2011 State Legislation: Accountable Care Organizations

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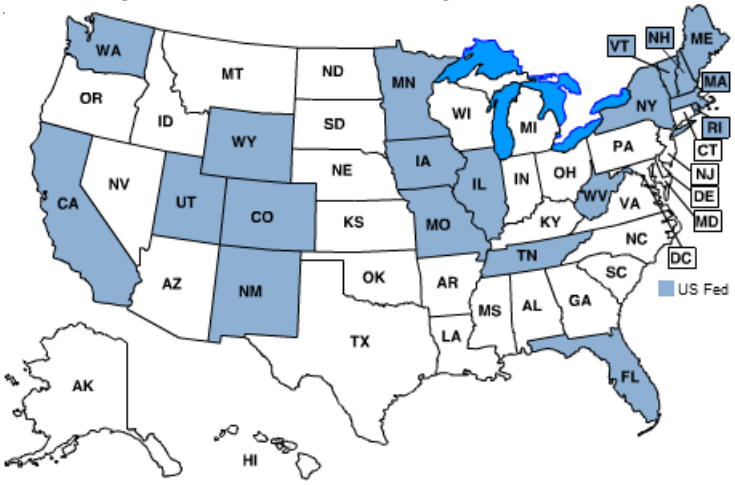
As of December 31, 2011, all 50 states convened for legislative session with 65 bills in 24 states referring to accountable care. The 57 bills in 24 states below attempt to define, study, promote or create a demonstration project for ACOs. States have introduced a variety of bills concerning ACOs—from creating studies to examine ACOs to state demonstration projects testing the feasibility of ACOs under state programs. In an effort to implement provisions of the federal *Patient Protection and Affordable Care Act (ACA)*, states also are altering existing insurance statutes to encourage the formation of ACOs in the private sector.

Sixteen states enacted 22 bills in 2011 concerning accountable care. **Colorado** enacted a measure to study integrative care systems, including ACOs. A new law in **Connecticut** allows the Social Services Commissioner to implement policies for the state to participate in pediatric ACOs under the ACA. **Florida** will include ACOs in the state expansion of Medicaid managed care and **Idaho** plans to move away from fee-for-service towards an accountable care system by incorporating elements of managed care into the state's Medicaid program. **New York** passed two bills requiring the Insurance Commissioner to promote and regulate ACOs. **Tennessee** amended state statutes to include ACOs in the broad definition of ""health care organization," and a new **Utah** law incorporates ACOs into the state plan. As part of its own health reform legislation, **Vermont** created a board to review plans on various issues, including payment to ACOs. One **Washington** bill promotes accountable care systems for disabled workers, while another creates a "Medicaid modernization" demonstration to test innovative reimbursement methods, including ACOs. A new **Wyoming** law creates an advisory study committee.

States Considering Legislation
Referring to Accountable Care Organizations, 2011-2012



Source: American Academy of Family Physicians, 2012.

This summary is only informational intended to provide background on the scope of projects currently before state legislatures. The reader should not consider this document to be comprehensive or to reflect AAFP policy.

For bill text and status of all active state exchanges legislation, please visit the AAFP bill tracking webpage: http://www.aafp.org/online/en/home/policy/state/statetrack.html

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States Considering Legislation to
Define, Study, Promote or Create a Demonstration Project
for Accountable Care Organizations

ARKANSAS

2011 SB 807 – An Act to Amend Arkansas Law Concerning ACOs

*Status: **FAILED** upon adjournment – 4/27/2011*

- Requires that accountable care organizations ensure that medical decisions are not based on commercial interests but on professional medical judgment that puts first the interests of patients.
- Allows collaborative efforts between physicians, hospitals, and other qualified providers to form ACOs as long as those arrangements ensure that health care decisions are made by health care professionals.
- Defines "accountable care organization" as a group of health care providers:
  - that is intended to be associated with a defined population of patients;
  - that is accountable for the quality and cost of care that is delivered to a defined population of patients;
  - through which providers share in savings created by (1) improving the quality of care to the defined population; and (2) reducing the growth of the cost of care delivered to the defined population.
- Allows ACOs operating in the state to be formed as legal business entities.
- Requires ACOs to be a separate legal entity with a separate and independent governing body, if a non-physician owned business is part of the ACO.
- Requires ACO boards of directors to be at least 50 percent comprised of physicians participating in the ACO.

