
Recommendations Regarding State Action to Promote and Regulate Accountable Care Organizations (ACOs)

**A Legislative Report Required by Section 6(n) of
the Rhode Island Health Care Reform Act of 2013
RIGL 42-14.5-3**

**Submitted by the Rhode Island Office of the Health Insurance Commissioner
July 28, 2014**

Executive Summary

As directed by Section 6(n) of the Rhode Island Health Care Reform Act of 2013, the Office of the Health Insurance Commissioner (OHIC), in collaboration with the Office of the Lieutenant Governor and the Department of Health, has developed the following recommendations regarding state action to promote and regulate Accountable Care Organizations (ACOs). The act obligates addressing, at a minimum, (1) utilization review; (2) contracting, and; (3) licensing and regulation. For purposes of this report ACOs have been defined as provider-organized entities which:

1. assume accountability for the health and health care of a defined population and use performance measures to self-assess performance;
2. provide or arrange for the provision of services for the covered population and seek to promote coordinated service delivery across the continuum of care;
3. are reimbursed using payment models that at least partially mitigate the volume incentive of fee-for-service payments through opportunity to share generated savings, and perhaps to share generated financial losses relative to a defined budget, and
4. are subject to financial incentives to maintain and/or improve quality, access and/or patient experience.

Recommendations in this report are categorized according to five distinct roles that a state may play in advancing policy:

- **State as convener.** The State can use its informal powers to bring stakeholders together to find common ground among different perspectives and develop consensus positions while providing anti-trust protection.
- **State as purchaser.** The State purchases health care services for approximately 35%¹ of Rhode Islanders, and specifically for state and municipal employees, dependents and retirees, and for Medicaid beneficiaries. The state also contracts with insurers to offer coverage through HealthSource Rhode Island, resulting in coverage of approximately 28,000 Rhode Islanders as of March 31, 2014.²
- **State as regulator.** OHIC influences health insurer, and indirectly, provider behavior through its rate review process and its Affordability Standards. So, too, do the EOHHS agencies exert influence through application of their regulatory authority. DOH regulates health care facilities, but does not currently license or otherwise directly regulate ACOs.
- **State as infrastructure funder.** By funding the development of key infrastructure needed for delivery system transformation, the State can promote delivery system transformation.
- **State as evaluator.** Understanding the impact of decisions made is critical to making wise decisions in the future. One important way to assess the impact of State activities to promote ACO development is to fund an independent evaluation of those activities.

¹ Based on numbers provided by the Office of Employee Benefits, EOHHS, and the Office of Management and Budget.

² Source: Healthsource Rhode Island. See www.healthsourceri.com/press-releases/healthsource-ri-releases-enrollment-demographic-and-volume-data-through-march-31/

The recommendations of the Office of the Health Insurance Commissioner, developed in collaboration with the Office of the Lieutenant Governor and the Department of Health, are as follows.

State as convener

Build on OHIC's continuing effectiveness serving as convener with respect to the Affordability Standards and implement legislation that:

- Designates OHIC as the state agency charged with 1) convening external stakeholders to jointly develop voluntary consensus ACO standards that promote ACO development without inhibiting innovation around new delivery systems and 2) collaborating with the Executive Office of Health and Human Services and the Department of Health to align ACO strategies and support ACO standards development.
- Instructs OHIC to facilitate the development of voluntary standards that address, at a minimum, the following ACO activities:
 - minimum ACO membership for shared savings and/or shared risk contracts;
 - payment models that promote value (i.e., reduced spending growth, improved health care quality and improved population health);
 - accountability for the health outcomes of a defined population;
 - promotion of population health, including via strategies aligned with public health objectives and activities;
 - a common set of measures to track and evaluate ACO performance, and be used in insurer contractual payment arrangements;
 - delivery system models to promote integrated, organized processes across the continuum of care, including care management and integrated behavioral health and substance abuse services, home health care and physical therapy, and
 - governance.
- Provides participating providers and insurers some measure of anti-trust protection when participating in development of voluntary ACO standards by clearly stating that development and implementation of ACOs further State goals of reducing health care costs and improving quality and affordability and that the convening process is intended to qualify for anti-trust immunity under the State Action doctrine.

State as purchaser

Leverage the State's purchasing power by aligning purchasing strategies for obtaining health care coverage for state and municipal employees, dependents and retirees, and for Medicaid beneficiaries, and using the contracting strategies of HealthSource Rhode Island (HealthSource RI), by implementing legislation that:

1. Requires that the Office of Employee Benefits (OEB) health insurer and third-party administrator (TPA) contracts, the Interlocal Risk Management Trust health TPA contracts, and EOHHS Medicaid managed care plan contracts:
 - a. specify that contracted TPAs and health plans pay an increasing percentage of health claims using population-based payment

