provide the hospital with a reasonable opportunity to remedy any deficiencies in the plan, and may terminate a plan that continues to fail to meet the requirements of this act.

c. (1) A participating physician may withdraw from a plan upon reasonable notice to the hospital.

(2) A hospital may terminate a plan upon reasonable notice to the department and to physicians participating in the plan.

d. Patients shall be notified of the hospital and physician incentive plan in advance of admission to the hospital.

4. (New section) a. A hospital steering committee shall establish institutional and specialty-specific goals related to patient safety, quality of care, and operational performance, which may incorporate specific patient management tasks, care redesign initiatives, and patient safety and quality of care objectives. In establishing these goals, the committee shall prioritize institution-specific quality commitments and shall condition incentive payments, as well as physician participation, upon the successful response to these goals. In addition, the committee shall ensure that:

(1) no payments may be made for reducing or limiting medically necessary care;

(2) the appropriate course of treatment for each patient is determined, in consultation with the patient or the patient's representative, by the attending physician or surgeon of record;

(3) adequate safeguards are in place to ensure that there are no incentives to avoid difficult or complex medical cases, or to withhold, reduce, or limit quality care;

(4) no incentive payment may be made in any individual case for exceeding best practice standards established under the plan; and

(5) overall payments to individual physicians under a plan shall not exceed 50 percent of the total professional payments for services related to the cases for which that physician receives incentive payments under the plan.

b. The steering committee shall establish an incentive payment methodology, which shall be internally consistent and shall ensure that:

(1) individual physician performance is objectively measured, taking into account the severity of the medical issues presented by an individual patient;

(2) incentive payments objectively correlate with physician performance and are applied in a consistent manner to all physicians participating in the plan;

(3) participating physicians are treated uniformly relative to their respective individual contributions to institutional efficiency and quality of patient care;

(4) performance and best practice standards established under the plan are based primarily on local and regional data;

(5) the methodology recognizes both individual physician performance, including a physician's utilization of inpatient

resources compared to the physician's peers, and improvements in individual physician performance, including a physician's utilization of inpatient resources compared with the physician's own performance over time; and

(6) the elements of the methodology are properly balanced to meet the needs of physicians, hospitals, and patients.

c. The steering committee shall adopt a mechanism to protect the financial health of the hospital.

d. At least half of the members of the steering committee shall be physicians.

5. This act shall take effect immediately.

STATEMENT

This bill permits hospitals to implement hospital and physician incentive plans to provide physicians with performance-based incentive payments to increase quality of care and reduce costs.

A hospital that seeks to implement a plan will be required to establish a steering committee to: develop institutional and specialty-specific goals related to patient safety, quality of care, and operational performance; implement an incentive payment methodology that ensures fair and consistent payments that correlate with individual and collective physician performance; and adopt a mechanism to protect the financial health of the hospital. The plan may additionally include specific patient management tasks, care redesign initiatives, and patient safety and quality of care objectives. At least half of the members of the committee are to be physicians.

In developing the goals for a plan, steering committees will be required to ensure that there exist no incentives to reduce the quality or provision of medically-necessary care or to exceed best practice standards. In developing the payment methodology for a plan, steering committees will be required to ensure that physician performances are objectively measured in light of each physician's own performance, the nature of the care provided, improvements in the physician's performance over time, and local and regional standards. Additionally, the methodology is to ensure that payments objectively correlate with physician performances and are uniformly applied with regard to all physicians participating in the plan. Overall payments to individual physicians under a plan will be limited to 50 percent of the total professional payments for services related to the cases for which that physician receives incentive payments under the plan.

Hospital and physician incentive plans will be administered by an independent third party, which will be responsible for applying the plan's incentive methodology and calculating direct incentive

payments to physicians based on the physician's performance in meeting the hospital's institutional and specialty-specific goals, as determined using an incentive payment methodology that meets the requirements set forth in the bill. If the plan includes multiple hospitals, the hospitals will utilize a facilitator-convener to coordinate with each hospital's independent third party administrator and steering committee to facilitate plan administration, disseminate best practices information, and serve as the point of contact with the Department of Health (DOH).