CALIFORNIA

2011 SB 42 – Health Care Service Plans: Shared Savings Agreements

Status: Amended, passed Senate Committee on Health and referred to Appropriations Committee – 5/9/2011

- The amended measure no longer includes language concerning ACOs.

COLORADO

2011 HB 1242 – Medicaid Provider Integration of Service

*Status: **SIGNED BY GOVERNOR** – 6/2/2011*

Committee amendments were technical in nature.

- Determines that an integrated approach to health care addresses mental health, including substance use disorder, oral health and physical health needs of a patient at the time health care services are provided, resulting in reduced costs, improvement in patient health outcomes, and a seamless continuum of care for the patient.
- States that various health care reform initiatives are being studied or implemented in the state, including accountable care organizations, medical homes, and regional care coordination organizations, all of which seek to improve the integration of health care services.

- Declares that current reimbursement policies for providers providing physical and behavioral health care services on the same day are complicated and such policies create a barrier to the seamless integration of these services for the well-being of the patient.
- Requires the Department of Health Care Policy and Financing to:
    - review (1) physical and mental health care services to a patient during the same appointment as part of an integrated system of patient care, (2) any barriers to integrated care, (3) revisions to statutes or regulations that would facilitate integration of care, and (4) incentives to increase the number of health care providers delivering integrated health services;
    - seek input from behavioral health organizations and community health centers, as well as other health care providers; and
    - report to the general assembly by January 31, 2012.

CONNECTICUT

2011 SB 1240 – An Act Concerning the Bureau of Rehabilitative Services and Implementations of Provisions of the Budget Concerning Human Services and Public Health

Status: ***SIGNED BY GOVERNOR*** *– 6/13/2011*

- Allows the commissioner to implement policies to establish a demonstration project that would allow pediatric medical providers to organize as accountable care organizations while in the process of adopting other medical home policies and procedures in ACA regulation form.

2011 SB 1154 – An Act Concerning the Reporting of Claims Information to the Comptroller and Additional Duties of the Comptroller

Status: ***SIGNED BY GOVERNOR*** *– 6/4/2011*

Committee substitute made technical changes to language

- Allows the Commissioner of Social Services to implement policies and procedures necessary to (1) establish medical homes, and (2) pursue optional initiatives authorized pursuant to the Affordable Care Act, relating to the establishment of a demonstration project to allow pediatric medical providers to organize as accountable care organizations.

FLORIDA

2011 HB 7107 – Medicaid Managed Care

Status: ***SIGNED BY GOVERNOR*** *– 6/2/2011*

- Establishes the statewide Medicaid program as an integrated managed care program for all covered services.
- Includes accountable care organizations—in addition to health insurers, exclusive provider organizations, health maintenance organizations, and provider service networks—in the definition of "eligible plan"

2011 SB 1972 – Health and Human Services

Status: Substituted by HB 7107 – 5/5/2011

Committee amendments did not change the ACO provisions

- Amends current state statutes concerning social and economic assistance programs (409.901).
- Defines a "managed care plan" as a health insurer, an exclusive provider organization, a health maintenance organization, a provider service network or an accountable care organization authorized under federal law.

IDAHO

2011 HB 221 – Medicaid

Status: ***FAILED*** *upon adjournment – 4/7/2011*

- Repeals current state statutes 39-5606 and 56-102, and amends statutes 56-108, 56-117, 56-118, 56-255, 56-257 concerning payment under the state's Medicaid program.

- States that the legislature finds that the current health care delivery system of payment to Medicaid health care providers on a fee-for-service basis does not provide the appropriate incentives and can be improved by incorporating managed care tools, including capitation and selective contracting, with the objective of moving toward an accountable care system that results in improved health outcomes.
- Requires the Department of Health and Welfare to present to the legislature a plan for Medicaid managed care with focus on high-cost population, including dual eligibles and high-risk pregnancies.
- Requires the Medicaid managed care plan to include primary care medical homes and risk-sharing on a capitated basis.

2011 HB 260 – Medicaid

*Status: **SIGNED BY GOVERNOR** – 4/5/2011*

- This measure is similar to above 2011 HB 221, and the current versions have the same bill summary.