- methodologies³ with ACOs over the contract term, with an increasing percentage of population-based payment involving downside risk assumption by the contracting ACO over the contract term;
- b. contain adequate and auditable mechanisms to ensure that the contracts adhere to these requirements with public reporting of audit findings;
 - c. be consistent with OHIC Affordability Standards and include no new carrier requirements that are in conflict with the Affordability Standards regarding population-based payment and provider downside risk assumption, and
 - d. be consistent with the voluntary ACO standards developed through the multi-stakeholder convening process.
2. Requires that the plans selected by HealthSource RI utilize population-based provider agreements:
 - a. pay an increasing percentage of health claims using population-based payment methodologies with ACOs over the contract term, with an increasing percentage of population-based payments involving downside risk assumption by the ACO over the contract term;
 - b. contain adequate and auditable mechanisms to ensure that the contracts adhere to these requirements, with public reporting of audit findings;
 - c. be consistent with OHIC Affordability Standards and include no new carrier requirements that are in conflict with the Affordability Standards regarding population-based payment and provider downside risk assumption, and
 - d. be consistent with the voluntary ACO standards developed through the multi-stakeholder convening process.
 3. Continue to support the adoption of patient-centered medical homes by requiring contracts that HealthSource RI, EOHHS and the Office of Employee Benefits have with payers include targets for the percentage of primary care sites that are externally recognized as medical homes and do so in a manner that is consistent with the goals of the OHIC Affordability Standards

³ “Population-based payment methodologies” establish an expected per member per month spending level for a defined patient population against which an ACO’s performance is evaluated. ACOs may share in savings should actual spending fall below the expected level, and may also sometimes share in losses should spending exceed the expected level.

State as regulator

Do not initiate new regulatory activity by state agencies. It is premature to develop licensing standards at this time. Use of existing regulatory authority, and the development of voluntary standards as recommended above, constitutes preferred courses of action.

OHIC, in consultation with DOH, should, however, study the implications of risk assumption by ACOs and consider the potential future need for statutory authority to protect consumers from lost access to necessary services should ACO-associated providers be excessively harmed as a result of downside risk assumption and the financial losses that could result from it.

Finally, determine if licensing complexities are acting as a barrier to ACO development by asking the Department of Health to conduct a study and develop recommendations for the legislature on how state provider licensing requirements could be modernized and streamlined to promote care integration while continuing to protect the safety of patients.

State as funder of infrastructure

Assure the universal availability of key infrastructure that is essential for the successful development and implementation of integrated, coordinated care that is the hallmark of ACOs by passing legislation to:

- Continue to fund the development and implementation of Rhode Island's All-Payer Claims Database (APCD), beginning in 2016 when grant funding ends. Development of the Rhode Island APCD is on-going under the leadership of the Lieutenant Governor's Office with active participation from EOHHS, the Department of Health, OHIC and HealthSource RI. The APCD will support the development of ACOs by responding to a need for comprehensive multi-payer data that allows providers (including those organizing ACOs), consumers, regulators and payers to understand the cost, quality, and utilization of health care. APCDs fill critical information gaps and provide transparency of health care cost, quality and utilization data.
- Enable Rhode Island's many small, unaffiliated primary care practices to operate as medical homes by creating and funding community health teams that provide care management and care coordination services to small practices that are typically without the resources or patient volume to fund internal positions. The community health teams will provide critical transformational services to small, unaffiliated practices, including care management for high-risk patients, and transition of care services to patients moving from inpatient to another facility or to home. By providing these services, the small, unaffiliated practices will be able to move towards a population-based practice model that promotes better chronic care management and prevention. In time, they may also be able to organize and serve as ACOs.
- Fund a public awareness campaign to increase the public's understanding of CurrentCare and how to enroll in order to increase participation. Because CurrentCare employs an "opt-in" model, patients need to understand the benefits of participating in order to make the effort to enroll. A public campaign

can increase awareness of the benefits of CurrentCare and will reinforce requests from providers that patients enroll. In a related appeal, educate Rhode Island physicians on the benefits of using CurrentCare to increase physician use of CurrentCare.

Consider funding some or all of the following infrastructure projects when federal funds become available through the State Innovation Model initiative grant process⁴:

- Create and fund incentives to Medicaid providers who do not qualify for federal Meaningful Use electronic health record incentives, including long-term care providers and behavioral health providers, to adopt electronic health records in order to eliminate service silos and improve integrated care delivery. Long-term care and behavioral health care costs represent a significant portion of the Rhode Island Medicaid budget. The implementation of electronic health records (EHRs) by these providers will open up the opportunity to improve care coordination across the continuum of care, which can lead to cost savings.
- Fund a Rhode Island Care Transformation and Innovation Center and a state-wide learning collaborative to provide technical and educational assistance to providers. Experience in Rhode Island and elsewhere has demonstrated the need for both financial incentives *and* technical assistance to drive successful health care delivery transformation.
- Fund workforce development to meet the new workforce needs of a transformed delivery system. Provider organizations are creating new positions and redefining existing positions. For example, ACOs will need clinical and social service care managers trained in population-based care management principles, medical assistants trained in taking medical histories and managing patient registries, and office nurses trained in quality improvement models. To meet these new workforce challenges, educational initiatives are needed that prepare both those entering the workforce and retrain current workers for these changes.

State as evaluator

Understanding the impact of ACOs and steps taken to promote their growth is critical to making wise decisions in the future. Using federal SIM monies, fund an impartial, in-depth evaluation of ACO impact to ensure that State action to promote ACO development has been to the benefit of patients, employers, providers and to the State as a whole.

⁴ CMS released a Funding Opportunity Announcement for states on May 23, 2014. See <http://innovation.cms.gov/Files/x/StateInnovationRdTwoFOA.pdf>.