Except for plans limited to specific clinical specialties or diagnosis related groups, hospital and physician incentive plans will apply to all admissions and all inpatient costs related to those admissions in a given program. Plans will be open to all surgeons and attending physicians of record who have been on the medical staff of the hospital for at least one year, except that this restriction will not apply to hospitalists and physicians who are new to the participating hospital's geographic area. Hospitals will have the discretion to additionally open their plans to other physicians involved in the provision of inpatient care. Each plan is to include a mechanism to limit incentives attributable to year-to-year increases in patient volume for physicians on staff with multiple admitting privileges. Patients are to be notified of a hospital and physician incentive plan in advance of admission.

A hospital or facilitator-convener will be required to file a prospective plan with DOH prior to the anticipated start date of the plan, and will be required to submit an annual report to DOH detailing distributions to physicians, the plan's quality and cost performance standards, proposed revisions to the plan, and such other information as the department may require. DOH will be required to notify a hospital if its plan does not meet the requirements established under the bill, and provide the hospital with a reasonable opportunity to remedy any deficiencies in the plan. If a hospital does not bring its plan into compliance with the requirements of the bill, DOH will be permitted to terminate the plan. Physicians will be permitted to withdraw from a plan upon reasonable notice to the hospital, and hospitals may terminate a plan upon reasonable notice to DOH and to participating physicians.

The bill amends P.L.1989, c.19 (C.45:9-22.4 et seq.) to provide that payments made to a physician under a hospital and physician incentive plan do not violate the statutory prohibition against physician self-referrals.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

SENATE, No. 913

with committee amendments

STATE OF NEW JERSEY

DATED: NOVEMBER 3, 2016

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with committee amendments Senate Bill No. 913.

As amended by the committee, this bill permits hospitals to implement hospital and physician incentive plans to provide physicians with performance-based incentive payments to increase quality of care and reduce costs.

A hospital that seeks to implement a plan will be required to establish a steering committee to: develop institutional and specialty-specific goals related to patient safety, quality of care, and operational performance; implement an incentive payment methodology that ensures fair and consistent payments that correlate with individual and collective physician performance; and adopt a mechanism to protect the financial health of the hospital. The plan may additionally include specific patient management tasks, care redesign initiatives, and patient safety and quality of care objectives. At least half of the members of the committee are to be physicians.

In developing the goals for a plan, steering committees will be required to ensure that there exist no incentives to reduce the quality or provision of medically-necessary care or to exceed best practice standards. In developing the payment methodology for a plan, steering committees will be required to ensure that physician performances are objectively measured in light of each physician's own performance, the nature of the care provided, improvements in the physician's performance over time, and local and regional standards. Additionally, the methodology is to ensure that payments objectively correlate with physician performances and are uniformly applied with regard to all physicians participating in the plan. Overall payments to individual physicians under a plan will be limited to 50 percent of the total professional payments for services related to the cases for which that physician receives incentive payments under the plan.

Hospital and physician incentive plans will be administered by an independent third party, which will be responsible for applying the

plan's incentive methodology and calculating direct incentive payments to physicians based on the physician's performance in meeting the hospital's institutional and specialty-specific goals, as determined using an incentive payment methodology that meets the requirements set forth in the bill. If the plan includes multiple hospitals, the hospitals will utilize a facilitator-convener to coordinate with each hospital's independent third party administrator and steering committee to facilitate plan administration, disseminate best practices information, and serve as the point of contact with the Department of Health (DOH).

Except for plans limited to specific clinical specialties or diagnosis related groups, hospital and physician incentive plans will apply to all admissions and all inpatient costs related to those admissions in a given program. Plans will be open to all surgeons and attending physicians of record who have been on the medical staff of the hospital for at least one year, except that this restriction will not apply to hospitalists and physicians who are new to the participating hospital's geographic area. Hospitals will have the discretion to additionally open their plans to other physicians involved in the provision of inpatient care. Each plan is to include a mechanism to limit incentives attributable to year-to-year increases in patient volume for physicians on staff with multiple admitting privileges. Patients are to be notified of a hospital and physician incentive plan in advance of admission.