ILLINOIS

2011 HB 2982 – Regional Behavioral Health Network

*Status: **SIGNED BY GOVERNOR** – 8/15/2011 (Public Act 97-0381)*

- Requires the Department of Human Services to establish Regional Integrated Behavioral Health Networks for the purpose of ensuring and improving access to appropriate mental health and substance abuse services throughout the state.
- Establishes a Regional Network Advisory Council in each of the Department's regions comprised of representatives of community stakeholders represented in the Network, as well as relevant trade and professional associations, hospitals, and community providers.
- Requires each Council to develop a strategic plan that identifies opportunities to improve access to mental and substance abuse services through the integration of specialty behavioral health services with primary care, including, but not limited to:
    - availability of Federally Qualified Health Centers in community with mental health staff;
    - development of accountable care organizations or other primary care entities; and
    - availability of acute care hospitals with specialized psychiatric capacity.

INDIANA

2011 SB 174 – Exempts ACOs from Corporate Practice of Medicine Limitation

*Status: **FAILED** upon adjournment – 4/29/2011*

- Amends current state statutes (34-18-2; 34-6-2; 34-30-15).
- Defines Accountable Care Organization as a group of health care providers:
    - that is associated with a defined population of patients;
    - that is accountable for the quality and cost of care that is delivered to that population; and
    - through which health care providers share in savings created by improving the quality and reducing growth of cost.
- Adds ACO to the definition of "health care provider."
- Exempts ACOs from the corporate practice of medicine limitation and includes ACOs in the application of laws concerning medical malpractice and peer review.

IOWA

2011 HF 649 – Relating to and Making Appropriations for Health and Human Services

*Status: Item Vetoed, **SIGNED BY GOVERNOR** – 7/26/2011*

- Requires the department of human services to work with any entity—that is certified by the U.S. Department of Health and Human Services as an accountable care organization—to provide access to the complete de-identified claims data of the medical assistance recipients receiving health care services through the pilot project to identify areas of utilization, need and potential cost savings to the medical assistance program.

- Allows the department to employ new payment models, information technology, and data analytics provisions necessary to the administration of the pilot project.
- Requires the department to work with an entity to administer an accountable care organization pilot project, if CMS approves the project.
- Requires the project to:
    - at a minimum, include the participation of a prospective payment system hospital, 10 primary care physicians, a home health care practice, a palliative care services, a hospice service, and a community mental health center, all of which agree to be paid under a partial or global payment for identified services;
    - require all participating providers to utilize electronic health records; and
    - include delivery of mental health services to recipients of medical assistance through collaboration with the regional community mental health center, a federally qualified health center, and at least one nursing facility.
- Requires the entity to report to the Joint Appropriations Subcommittee for Health and Human Services during the 2012 legislative session detailing the progress and expected outcomes of the project.

2011 SF 348 (formerly 2011 SSB 1063) **– Relating to Establishment of an Iowa Health Benefit Exchange**

Status: Referred to Senate State Government Committee – 3/31/2011

- Establishes the Iowa Health Benefit Exchange to comply with the requirement of the federal *Patient Protection and Affordable Care Act*.
- Directs the Board of Directors to submit an annual report—to the Secretary of the U.S. Department of Health and Human Services, the Governor, the Insurance Commissioner, the General Assembly, and the public—examining the operations of the exchange and the demographics of those enrolled.
- Requires the board, by August 1, 2012, to research, investigate, produce and submit one or more reports on a variety of issues, including development of strategies to reduce health care costs, such as encouraging the use of accountable care organizations and the medical home model, and the effect of such changes on health care costs and health insurance premiums for exchange enrollees.

2011 SF 480 (formerly 2011 SF 117) **– Relating to Health Care and Policy, and Health Care Infrastructure and Integration of Public and Private Programs**

Status: Fiscal note. HCS. – 4/13/2011

- Amends current state statutes (Title IV Public Health, Subtitle 2 Health-Related Activities135.164).
- Requires the Division of Health Policy to develop a strategic plan for health care delivery infrastructure and health care workforce resources, describing the existing health care system and providing rationale for the desired health care system, methods to evaluate the system, and an action plan for implementation of changes necessary to achieve the desired health care system.
- Requires that the strategic plan include various components, including a provider payment system plan to:
    - provide recommendations to reform the health care provider payment system as an effective way to promote coordination of care, lower costs, and improve quality; and
    - analyze and make recommendations regarding but not limited to accountable care organizations, a global payment system, or an episode of care payment system.