I. Background

Efforts to constrain medical expense growth have traditionally focused on administrative mechanisms such as prior authorization of services and limitation of fee growth. These strategies proved ineffective, so focus turned to changing the way that providers were paid for services. Early efforts included the introduction of pay-for-performance arrangements, whereby payers offered incentives to providers for achieving cost and quality performance targets. This, too, generally proved ineffective. As a result focus shifted again, this time to organization of care delivery, and payment models to support new care models.

These new arrangements offered incentives for providers accepting responsibility for the health of a group of patients (often called “population-based care”), and first targeted primary care providers to become patient-centered medical homes (PCMHs). The PCMH concept gained prominence in 2006 when the American College of Physicians developed “The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care” and proposed fundamental changes in the way primary care is developed and reimbursed. In 2007, the major national primary care physician associations developed and endorsed the Joint Principles of the Patient-Centered Medical Home. In 2008 the Rhode Island Office of the Health Insurance Commissioner (OHIC) launched the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) with five primary care practices in order to promote PCMH development in Rhode Island. Concurrently, academics and policy makers were starting to develop new delivery concepts that focused more directly on addressing the fragmented, poorly coordinated health care system that has resulted in waste and poor quality care. In 2006, the Institute of Medicine called for efforts to foster shared accountability among all providers for the quality and cost of care. In a 2007 landmark article, Elliott Fisher, MD of The Dartmouth Institute for Health Policy and Clinical Practice, coined the term Accountable Care Organization (ACO) and provided data to demonstrate the feasibility of defining and evaluating the performance of such organizations.

While there is no single, well-accepted definition of an ACO, there is general agreement that ACOs constitute groups of providers – physicians, other clinicians, hospitals or other providers – that together provide care and share accountability for the cost and quality of care for a population of patients. Payers contract with ACOs to care for a defined group of patients, using financial incentives to encourage ACOs to meet cost and quality goals.

The Patient Protection and Affordable Care Act of 2010 promoted ACO development through CMS Medicare demonstration programs. Provider participation in these demonstration programs has grown significantly since the initial launch in 2011. Medicare announced 32 ACOs in December 2011,⁵ 27 in April 2012,⁶ nearly 90 in July 2012,⁷ and over a hundred in January 2013.⁸ Two organizations serving Rhode Island

⁵ See <http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/>

⁶ See www.cms.gov/apps/media/press/factsheet.asp?Counter=4334

⁷ See www.cms.gov/apps/media/press/factsheet.asp?Counter=4405

residents are participating in the CMS Shared Savings Program ACO program: Coastal Medical, Inc. joined in July 1, 2012 and Southcoast Accountable Care Organization, LLC joined in January 2013.

Commercial payers have also been promoting ACO development. An assessment of the OHIC Affordability Standards in 2013 found that UnitedHealthcare (United) had a shared savings agreement with Lifespan and in June 2014, Blue Cross & Blue Shield of Rhode Island (BCBSRI) announced that it had an accountable care payment model in place with Care New England and a risk-sharing agreement with Lifespan. Coastal Medical has risk sharing contracts with both United and BCBSRI. OHIC conversations with BCBSRI, Tufts Health Plan and United in the spring of 2014 revealed expanding alternative payment activity with emerging ACOs.

With national discussion of ACOs and the start of ACO formation by Rhode Island providers, the state legislature directed the Office of the Health Insurance Commissioner, working with the Office of the Lieutenant Governor, and the Department of Health, to develop recommendations regarding the promotion and regulation of Accountable Care Organizations. This report includes those recommendations.

A. Legislative Mandate

Section 6(n) of the Rhode Island Health Care Reform Act of 2013 specifies as follows:

“On or before July 1, 2014, the Office of the Health insurance commissioner in collaboration with the director of health and lieutenant governor’s office shall submit a report to the general assembly and the governor to inform the design of accountable care organizations (ACOs) in Rhode Island as unique structures for comprehensive healthcare delivery and value based payment arrangements, that shall include, but not limited to:

- (1) Utilization review
- (2) Contracting; and
- (3) Licensing and regulation”

B. Definition of ACO

For the purposes of this report ACOs are defined as provider-organized entities which:

1. assume accountability for the health and health care of a defined population and use performance measures to self-assess performance;
2. provide or arrange for the provision of services for the covered population and seek to promote coordinated service delivery across the continuum of care;
3. are reimbursed using payment models that at least partially mitigate the volume incentive of fee-for-service payments through opportunity to share generated savings, and perhaps to share generated financial losses relative to a defined budget, and

⁸ See www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html

4. are subject to financial incentives to maintain and/or improve quality, access and/or patient experience.

ACOs nationally take different configurations. For example, some ACOs include hospitals and employed physicians, some center around a multi-specialty physician practice, and some have been formed through a confederation of individual provider organizations.

C. Approach

OHIC conducted a thorough review of the different approaches to promotion of ACO development and ACO regulation in states that have been active in promoting ACOs and like organizations, including Alabama, Maine, Massachusetts, Minnesota, New Jersey, New York, Oregon and Vermont. In addition, OHIC and contractors interviewed key stakeholders in Rhode Island, including the Department of Health, the Attorney General's Office, HealthSource Rhode Island, representatives from physician provider organizations and health systems, insurers, business representatives, and health services researchers. Working with the Lieutenant Governor's Office, OHIC also reviewed current public and private activities in Rhode Island regarding ACO activities. OHIC, in collaboration with the Lieutenant Governor's Office and informed by the Department of Health, developed this consensus set of recommendations.