A hospital or facilitator-convener will be required to file a prospective plan with DOH prior to the anticipated start date of the plan, and will be required to submit an annual report to DOH detailing distributions to physicians, the plan's quality and cost performance standards, proposed revisions to the plan, and such other information as the department may require. DOH will be required to notify a hospital if its plan does not meet the requirements established under the bill, and provide the hospital with a reasonable opportunity to remedy any deficiencies in the plan. If a hospital does not bring its plan into compliance with the requirements of the bill, DOH will be permitted to terminate the plan. Physicians will be permitted to withdraw from a plan upon reasonable notice to the hospital, and hospitals may terminate a plan upon reasonable notice to DOH and to participating physicians.

The DOH will review each hospital and physician incentive plan at least once every six years to determine whether the plan is operated in compliance with this act and other relevant State and federal laws and regulations, and whether the hospital and physician incentive plan has resulted in a degradation of quality of health care provided to patients attributable to the hospital and physician incentive plan. The department will have authority to terminate a hospital and physician incentive plan if the department's review finds that the hospital and physician incentive plan fails to comply with State or federal law, or if it results in a degradation of quality of patient care. A hospital and

physician incentive plan would not expire or otherwise be terminated solely as a result of the department's failure to conduct such a review.

The bill amends P.L.1989, c.19 (C.45:9-22.4 et seq.) to provide that payments made to a physician under a hospital and physician incentive plan do not violate the statutory prohibition against physician self-referrals.

The committee amended the bill to add the requirement that the DOH review, and potentially terminate, hospital and physician incentive plans every six years.

ASSEMBLY, No. 3404

STATE OF NEW JERSEY

217th LEGISLATURE

INTRODUCED MARCH 3, 2016

Sponsored by:
Assemblyman JOHN J. BURZICHELLI
District 3 (Cumberland, Gloucester and Salem)
Assemblyman CRAIG J. COUGHLIN
District 19 (Middlesex)

Co-Sponsored by:
Assemblywoman Pinkin

SYNOPSIS

Permits hospitals to establish system for making performance-based incentive payments to physicians.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 3/15/2016)

AN ACT concerning performance-based incentive payments for physicians, amending P.L.1989, c.19, and supplementing Title 26 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 1 of P.L.1989, c.19 (C.45:9-22.4) is amended to read as follows:

For the purposes of this act:

"Health care service" means a business entity which provides on an inpatient or outpatient basis: testing for or diagnosis or treatment of human disease or dysfunction; or dispensing of drugs or medical devices for the treatment of human disease or dysfunction. Health care service includes, but is not limited to, a bioanalytical laboratory, pharmacy, home health care agency, rehabilitation facility, nursing home, hospital, or a facility which provides radiological or other diagnostic imagery services, physical therapy, ambulatory surgery, or ophthalmic services.

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"Immediate family" means the practitioner's spouse and children, the practitioner's siblings and parents, the practitioner's spouse's siblings and parents, and the spouses of the practitioner's children.

"Practitioner" means a physician, chiropractor, or podiatrist licensed pursuant to Title 45 of the Revised Statutes.

"Significant beneficial interest" means any financial interest; but does not include ownership of a building wherein the space is leased to a person at the prevailing rate under a straight lease agreement, payments made by a hospital to a physician pursuant to a hospital and physician incentive plan, or any interest held in publicly traded securities.

(cf: P.L.1991, c.187, s.83)

2. (New section) a. A hospital may establish a hospital and physician incentive plan, which shall meet the requirements set forth in sections 2, 3, and 4 of this act.

b. A hospital that establishes a hospital and physician incentive plan shall contract, directly or indirectly, with an independent third party to administer the plan, including applying the plan's incentive methodology and calculating direct payments of incentives from the hospital to physicians, which shall be based on the physician's

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

performance in meeting the hospital's institutional and specialty-specific goals as determined using an incentive payment methodology that meets the requirements set forth in section 4 of this act.

c. A hospital that establishes a hospital and physician incentive plan shall establish a hospital steering committee, which shall meet the requirements set forth in section 4 of this act.

d. If a hospital and physician incentive plan includes multiple hospital participants, the plan shall utilize a facilitator-convener to provide for efficient implementation and operation of the plan. For each hospital, the facilitator-convener shall coordinate with the independent third party administering the plan and with the hospital steering committee to facilitate plan administration, disseminate information concerning best practices, and serve as the point of contact for the Department of Health.

