CHAPTER 111

AN ACT concerning patient referrals by health care practitioners and amending and supplementing P.L.1989, c.19.

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:

C.45:9-22.4 Definitions.

1. For the purposes of P.L.1989, c.19 (C.45:9-22.4 et seq.), P.L.2009, c.24 (C.45:9-22.5a et seq.), and P.L.2017, c.111 (C.45:9-22.5c et al.):

"Alternative payment entity" means an entity authorized to receive compensation for the provision of health care on a basis that entails the assumption of financial risk, including but not limited to an organized delivery system licensed pursuant to P.L.1999, c.409 (C.17:48H-1 et seq.).

"Alternative payment model" means a model of payment operated by Medicare, Medicaid, or a health insurance carrier that:

(1) has been filed with the Department of Health pursuant to section 3 of P.L.2017, c.111 (C.45:9-22.5c);

(2) provides for payment for covered professional services earned by participating health care practitioners and health care services based on approved quality measures; and

(3) (a) requires an alternative payment entity to bear financial risk for monetary losses under the alternative payment model;

(b) is a medical home; or

(c) is an accountable care organization authorized by the Medicare Shared Savings Program pursuant to 42 U.S.C. s.1395jjj or the Center for Medicare and Medicaid Innovation described at 42 U.S.C. s.1315a.

"Alternative payment model standards" means institutional and specialty-specific goals under an alternative payment model related to patient safety, use of approved quality measures, and any other applicable quality of care goals, and operational performance, which may incorporate specific patient management tasks, care redesign initiatives, and patient safety and quality of care objectives.

"Approved quality measure" means an objective measure of quality that:

(1) is identified and submitted by a nationally recognized specialty board of certification or equivalent certification board, or other similar stakeholder;

(2) has been submitted for publication in applicable specialty-appropriate, peer-reviewed journals, with sufficient information to allow an individual with reasonable knowledge of the health care industry to understand the methods for developing and selecting the measure, including clinical and other data supporting the measure;

(3) has been adopted or endorsed by a consensus organization, including but not limited to the National Quality Forum or Ambulatory Care Quality Alliance, including measures that have been submitted by a physician specialty, and that the United States Department of Health and Human Services identifies as having used a consensus-based process for developing such measures;

(4) is included in an annual list of approved quality measures by the Centers for Medicare & Medicaid Services, or on a similar list developed by the Department of Health; or

(5) is collected and reported using a qualified clinical data registry approved for the purpose of reporting the measure by the Centers for Medicare & Medicaid Services.

"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.2017, c.46 (C.26:2H-12.80 through C.26:2H-12.82) 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.

“Participant” means an entity identified by a Tax Identification Number through which one or more practitioners may bill a health insurance carrier or other payor that is operating an Alternative Payment Model, which alone or together with one or more participants compose an alternative payment model.

"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.

2. Section 2 of P.L.1989, c.19 (C.45:9-22.5) is amended to read as follows:

C.45:9-22.5 Referral of patient by practitioner regulated.

2. a. A practitioner shall not refer a patient or direct an employee of the practitioner to refer a patient to a health care service in which the practitioner, or the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a significant beneficial interest; except that, in the case of a practitioner, a practitioner's immediate family, or a practitioner in combination with the practitioner's immediate family who had the significant beneficial interest prior to the effective date of P.L.1991, c.187 (C.26:2H-18.24 et al.), and in the case of a significant beneficial interest in a health care service that provides lithotripsy or radiation therapy pursuant to an oncological protocol that was held prior to the effective date of this section of P.L.2009, c.24, the practitioner may continue to refer a patient or direct an employee to do so if that practitioner discloses the significant beneficial interest to the patient.

b. If a practitioner is permitted to refer a patient to a health care service pursuant to this section, the practitioner shall provide the patient with a written disclosure form, prepared pursuant to section 3 of P.L.1989, c.19 (C.45:9-22.6), and post a copy of this disclosure form in a conspicuous public place in the practitioner's office.

c. The restrictions on referral of patients established in this section shall not apply to:

(1) medical treatment or a procedure that is provided at the practitioner's medical office and for which a bill is issued directly in the name of the practitioner or the practitioner's medical office;