II. Recommendations

This report includes recommendations for State action to advance and guide ACO development. The recommended State actions are defined as falling within five traditional policy-making roles of a state:

- facilitating the development of ACOs as a convener of stakeholders to attain policy consensus;
- promoting the development of ACOs through state purchasing strategies;
- shaping ACOs through regulatory activities to assure that they have the functionality needed to be accountable for the health of a defined population and the financial strength to participate in risk-sharing arrangements with payers and protect consumers;
- supporting development of key infrastructure that ACOs need to be successful, such as an All-Payer Claims Database and health information exchanges, and
- evaluating the effectiveness of ACOs in meeting the health needs of Rhode Island residents.

A. Facilitate ACO development by convening stakeholders for collaboration

The State has a unique opportunity to promote ACO development and ensure necessary protections by convening stakeholders to collaborate on ACO development and implementation. OHIC has very successfully served as a convener to support the development of patient-centered medical homes (PCMHs) for the commercial market. A similar and important role can be served by the State with respect to ACO development.

Recommendation: We recommend that the legislature support OHIC as a convener of stakeholders to support collaborative ACO development, and that the legislature do so by enacting legislation that has three interrelated components:

1. Designate OHIC as the state agency charged with a) convening external stakeholders to jointly develop voluntary consensus ACO standards that promote ACO development without inhibiting innovation around new delivery systems and b) collaborating with the Executive Office of Health and Human Services and the Department of Health to align ACO strategies and support ACO standards development.
2. Instruct OHIC to facilitate the development of voluntary ACO standards that address, at a minimum, the following ACO activities:
 - a. minimum ACO membership for shared savings and/or shared risk contracts;
 - b. payment models that promote value (i.e., reduced spending growth, improved health care quality and improved population health);
 - c. accountability for the health outcomes of a defined population;
 - d. promotion of population health, including via strategies aligned with public health objectives and activities;
 - e. a common set of measures to track and evaluate ACO performance, and be used in insurer contractual payment arrangements;
 - f. delivery system models to promote integrated, organized processes across the continuum of care, including care management and integrated behavioral health and substance abuse services, home health care and physical therapy, and
 - g. governance.
3. Provide participating providers and insurers some measure of anti-trust protection when participating in development of voluntary ACO standards by clearly stating that development and implementation of ACOs further State goals of reducing health care costs and improving quality and affordability and that the convening process is intended to qualify for state action immunity under antitrust laws.

Justification: Unlike many other states, Rhode Island has a track record of successful stakeholder collaborations. The Rhode Island Chronic Care Sustainability Initiative (CSI-RI) experience has demonstrated the willingness of Rhode Island stakeholders to participate in the development of consensus standards and to implement them with the regulatory support of OHIC. This experience has also demonstrated that by working collaboratively under OHIC leadership, the parties are able to develop bold programs that can have a profound impact on Rhode Island's health care sector in a manner that

promotes innovation. In the convener role, OHIC has worked with stakeholders to develop and implement a common patient-centered medical home model, establishing a shared payment model, delineating specific plan responsibilities and collecting, analyzing and distributing a core set of performance measures. By creating a common programmatic framework, OHIC moved the market in a single direction and set the timeframe for change to occur. With all payers acting consistently, providers were able to undertake transformation because they had a sufficient number of patients covered by the PCMH model and funding tied to clear transformation expectations. Both insurer and provider participants have expressed appreciation of having a single, coordinated program because it eases implementation and promotes focused attention.

Within this context, the legislation will provide the necessary policy direction and framework for the convening process to be effective for ACO promotion and development. The legislation will also provide important general guidance regarding the types of standards that OHIC, in collaboration with EOHHS and DOH, might help stakeholders develop and then implement for maximum beneficial impact.

Finally, because there are real risks to insurers and providers for violating anti-trust laws when collaborating on ACO development, including on payment models, the legislation will provide the essential foundation for evoking the State Action doctrine which provides participants with anti-trust protection. To use the State Action doctrine the State must be acting to achieve a clearly stated policy goal and provide active oversight. To provide active oversight, legal experts believe that the convening state agency must attend and provide oversight at all meetings of stakeholders.

B. Promote the development of ACOs through state purchasing activity

Rhode Island has the opportunity to promote ACO development through use of its purchasing authority for state employees, dependents and retirees; for Medicaid beneficiaries; for municipal employees, dependents and retirees (through the Interlocal Risk Management Trust), and for individuals and small businesses (through HealthSource Rhode Island⁹). By aligning its purchasing strategies across these multiple purchasing entities, the State can create critical momentum for ACO development and create a model for private employers to follow.

Recommendation: We recommend that the legislature enact legislation that requires the development and implementation of an aligned purchasing strategy with the following components:

1. The Office of Employee Benefits (OEB) health insurer or third-party administrator (TPA) contracts, the Interlocal Risk Management Trust TPA contracts, and EOHHS managed care plan contracts must:
 - a. specify that contracted TPAs and health plans pay an increasing percentage of health claims using population-based payment methodologies with ACOs over the contract term, and specify that an

⁹ While HealthSource Rhode Island technically does not purchase coverage, it does assume some of the responsibilities of a purchaser when it specified the performance expectations of the carriers who make their products available through HealthSource Rhode Island.