3. (New section) a. Except for plans limited to specific clinical specialties or diagnosis related groups, a hospital and physician incentive plan shall apply to all admissions and all inpatient costs related to those admissions in a given program. Plans shall be open to all surgeons and attending physicians of record and may, at the discretion of a participating hospital, include other physicians involved in the provision of inpatient care. A physician shall not be eligible to participate in a plan unless the physician has been on the medical staff of the hospital for at least one year, except that these restrictions shall not apply to hospitalists and physicians who are new to the participating hospital's geographic area. Each plan shall include a mechanism to limit incentives attributable to year-to-year increases in patient volume for physicians on staff with multiple admitting privileges.

b. (1) A hospital and physician incentive plan shall be filed with the Department of Health by the hospital or facilitator-convener prior to the anticipated start date of the plan. The plan shall set forth the physician incentive methodology, institutional and specialty-specific goals, quality and cost performance standards, and any standards, programs, or protocols designed to ensure the plan meets the requirements of this act. Hospitals that have implemented a hospital and physician incentive plan shall submit an annual report to the department setting forth the distributions made to physicians, quality and cost performance standards, proposed revisions to the plan, if any, and such other information as the department may require.

(2) The department shall review plans submitted pursuant to paragraph (1) of this subsection, and shall notify the hospital if its plan does not meet the requirements of this act. The department shall provide the hospital with a reasonable opportunity to remedy any deficiencies in the plan, and may terminate a plan that continues to fail to meet the requirements of this act.

c. (1) A participating physician may withdraw from a plan upon reasonable notice to the hospital.

(2) A hospital may terminate a plan upon reasonable notice to the department and to physicians participating in the plan.

d. Patients shall be notified of the hospital and physician incentive plan in advance of admission to the hospital.

4. (New section) a. A hospital steering committee shall establish institutional and specialty-specific goals related to patient safety, quality of care, and operational performance, which may incorporate specific patient management tasks, care redesign initiatives, and patient safety and quality of care objectives. In establishing these goals, the committee shall prioritize institution-specific quality commitments and shall condition incentive payments, as well as physician participation, upon the successful response to these goals. In addition, the committee shall ensure that:

(1) no payments may be made for reducing or limiting medically necessary care;

(2) the appropriate course of treatment for each patient is determined, in consultation with the patient or the patient's representative, by the attending physician or surgeon of record;

(3) adequate safeguards are in place to ensure that there are no incentives to avoid difficult or complex medical cases, or to withhold, reduce, or limit quality care;

(4) no incentive payment may be made in any individual case for exceeding best practice standards established under the plan; and

(5) overall payments to individual physicians under a plan shall not exceed 50 percent of the total professional payments for services related to the cases for which that physician receives incentive payments under the plan.

b. The steering committee shall establish an incentive payment methodology, which shall be internally consistent and shall ensure that:

(1) individual physician performance is objectively measured, taking into account the severity of the medical issues presented by an individual patient;

(2) incentive payments objectively correlate with physician performance and are applied in a consistent manner to all physicians participating in the plan;

(3) participating physicians are treated uniformly relative to their respective individual contributions to institutional efficiency and quality of patient care;

(4) performance and best practice standards established under the plan are based primarily on local and regional data;

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resources compared to the physician's peers, and improvements in individual physician performance, including a physician's utilization of inpatient resources compared with the physician's own performance over time; and

(6) the elements of the methodology are properly balanced to meet the needs of physicians, hospitals, and patients.

c. The steering committee shall adopt a mechanism to protect the financial health of the hospital.

d. At least half of the members of the steering committee shall be physicians.