2011 SSB 1218 – A study bill for an act relating to and making appropriations for health and human services and including other related pros visions, providing penalties, and including effective, retroactive, and applicability date provisions

Status: Voted – Appropriations – 6/20/2011

- If the department submits medical assistance program state plan amendments and they are approved by CMS, state may adopt administrative rules pursuant to chapter 17A to implement ACO pilot programs if they were shown to be successful (within 2 years of implementation)
- $100,000 will be appropriated for the ACO pilot project if an entity applies for certification from HHS by 1/1/2012 and is certified to administer an ACO pilot project, the state department of human services will provide access to complete de-identified claims data of the medical assistance recipients receiving health care services through the pilot project.

2011 SSB 1063 – A study bill for an act relating to establishment of an Iowa health benefit exchange, abolishment of the Iowa insurance information exchange, and including effective date provisions

Status: Voted – State Government – 2/28/2011

- Requires that the board include in their report development strategies to reduce health care costs a section about encouraging the use of accountable care organizations.

2011 – SF 542 – A bill for an act relating to and making appropriations for health and human services and including other related provisions, providing penalties, and including effective, retroactive, and applicability date provisions.

Status: Read first time, referred to Appropriations. H.J. 1259 – 6/22/2011

- Allows the department to submit to HHS for state plan amendments to CMS to implement accountable care organization pilot programs.
    - ACO pilot programs must demonstrate positive value to the state within two years of implementation
    - $100,000 shall be used for an ACO plot project (see section 71)
    - If an entity applies for certification from HHS by 1/1/2012 and is certified to administer an ACO pilot project, the state department of human services will provide access to complete de-identified claims data of the medical assistance recipients receiving health care services through the pilot project.
    - Health care cost containment, provider payment system pilot plans must provide analysis and recommendations regarding ACO's.
    - $50,000 will be appropriated for an ACO pilot project under section 139.

2011 SF 525 – A bill for an act relating to reforming state and county responsibilities for adult disability services, making appropriations, and including effective date provisions.

*Status: **SIGNED BY GOVERNOR** – 7/26/2011*

- Requires that alternative reimbursement and service models, such as accountable care organizations be evaluated.

2011 SF 117 – A bill for an act relating to health care and policy, and health care infrastructure and integration of public and private programs, and related matters, and including effective date provisions.

Status: Directed to Subcommittee 2/1/2011

- Directs the department of health to consider provider payment systems in their strategic plan including ACO's.

2011 HF 697 - A bill for an act relating to state and local finances by providing for funding of property tax credits and reimbursements, by making and adjusting appropriations, providing for salaries and compensation of state employees, providing for matters relating to taxation, providing for fees and penalties, providing for legal responsibilities, and providing for properly related matters, and including effective date and retroactive and other applicability provisions.

Status: Fiscal note. HCS. – 6/7/2011

- Allows the state to submit for medical assistance program state plan amendments to CMS of the US HHS to implement accountable care organization pilot programs. Must demonstrate value within 2 years of implementation

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MARYLAND

2011 HJR 6 – Safe Harbor Legislation and Regulations Needed to Form ACOs

*Status: **FAILED** upon adjournment – 4/11/2011*

- Urges the United State Congress and the Federal Trade Commission to pass legislation and adopt regulations that will establish safe harbors for physicians to collaborate in health insurance markets dominated by one or two health insurers and form accountable care organizations.

2011 SJR 6 – Safe Harbor Legislation and Regulations Needed to Form ACOs

*Status: **FAILED** upon adjournment – 4/11/2011*

- Urges the Federal Trade Commission, the Department of Justice and the Department of Health and Human Services to act expeditiously to adopt regulations that will guide the development of accountable care organizations and establish safe harbors for physicians, hospitals and other health care providers to form and deliver care through accountable care organizations.
- Requests the United States Congress to consider whether additional legislation, including antitrust safe harbor protections, is desirable to ensure that the potential value of health care delivery system reforms, including the formation of ACOs, can be fully realized.