- increasing percentage of population-based payment involve downside risk assumption by the ACO over the contract term;
 - b. contain adequate and auditable mechanisms to ensure that the contracts adhere to these requirements, with public reporting of audit findings;
 - c. be consistent with OHIC Affordability Standards and include no new carrier requirements that are in conflict with the Affordability Standards regarding population-based payment and provider downside risk assumption, and
 - d. be consistent with the voluntary ACO standards developed through the multi-stakeholder convening process.
- 2. The plans selected by HealthSource Rhode Island (Healthsource RI) utilize population-based provider agreements that must:
 - a. pay an increasing percentage of health claims using population-based payment methodologies with ACOs over the contract term, and specify an increasing percentage of population-based payment involve downside risk assumption by the ACO over the contract term;
 - b. contain adequate and auditable mechanisms to ensure that the contracts adhere to these requirements, with public reporting of audit findings;
 - c. be consistent with OHIC Affordability Standards and include no new carrier requirements that are in conflict with the Affordability Standards regarding population-based payment and provider downside risk assumption, and
 - d. be consistent with the voluntary ACO standards developed through the multi-stakeholder convening process.

Justification: As a major purchaser of health insurance coverage in Rhode Island, the state has the market power to motivate and inform responsible payment reform and delivery system transformation. In total, the State purchases health care coverage for over 375,000 people. By requiring insurers and third-party administrators to steadily increase the percentage of covered lives receiving care from PCMHs and under population-based contracts, the State will be providing impetus for both payers and providers to move towards ACO development that is built on a strong primary care foundation and on the consensus standards to reduce spending growth and improve quality. The OHIC Affordability Standards will reinforce the contractual requirements. Other states have used their purchasing powers to differing degrees to promote ACO development. For example, in Illinois legislators have mandated that 50% of Medicaid beneficiaries be enrolled in a coordinated care program by 2015, with one program option being an ACO. The Minnesota and New Jersey legislatures have mandated that each state's Medicaid agency undertake an innovative health care delivery system demonstration, which would include ACOs, without specifying its scope. In both states the Medicaid agencies have pursued ACO contracts as a result of the legislative action. The California Public Employees' Retirement System (CalPERS) promoted ACO development by initiating a successful four-year ACO pilot with hospital systems and

physician groups to provide services to a specified number of patients receiving care from those providers.¹⁰

Health insurance exchanges represent a new mechanism for promoting ACO development. Rhode Island, through HealthSource RI, can support ACO contracting by requiring an increasing percentage of covered lives to be covered by population-based contracts. For providers, this will result in more of their total patient population being covered by population-based payments. This, in turn, provides the critical mass of patient lives and associated funding to warrant undertaking the hard work of health systems transformation. Covered California, the health insurance exchange in that state, used its request for proposals process to direct insurers to pursue value-based payment methods with contracted providers.¹¹

Recommendation: We recommend enacting legislation that continues to support the adoption of patient-centered medical homes by requiring that HealthSource RI, EOHHS and the Office of Employee Benefits contracts with payers include targets as to the percentage of primary care sites that are externally recognized as medical homes and do so in a manner that is consistent with the goals established under the OHIC Affordability Standards.

Justification: On-the-ground experience indicates that a strong primary care foundation is key for ACOs to be successful because of primary care's role in providing enhanced access to efficient care, care coordination and population health management.¹² National discussions support this perspective.¹³ Rhode Island continues to expand PCMH practice transformation through the Affordability Standards. By having HealthSource RI, EOHHS and the Office of Employee Benefits also support PCMH transformation, practices will have the additional critical mass of patients and associated payments to see transformation as achievable. For practices that do not join an ACO, functioning as a PCMH will promote better coordinated, high quality, lower cost care.

C. Promote the development of ACOs through state regulatory activity

We are not recommending the promulgation of any new regulations. We find it to be premature to develop licensing standards at this time. Use of existing regulatory authority, and the development of voluntary standards as recommended above, constitute a preferred course of action. However, there is reason to consider potential future action to respond to risks to consumers should insurers transfer financial risk to ACOs. In addition, concerns have been raised that existing licensing requirements are inhibiting the development of ACOs.

¹⁰ See <http://healthaffairs.org/blog/2014/04/17/four-years-into-a-commercial-aco-for-calpers-substantial-savings-and-lessons-learned/>

¹¹ See <http://hbex.coveredca.com/solicitations/QHP/>

¹² See a discussion of the experience of Mercy Medical Partners & Mercy Clinical Integrated Network, available at: www.beckershospitalreview.com/accountable-care-organizations/transforming-aco-physician-practices-into-patient-centered-medical-homes.html

¹³ Kibbe DC. "PCMH and ACO: Opposed or Mutually Supportive?" *Family Practice Management* November-December 2010.

Recommendation: a) Direct OHIC to study emerging patterns in ACO financial risk assumption and practices in other states to regulate provider risk assumption in some fashion (e.g., Massachusetts' new requirements for "risk-bearing entities") and, in consultation with DOH, make future recommendations regarding potentially statutory authority to protect consumers should ACO financial risk assumption result in injurious losses to ACO-associated providers that create impediments to health care access. b) Ask the Department of Health to conduct a study and develop recommendations for the legislature on how health care facility licensing requirements could be modernized and streamlined to promote ACO care integration while continuing to protect the safety of patients.