5. This act shall take effect immediately.

STATEMENT

This bill permits hospitals to implement hospital and physician incentive plans to provide physicians with performance-based incentive payments to increase quality of care and reduce costs.

A hospital that seeks to implement a plan will be required to establish a steering committee to: develop institutional and specialty-specific goals related to patient safety, quality of care, and operational performance; implement an incentive payment methodology that ensures fair and consistent payments that correlate with individual and collective physician performance; and adopt a mechanism to protect the financial health of the hospital. The plan may additionally include specific patient management tasks, care redesign initiatives, and patient safety and quality of care objectives. At least half of the members of the committee are to be physicians.

In developing the goals for a plan, steering committees will be required to ensure that there exist no incentives to reduce the quality or provision of medically-necessary care or to exceed best practice standards. In developing the payment methodology for a plan, steering committees will be required to ensure that physician performances are objectively measured in light of each physician's own performance, the nature of the care provided, improvements in the physician's performance over time, and local and regional standards. Additionally, the methodology is to ensure that payments objectively correlate with physician performances and are uniformly applied with regard to all physicians participating in the plan. Overall payments to individual physicians under a plan will be limited to 50 percent of the total professional payments for services related to the cases for which that physician receives incentive payments under the plan.

Hospital and physician incentive plans will be administered by an independent third party, which will be responsible for applying the plan's incentive methodology and calculating direct incentive

payments to physicians based on the physician's performance in meeting the hospital's institutional and specialty-specific goals, as determined using an incentive payment methodology that meets the requirements set forth in the bill. If the plan includes multiple hospitals, the hospitals will utilize a facilitator-convener to coordinate with each hospital's independent third party administrator and steering committee to facilitate plan administration, disseminate best practices information, and serve as the point of contact with the Department of Health (DOH).

Except for plans limited to specific clinical specialties or diagnosis related groups, hospital and physician incentive plans will apply to all admissions and all inpatient costs related to those admissions in a given program. Plans will be open to all surgeons and attending physicians of record who have been on the medical staff of the hospital for at least one year, except that this restriction will not apply to hospitalists and physicians who are new to the participating hospital's geographic area. Hospitals will have the discretion to additionally open their plans to other physicians involved in the provision of inpatient care. Each plan is to include a mechanism to limit incentives attributable to year-to-year increases in patient volume for physicians on staff with multiple admitting privileges. Patients are to be notified of a hospital and physician incentive plan in advance of admission.

A hospital or facilitator-convener will be required to file a prospective plan with DOH prior to the anticipated start date of the plan, and will be required to submit an annual report to DOH detailing distributions to physicians, the plan's quality and cost performance standards, proposed revisions to the plan, and such other information as the department may require. DOH will be required to notify a hospital if its plan does not meet the requirements established under the bill, and provide the hospital with a reasonable opportunity to remedy any deficiencies in the plan. If a hospital does not bring its plan into compliance with the requirements of the bill, DOH will be permitted to terminate the plan. Physicians will be permitted to withdraw from a plan upon reasonable notice to the hospital, and hospitals may terminate a plan upon reasonable notice to DOH and to participating physicians.

The bill amends P.L.1989, c.19 (C.45:9-22.4 et seq.) to provide that payments made to a physician under a hospital and physician incentive plan do not violate the statutory prohibition against physician self-referrals.

ASSEMBLY HEALTH AND SENIOR SERVICES COMMITTEE

STATEMENT TO

ASSEMBLY, No. 3404

with committee amendments

STATE OF NEW JERSEY

DATED: DECEMBER 5, 2016

The Assembly Health and Senior Services Committee reports favorably and with committee amendments Assembly Bill No. 3404.

As amended, this bill permits hospitals to implement hospital and physician incentive plans to provide physicians with performance-based incentive payments to increase quality of care and reduce costs.

A hospital that seeks to implement a plan will be required to establish a steering committee to: develop institutional and specialty-specific goals related to patient safety, quality of care, and operational performance; implement an incentive payment methodology that ensures fair and consistent payments that correlate with individual and collective physician performance; and adopt a mechanism to protect the financial health of the hospital. The plan may additionally include specific patient management tasks, care redesign initiatives, and patient safety and quality of care objectives. At least half of the members of the committee are to be physicians.