(2) renal dialysis;

(3) ambulatory surgery or procedures requiring anesthesia performed at a surgical practice registered with the Department of Health pursuant to subsection g. of section 12 of P.L.1971, c.136 (C.26:2H-12) or at an ambulatory care facility licensed by the Department of Health to perform surgical and related services or lithotripsy services, if the following conditions are met:

(a) the practitioner who provided the referral personally performs the procedure;

(b) the practitioner's remuneration as an owner of or investor in the practice or facility is directly proportional to the practitioner's ownership interest and not to the volume of patients the practitioner refers to the practice or facility;

(c) all clinically related decisions at a facility owned in part by non-practitioners are made by practitioners and are in the best interests of the patient; and

(d) disclosure of the referring practitioner's significant beneficial interest in the practice or facility is made to the patient in writing, at or prior to the time that the referral is made, consistent with the provisions of section 3 of P.L.1989, c.19 (C.45:9-22.6);

(4) medically necessary intraoperative monitoring services rendered during a neurosurgical, neurological, or neuro-radiological surgical procedure that is performed in a hospital; and

(5) Referrals that a practitioner makes, or directs an employee of the practitioner to make, to a health care service in which the referring practitioner has a significant beneficial interest, when participants in an alternative payment model registered with the Department of Health pursuant to section 3 of P.L.2017, c.111 (C.45:9-22.5c) make a bona fide determination that the significant beneficial interest is reasonably related to the alternative payment model standards filed with the Department of Health, provided that the determination is documented and retained for a period of 10 years.

C.45:9-22.5c Application package to operate an alternate payment model.

3. a. Participants desiring to establish an alternative payment model shall submit to the Department of Health, in a form and manner established by the Department of Health, an application package to operate an alternative payment model. The application shall include:

(1) a description of the alternative payment model, including the participants in the model and how the model satisfies the definition of an alternative payment model in section 1 of P.L.1989, c.19 (C.45:9-22.4);

(2) a description of the organizational structure of the entity responsible for carrying out the alternative payment model, including information on the organizational role of the participants in the alternative payment model, and information regarding the compliance of any alternative payment entity with applicable provisions of P.L.1999, c.409 (C.17:48H-1 et seq.) and regulations adopted pursuant thereto;

(3) the date on which the alternative payment model is proposed to begin operation;

(4) an explanation of how the alternative payment model satisfies the alternative payment model standards; and

(5) other information reasonably requested by the Department of Health.

b. The Department of Health shall review the application submitted pursuant to subsection a. of this section, and shall notify participants in no more than 60 days if the proposed alternative payment model does not meet the requirement of this act. The Department of Health shall provide the participants with a reasonable opportunity to remedy any deficiencies in the alternative payment model proposal, and may terminate an alternative payment model that continues to fail to meet the requirements of this act.

c. Notwithstanding subsections a. and b. of this section, an alternative payment model shall be deemed approved by the Department of Health without further review, and no participant shall be required under this section to file additional information with the department concerning such an alternative payment model, if the alternative payment model has been authorized and approved under the Medicare Shared Savings Program pursuant to 42 U.S.C. s.1395jjj or under a demonstration operated by the Center for Medicare and Medicaid Innovation described at 42 U.S.C. s.1315a.

C.45:9-22.5d Review by DOH.

4. a. The Department of Health shall review each registered alternative payment model at least once every six years to determine whether the participants in the alternative payment model have complied with this act and other relevant State and federal laws and regulations, and whether the alternative payment model has resulted in a degradation of quality of health care provided to patients attributable to the alternative payment model.

b. The department shall have authority to revoke the registration of an alternative payment model if the department's review finds that the alternative payment model fails to comply with State or federal law, or if it results in a degradation of quality of patient care.

c. An alternative payment model's registration 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.

C.45:9-22.5e Rules, regulations.

5. The Commissioner of Health shall, in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), adopt any rules and regulations as the commissioner deems necessary to carry out the provisions of this act.

6. This act shall take effect on the first day of the seventh month next following the date of enactment, except that the Commissioner of Health may take any anticipatory administrative action in advance as shall be necessary for the implementation of this act.

Approved July 13, 2017.