Justification: a) While our study revealed that Rhode Island ACOs are not currently assuming downside financial risk, we anticipate their doing so in the future. For ACOs with sufficient management, infrastructure and financial capacity, this evolutionary step may result in improved care management and insurance affordability. However, for providers ill-prepared to assume downside risk, there is reason for concern that large financial losses would harm ACO-associated providers, and indirectly, Rhode Islanders. Therefore, OHIC monitoring and consideration of the potential future need for and shape of statutory authority is warranted and recommended.

b) One barrier to ACO development that was identified through provider interviews is the State's complicated and inconsistent licensing process. Currently licensing requirements are tied to the type of organization seeking a license (e.g., hospital, organized ambulatory care facility, physician) and not to the type of service being provided. As a result, while opening a one-doctor medical office requires no public review if a doctor is the initiator, if a community health center is the initiator, the new office is considered an entirely new health care facility that requires Health Services Council consideration and DOH Director approval. Furthermore, if a hospital is the initiator, the hospital is adding an "additional premise" that requires administrative approval by DOH staff. Thus, there are three different approval processes for the same licensed professional, providing the same services, in the same location depending upon the entity opening the practice.

As ACOs develop under different organizational structures -- with some being hospital-driven, others physician-driven, and still others being community health center-driven -- simplifying licensing requirements to facilitate expansion of community-based services and improving patient access to care could remove a key barrier to the benefits envisioned for ACOs.

D. Support ACO development by creating infrastructure needed for ACO operation

We have identified three key areas of infrastructure development that would promote ACO operation and which would benefit from state funding support. We have also recommended that Rhode Island use federal State Innovation Model (SIM) funds,

should they become available in the future following state application¹⁴, to support three additional infrastructure projects. Each infrastructure project is discussed below.

State-funded projects

1. All-payer claims database

Providers, policymakers, employers and consumers must have timely and reliable information to guide development and oversight of effective ACOs that reduce costs and improve quality. Over the past ten years, a growing number of states have been establishing All-Payer Claims Databases (APCD), which are large-scale databases that systematically collect medical and pharmacy claims and eligibility and provider files from private and public payers. They are intended to fill critical public information gaps, support health care and payment reform initiatives, and generally address the need for transparency in health care.

Currently Rhode Island consumers receive little data and providers may receive a variety of different reports from payers that do not convey the same information in the same format, making it very difficult to use on a practice or ACO level. To respond to this need, Rhode Island is in the process of developing an APCD. The APCD project is an interagency initiative, facilitated by the Lieutenant Governor's Office, with active participation from EOHHS, the Department of Health, OHIC and HealthSource RI. Currently, the APCD development is funded through grant dollars which end in 2015.

Recommendation: At the end of 2015, continue to fund the operational costs of Rhode Island's all-payer claims database.

Justification: The mission of the Rhode Island APCD is to provide actionable data to support the study and comparison of healthcare utilization, cost, and trends; to identify opportunities for improvement in health care quality in Rhode Island; and, to inform consumers.¹⁵

Still in its development, when fully implemented, the APCD will serve as a tool for state government and academic researchers to provide information to identify areas for improvement across the health care system and to provide actionable comparison data for consumers, payers, providers and policy makers. It will provide Rhode Island policy makers with data capable of improving their understanding of disease prevalence and trends in utilization, cost and quality of the care provided to Rhode Islanders.

The APCD will also be used to ensure transparency of information about the quality, cost, efficiency, and access of Rhode Island's health care delivery system. It will provide state agencies and policy makers with the information they need to improve the value of

¹⁴ CMS released a Funding Opportunity Announcement for states on May 23, 2014. See <http://innovation.cms.gov/Files/x/StateInnovationRdTwoFOA.pdf>.

¹⁵ See the Rhode Island Department of Health website. Available at: www.health.ri.gov/partners/collaboratives/allpayerclaimsdatabase/

health care for Rhode Islanders.¹⁶ Examples of reports using APCD data developed by other states are available at the APCD Council's website.¹⁷

Implementation has begun with Rhode Island payers submitting initial membership files in May. The current timeframe anticipates that claims submissions will begin in mid-June 2014. The State is also in the process of procuring a vendor responsible for running the business intelligence tool and generating reports.

Of the eight states investigated by OHIC for supporting ACO or ACO-like development, Maine, Massachusetts, Minnesota, New York, Oregon and Vermont are publicly funding APCDs. With respect to the other two states, a bill is before the New Jersey legislature to create a publicly funded APCD, and Alabama has no current APCD activity.