In developing the goals for a plan, steering committees will be required to ensure that there exist no incentives to reduce the quality or provision of medically-necessary care or to exceed best practice standards. In developing the payment methodology for a plan, steering committees will be required to ensure that physician performances are objectively measured in light of each physician's own performance, the nature of the care provided, improvements in the physician's performance over time, and local and regional standards. Additionally, the methodology is to ensure that payments objectively correlate with physician performances and are uniformly applied with regard to all physicians participating in the plan. Overall payments to individual physicians under a plan will be limited to 50 percent of the total professional payments for services related to the cases for which that physician receives incentive payments under the plan.

Hospital and physician incentive plans will be administered by an independent third party, which will be responsible for applying the plan's incentive methodology and calculating direct incentive

payments to physicians based on the physician's performance in meeting the hospital's institutional and specialty-specific goals, as determined using an incentive payment methodology that meets the requirements set forth in the bill. If the plan includes multiple hospitals, the hospitals will utilize a facilitator-convener to coordinate with each hospital's independent third party administrator and steering committee to facilitate plan administration, disseminate best practices information, and serve as the point of contact with the Department of Health (DOH).

Except for plans limited to specific clinical specialties or diagnosis related groups, hospital and physician incentive plans will apply to all admissions and all inpatient costs related to those admissions in a given program. Plans will be open to all surgeons and attending physicians of record who have been on the medical staff of the hospital for at least one year, except that this restriction will not apply to hospitalists and physicians who are new to the participating hospital's geographic area. Hospitals will have the discretion to additionally open their plans to other physicians involved in the provision of inpatient care. Each plan is to include a mechanism to limit incentives attributable to year-to-year increases in patient volume for physicians on staff with multiple admitting privileges. Patients are to be notified of a hospital and physician incentive plan in advance of admission.

A hospital or facilitator-convener will be required to file a prospective plan with DOH prior to the anticipated start date of the plan, and will be required to submit an annual report to DOH detailing distributions to physicians, the plan's quality and cost performance standards, proposed revisions to the plan, and such other information as the department may require. DOH will be required to notify a hospital if its plan does not meet the requirements established under the bill, and provide the hospital with a reasonable opportunity to remedy any deficiencies in the plan. If a hospital does not bring its plan into compliance with the requirements of the bill, DOH will be permitted to terminate the plan. Physicians will be permitted to withdraw from a plan upon reasonable notice to the hospital, and hospitals may terminate a plan upon reasonable notice to DOH and to participating physicians.

As amended, the bill requires DOH to review each hospital and physician incentive plan at least once every six years to determine whether the plan is operated in compliance with the bill and other relevant State and federal laws and regulations, and whether the hospital and physician incentive plan has resulted in a degradation of quality of health care provided to patients attributable to the hospital and physician incentive plan. DOH will have the authority to terminate a hospital and physician incentive plan if its review finds that the hospital and physician incentive plan fails to comply with State or federal law, or if the plan results in a degradation of quality of

patient care. A hospital and physician incentive plan will not expire or otherwise be terminated solely as a result of DOH's failure to conduct this review.

As amended, the bill amends P.L.1989, c.19 (C.45:9-22.4 et seq.) to provide that payments made to a physician under a hospital and physician incentive plan do not violate the statutory prohibition against physician self-referrals.

COMMITTEE AMENDMENTS:

The committee amended the bill to add a requirement for the Department of Health to review, and potentially terminate, hospital and physician incentive plans every six years.

Governor Christie Takes Action On Pending Legislation

Monday, May 1, 2017 Tags: Addiction Taskforce

Trenton, NJ - Governor Chris Christie signed into law today several bills to empower New Jersey's military members and veterans, including a bipartisan initiative to create the "Veterans Diversion Program."

The new law, S-307/A-4362 (Van Drew, Allen/Andrzejczak, Mazzeo, Land, Tucker, Benson, Bramnick), requires the New Jersey Department of Military and Veterans Affairs to collaborate with its federal counterpart and develop a statewide program providing appropriate case management and mental health services to eligible military service members who have committed nonviolent offenses. The department will publicize a directory of existing federal and State case management and mental health program locations, which will serve as points of entry to facilitate support and services.