Nationally, over 35 states have, are implementing, or have strong interest in creating an APCD.¹⁸ A recent Robert Wood Johnson Foundation publication discusses how states can realize the potential benefits of APCDs and provides case studies of five states – Colorado, Massachusetts, Maine, New Hampshire, and Vermont – that are successfully supporting their reporting objectives.¹⁹

2. Fund the development and operation of community health teams

CSI-RI has had a dramatic impact on expanding the availability of patient-centered medical homes in Rhode Island. Many believe that ACOs must have a strong primary care foundation to be successful at managing costs and improving quality. Therefore, the continued expansion of PCMHs in Rhode Island is essential for ACO development. However, expansion of PCMHs faces significant structural barriers. Currently, BCBSRI, which is Rhode Island's dominant insurer, reports that 40% of its PCPs are in either CSI-RI or its own PCMH initiative. However, the remaining 60% of its primary care network is unable to participate in PCMH programs, according to BCBSRI, because the practices are small, unaffiliated primary care practices with one or two physicians. These practices do not have the internal staffing or financial capacity to undertake practice transformation. To surmount this barrier other states with a predominance of small, unaffiliated practices – most notably Vermont and North Carolina – have successfully created an infrastructure for sharing resources across multiple practices that are essential for practice transformation.

Recommendation: To provide additional impetus for primary care providers to transform into PCMHs, we recommend that the legislature adopt legislation to create and fund community health teams to provide care management and care coordination services to small, unaffiliated primary care practices.

¹⁶ See OHIC press release, dated May 1, 2014. Available at: www.health.ri.gov/materialbyothers/2014AllPayerClaimsDataStatement.pdf

¹⁷ See www.apcdshowcase.org/

¹⁸ See interactive map. Available at: www.apcdcouncil.org/state/map

¹⁹ L. Green, A. Lischko, T Bernstein. "Realizing the Potential of All-Payer Claims Databases: Creating the Reporting Plan." January 2014. Robert Wood Johnson Foundation, State Health and Value Strategy initiative. Available at: www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409989

Justification: The recommendation regarding community health teams is informed by experience showing that small, unaffiliated practices do not have the patient volume to financially support the hiring of a clinical care manager or other PCMH staff resources. A “community health team” is a multi-disciplinary team usually consisting of a clinical care manager, a social worker, a pharmacist and a data analyst who support multiple small, independent primary care practices that are located within geographic proximity. Maine, Minnesota, North Carolina and Vermont are a few of the states that have implemented the community health team concept. Recent evaluations of patient-centered medical home initiatives in Vermont²⁰, and Minnesota²¹ have generally found the patient-centered medical home practices to provide higher quality of health care and to generate savings. A national study of patient-centered medical homes sponsored by the Agency for Research and Quality identified a stronger primary care system as a lynchpin to improving quality outcomes and reducing costs and described the PCMH model as a promising innovation.²² With the development of community health teams, Rhode Island would be able to expand PCMH transformation to small, unaffiliated practices. It would also provide the opportunity for smaller practices to transform into PCMHs without having to join a larger organization; thus, preserving the small entrepreneur practitioner. In turn, these smaller practices could have the opportunity to jointly develop their own ACO in the future if they so elected.

3. Launch a public awareness campaign to encourage patient enrollment and physician use

CurrentCare is Rhode Island’s Health Information Exchange. It enables providers to share information electronically between electronic health records (EHRs) with the patient’s consent. CurrentCare is an “opt-in” system, which means that patients must affirmatively agree to allow treating providers to share their personal clinical information.

Recommendation: Fund a public awareness/call-to-action campaign to increase the public’s understanding of CurrentCare and the important function it plays in improving care and the steps to enroll. A related appeal should educate Rhode Island physicians on the benefits of using CurrentCare. The goal of both campaigns should be to increase the number of Rhode Island residents opting to share their information via CurrentCare and to increase the number of physicians accessing it.

Justification: Currently 33% of Rhode Island residents have joined CurrentCare. Approximately 10% of Rhode Island providers currently access CurrentCare to receive

²⁰ See Vermont Blueprint for Health, 2012 Annual Report, February, 2013. Available at: www.leg.state.vt.us/reports/2013ExternalReports/287348.pdf

²¹ See a summary of the findings at www.health.umn.edu/news-releases/u-of-m-evaluates-health-care-homes

²² D Peikes, A Zutshi, et al. “Early Evidence on the Patient-Centered Medical Home.” Agency for Healthcare Research and Quality. February 2012. Available at: <http://pcmh.ahrq.gov/sites/default/files/attachments/Early%20Evidence%20on%20the%20PCMH%20%2028%2012.pdf>

and send clinical information. To maximize effectiveness, CurrentCare needs to significantly increase the level of patient and provider participation.

The infrastructure for CurrentCare is in place. Without patient and physician participation, the system cannot be used to its maximum benefit.

Federally-funded projects

The State of Rhode Island has developed a State Health Care Innovation Plan (SHIP) and has submitted a large grant application to the federal Center for Medicare and Medicaid Innovation (CMMI) for State Innovation Model (SIM) funds. In the event that SIM funds are awarded to the State by CMMI's October 2014 target date, we recommend that a portion of those funds be used to support the following three infrastructure projects.

1. Expand EHR adoption among providers that do not qualify for federal EHR incentives

The adoption of EHRs by physicians and hospitals has been supported through federally-funded programs. Hospitals and physicians which adopt EHRs and meet a series of functionality requirements are eligible to receive substantial incentives to partially offset the costs of implementing an EHR system. Two key provider types, non-physician behavioral health providers and long-term care providers, do not qualify for federal Meaningful Use EHR incentives. Both provider types are important for serving Medicaid beneficiaries, however. Because of lack of funding and gaps in technology infrastructure, most non-physician behavioral health providers and long-term care providers (facilities and community-based providers) generally have not adopted EHRs.