"It is impossible to imagine the courage, sacrifices and experiences of the men and women who put their lives on the line to protect the American people and our freedom," Governor Christie said. "This critical legislation gives back by supporting New Jersey's military service members when they need it most and when their lives depend on it. This new program will strengthen families and communities, by empowering veterans with individualized, holistic care and steering them clear of the criminal justice system."

Other military and veterans' bills signed by Governor Christie today require the Department of Military and Veterans Affairs (DMAVA) to develop an informational website for Gold Star families; require DMAVA to notify local county veterans' affairs offices and State veterans service offices of the death of a New Jersey or other service member whose surviving beneficiary resides in the State in order to inform the beneficiaries of federal and state benefits and creates a designated Gold Star family member liaison for each county veterans' office; and, retains eligibility for New Jersey National Guard members or reserve components of the U.S. Armed Forces called to active federal military service who met maximum age requirements at the closing date of civil service examinations.

Governor Christie also took action on the following bills:

BILL SIGNINGS:

S-158/A-3631 (Madden, Cruz-Perez/Quijano, Schaer, Vainieri Huttle, Zwicker, Mukherji, Danielsen) - Permits holding companies of eligible New Jersey emerging technology companies to receive investments under "New Jersey Angel Investor Tax Credit Act"

S-227/A-963 (Holzapfel, Allen/Wolfe, McGuckin, Dancer) - Requires DOT, NJTA, and SJTA to use only native vegetation for landscaping, land management, reforestation, or habitat restoration

S-518/A-4452 (Beck/Downey, Houghtaling, Benson, Mukherji, Vainieri Huttle) - Requires sanitation vehicles display flashing lights in certain circumstances and imposes conditions on drivers approaching sanitation vehicles displaying flashing lights; designated as "Michael Massey's Law"

S-724/A-3604 (Cruz-Perez, Allen/Eustace, Wolfe, Mukherji) - Establishes "Integrated Roadside Vegetation Management Program"

S-792/A-1271 (Sarlo/ Caride, Schaer, Pintor Marin) - Permits newly created regional school districts or enlarging regional school districts to determine apportionment methodology for their boards of education on basis other than population

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S-913/A-3404 (Codey, Vitale/Burzichelli, Coughlin, Schaer, Singleton) - Permits hospitals to establish system for making performance-based incentive payments to physicians

S-1059/A-4462 (Diegnan/Lagana, Vainieri Huttle, Mukherji) - Permits amusement games license to be issued to holder of alcoholic beverage special concessionaire permit at certain airports; allows licensees to offer electronic amusements under certain circumstances

S-1398/A-1447 (Weinberg, Gill/Lampitt, Spencer, Vainieri Huttle, McKeon, Mukherji, Holley, Caride, Downey) - Expands infertility coverage under certain health insurance plans

S-1404/A-4423 (Weinberg/Johnson, Benson, Mukherji, Handlin) - Requires governmental affairs agents to disclose on notice of representation form compensation amount received from State or local government entities; requires notice to be posted on Internet site of Election Law Enforcement Commission

S-1475/A-3304 (Ruiz, Vitale/Vainieri Huttle, Mukherji, Holley, Jimenez) - Establishes three-year Medicaid home visitation demonstration project

S-1634/A-3991 (Turner, Stack/Muoio, Wimberly, Johnson, Pintor Marin, Mukherji) - Requires housing authority to advertise when applications are being accepted for housing assistance waiting lists online

S-1761/A-4473 (Rice, Cunningham, Pou/Johnson, Wimberly, Pintor Marin) - Directs Community College Consortium for Workforce and Economic Development to promote basic skills training through organizations dedicated to the economic empowerment of specific segments of society, such as the African American Chamber of Commerce

S-1825/A-3432 (Sarlo, Cruz-Perez, Gordon/Greenwald, Lampitt, Benson, Caride, Chiaravalloti) - Establishes task force to study and make recommendations concerning mobility and support services needs of NJ adults with autism spectrum disorder

S-1856/A-3846 (Pou, Allen/Phoebus, Tucker, Space) - Provides for retained eligibility for members of NJ National Guard or reserve component of US Armed Forces called to active federal military service who met maximum age requirement at closing date of civil service examination

S-2286/A-3083 (Weinberg, Gordon/Vainieri Huttle, Eustace, Johnson) - Establishes Mike Adler Aphasia Task Force to assess needs of persons with aphasia, and their families, and ensure adequate provision of support services and information thereto

S-2414/A-4056 (Scutari/Jimenez, Eustace, Giblin, McKnight) - Requires "Massage and Bodywork Therapist Licensing Act" to require certain class study and examination requirements

S-2856/A-4402 (Beach, Madden/Greenwald, Andrzejczak, Johnson, Rible, Jones, Land, Houghtaling, Benson) - Requires DMVA to notify county veterans' affairs office of death of certain military service members; requires office to have Gold Star liaisons

S-2857/A-4403 (Beach, Madden/Greenwald, Rible, Land, Johnson, Mazzeo, Andrzejczak, Houghtaling, Benson) - Requires Adjutant General to create informational webpage for Gold Star families

S-2868/A-4501 (Pou, Sarlo/Sumter, Wimberly) - Increases value of Economic Redevelopment and Growth Grant program residential tax credits to $823 million; restricts $105 million of tax credits to qualified residential projects and mixed use parking projects

S-3015/A-4623 (Rice, Ruiz/Sumter, Oliver, Schaer, Pintor Marin) - Requires study of program allowing community service in lieu of paying motor vehicle surcharges

SJR-49/AJR-106 (Ruiz, Oroho/Phoebus, Pintor Marin, Space, McKnight, Schepisi) - Designates third week in September of each year as Go Gold for Kids with Cancer Awareness Week"

SJR-75/AJR- 122 (Rice, Codey/Oliver, Giblin, Chiaravalloti, Sumter, Quijano, McKnight) - Establishes "Disparity in State Procurement Study Commission"

BILLS VETOED:

S-596/A-3422 (Cunningham, Greenstein, Sweeney/Benson, Mukherji, Muoio, Holley, Sumter, Downey, Lampitt, Oliver, Danielsen, Wimberly) - CONDITIONAL - Establishes compensation program for law enforcement officers and certain other employees injured while performing official duties

S-690/A-2921 (Gordon, Beach, Eustace, Houghtaling, Pinkin, Mazzeo) - CONDITIONAL - Increases flexibility, clarity, and available tools of optional municipal consolidation process

SCS for S-895/ACS for A-2182 (Lesniak, Beck, Cunningham/Sumter, Holley, Oliver, Jones, Wimberly) - CONDITIONAL - "Earn Your Way Out Act"; requires DOC to develop inmate reentry plan; establishes administrative parole release for certain inmates; requires study and report by DOC on fiscal impact

S-956/A-2202 (Gordon, Bateman/Eustace, Zwicker, O'Scanlon, Downey, Wisniewski, Pinkin) - CONDITIONAL - Authorizes special emergency appropriations for the payment of certain expenses incurred by municipalities to implement a municipal consolidation

S-2844/A-4425 (Vitale, Codey/Vainieri Huttle, Muoio, Eustace, Space, Benson) - CONDITIONAL - Eliminates certificate of need requirement for inpatient hospital beds for treatment of psychiatric and substance use disorder dual

diagnosis

S-3041/ACS for A-2338 (Lesniak/Benson, Vainieri Huttle, Eustace, Gusciora, Mukherji, Jimenez) - CONDITIONAL - Revises "Pet Purchase Protection Act" to establish new requirements for pet dealers and pet shops

S-3048/A-4520 (Weinberg, Turner, Greenstein/McKeon, Singleton, Moriarty, Quijano, Johnson, Benson) - CONDITIONAL - Requires candidates for President and Vice-President of United States to disclose federal income tax returns to appear on ballot; prohibits Electoral College electors from voting for candidates who fail to file income tax returns

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