Recommendation: Adopt legislation to create and fund incentives to Medicaid non-physician behavioral health providers and long-term care providers who do not qualify for Meaningful Use incentives to adopt EHRs.

Justification: A large percentage of Medicaid spending goes towards care provided by non-physician behavioral health providers and by nursing homes and community-based long-term care providers. Neither group has aggressively adopted EHRs even though EHRs provide the means to break down silos among different providers and improve the coordination of care. Better coordination of information between hospitals and nursing homes could reduce hospital utilization by facilitating a new level of care coordination across institutions. Also, many Medicaid beneficiaries have both behavioral health and physical health diagnoses. Those dually-diagnosed patients have better outcomes when both physical and mental health conditions are treated in coordinated manner. When all members of a patient's care team, including behavioral health providers, are able to share information electronically, there is an increased opportunity to provide a level of coordinated care that can result in improvements in the quality of life for the beneficiary and costs savings for the Medicaid program. Alabama is developing an incentive program to promote EHR adoption among providers not eligible for Meaningful Use incentives.

2. Support provider transformation through funding of a Rhode Island Care Transformation and Innovation Center and a state-wide learning collaborative

Experience in Rhode Island and elsewhere is showing that new payment models and restructured financial incentives to transform physician practice are insufficient to achieve that aim. Providers need technical assistance to learn how to transform their practices in response to new payment models. With the development of ACOs, the need for transformational training will extend beyond the primary care practices to specialists, hospitals, and post-acute providers. Currently there is no obvious place to obtain technical assistance for creating effective ACOs.

Recommendation: Fund the creation of a Rhode Island Care Transformation and Innovation Center and a state-wide learning collaborative.

Justification: A Care Transformation and Innovation Center (Center) would be able to assist provider transformation through several key activities, including identifying and documenting best practices, providing on-site practice coaching resources to struggling practices, holding targeted training sessions to address key but difficult core competencies, such as care management, patient-centered care, patient engagement, facilitating peer-to-peer learning, and providing resources on-line to increase accessibility to information. Through these activities, the Center would be spreading innovation more quickly than otherwise possible. Oregon has created a transformation center and reports that providers see great value in its programs.

It is recommended that one of the Center's activities be to hold a multi-session, state-wide learning collaborative on ACO development. Through participating in the collaborative, providers and administrators who are responsible for building ACOs will receive technical assistance to assure that best practices are adopted and the proverbial wheel is not continually reinvented. There will also be opportunities for peers to learn from one another. Oregon and Vermont are funding state-wide learning collaboratives with their SIM grant dollars, and several other states are operating them for selected providers.

3. Fund workforce development to meet the new workforce needs of a transformed delivery system

To successfully implement delivery system reform, health care workforce members, including medical assistants, registered nurses and physician assistants, are assuming new responsibilities and doing their jobs differently. Each new role requires training, which must begin in the professional or academic educational curriculum and continue with practice- or organization-based training.

Recommendation: Fund labor retraining and development activities that are responsive to the need for new types of jobs to support integrated, coordinated, population-based care delivery models.

Justification: Separate funding for workforce development would be needed if the Center (recommended above) were not funded. Funding is needed for workforce development and training in order to meet the new workforce needs of a transformed delivery system. Provider organizations are creating new positions and redefining existing positions. For example, ACOs will need clinical and social service care

managers trained in population-based care management principles, medical assistants trained in taking medical histories and managing patient registries, and office nurses trained in quality improvement models. To meet these new workforce challenges, educational initiatives are needed that prepare both those entering the workforce and retrain current workers for these changes. Funding is needed to hire experts to develop and teach new curricula in academic settings and to create and hold training sessions for the current workforce. Funding is also needed to cover the application costs to assure that clinicians attending training sessions receive continuing education credits.

E. Support the development of ACOs by funding impartial, in-depth evaluations of ACOs' impact on public policy goals

ACOs represent a significant change in the financing and delivery of health care. To further knowledge about ACO development and impact, there is a need for an impartial evaluation that examines whether ACOs are achieving stated public policy goals and any unanticipated impacts resulting from their development.

Recommendation: Use SIM grant monies to fund an evaluation of ACO impact on Rhode Island's health care delivery system, to be completed by 2018.

Justification: Funding an evaluation of ACOs is necessary if the State is to know if well-informed and well-intended policy achieved desired goals, and whether policy modifications are desirable. The evaluation will be most beneficial if it occurs after ACOs have had an opportunity to operate for two-to-three years before being evaluated. The evaluation, however, needs to be funded in time to create baseline measurements against which future performance can be measured. SIM funds extend over a four-year period, which would enable the state to designate specific SIM funds in time to collect baseline data, and to assure that the required funding is available to do the full assessment.

III. Conclusion

The state by exercising its powers as convener, regulator, purchaser, funder and evaluator has the opportunity to guide the development of Accountable Care Organizations in a way that can help meet the state's policy objectives of making quality care available and affordable to all Rhode Island residents. By convening stakeholders to develop consensus ACO standards and by aligning policies and implementation strategies across state agencies, the state can have a positive and profound impact on the shape of delivery system transformation in Rhode Island. The state can speed transformation and spread it to a broader array of providers by funding some critical infrastructure components. Finally, by evaluating ACO impact, Rhode Island can make informed decisions in the future to further enhance delivery system transformation.