MASSACHUSETTS

2011 HB 279 – An Act to Enable the Formation of ACOs

Status: Joint Committee on Financial Services Hearing Scheduled JFS – 10/25/2011

- Allows health care professionals negotiating through an accountable care organization to jointly negotiate with carriers and engage in joint activity regarding fees and fee-related matters, including:
  - the amount of payment or methodology for determining payment for a health care service;
  - the conversion factor for a resource-based relative value scale or similar reimbursement methodology for health care services;
  - the amount of any discount on the price of a health care service;
  - the procedure code or other description of the health care service covered under a payment; the amount of a bonus related to the provision of health care services or a withhold from the payment due for a health care service; and
  - the amount of any other component of the reimbursement methodology for a health care service.
- Prohibits provider contract terms, except those involving ACOs, to be effective until approved by the Attorney General.

2011 HB 1225 – An Act Concerning Medicaid and Accountable Care

Status: Joint Committee on Financial Services – hearing scheduled for 7/19/2011

- Requires the Office of Medicaid and the Executive Office of Health and Human Services (EOHSS) to establish a three-year Medicaid urban-area accountable care organization demonstration project by July 1, 2011, certifying up to five ACOs to participate.
- Defines “designated urban area” as a municipality or defined geographic area in which no fewer than 5,000 Medicaid beneficiaries reside.
- Requires the shared savings program operated as an urban ACO demonstration project to:
  - coordinate the provision of health care items and services paid by Medicaid;
  - encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and
  - facilitate the development of medical homes.
- Requires urban ACOs approved for participation in the demonstration project to be non-profit organizations formed through the voluntary participation of local hospitals, clinics, health centers, primary care physicians, nurses, and public health agencies for the purpose of improving the quality, capacity and accessibility of the local health care system for Medicaid beneficiaries residing in the region.
- Requires payments for services reimbursed by the Medicaid fee-for-service program to be made to the urban ACO and distributed to the participating providers in accordance with a written plan approved by the Office of Medicaid and EOHHS
- Requires the office of Medicaid and EOHHS, in developing the plan for distributing payment, to consider payment methodologies that promote care-coordination through multi-disciplinary teams, including payment for care of patients with chronic diseases and the elderly and that encourage services such as

- patient or family education for those with chronic diseases;
- home-based services;
- telephonic communication;
- group care; and
- culturally and linguistically appropriate care.

- Requires the payment system to be structured to reward quality and improved patient outcomes, particularly for high cost, high needs patients.
- Prohibits the payment system from increasing costs to Medicaid patients beyond the benchmark cost of care for those patients if they were not served by an ACO.

2011 HB 1498 – An Act to Promote Prevention and Wellness through a Public Health Trust

Status: Referred to Joint Committee on Health Care Financing – 7/21/2011

- Establishes a Prevention and Cost Control Trust Fund to be expended by the Department of Public Health.
- Creates a Prevention and Cost Control Advisory Board to make recommendations to the Commissioner concerning the administration and allocation of the fund.
- Requires the board to consist of 13 members appointed by the governor:
  - the commissioner of the department of public health, who shall serve as chair of the board;
  - the commissioner of the division of health care finance and policy;
  - the secretary of the executive office of health and human services;
  - a representative with expertise in the field of public health economics;
  - a representative with expertise in public health research;
  - a representative with expertise in the field of health equity;
  - a representative from a local board of health for a city with population greater than 50,000;
  - a representative of a board of health with a population under 50,000;
  - a representative from the health insurance industry;
  - a representative from a consumer health organization;
  - a representative from a hospital association;
  - a representative from a statewide public health organization; and
  - a representative from an accountable care organization.

2011 SB 486 – An Act Concerning Medicaid and Accountable Care

Status: Joint Committee on Health Care Financing Hearing scheduled – 7/19/2011

- This measure is similar to above 2011 HB 1225, and the current versions have the same bill summary.

2001 HB 1849 – An act relative to improving the quality of health care and controlling costs by reforming health systems and payments

Status: Hearing Scheduled with Joint Committee on Health Care Financing – 7/8/2011

- Attempts to limit health care costs while improving health care services by encouraging formation of ACO's
- Section 4 – report should include analysis of current state and federal antitrust law to provide adequare remedies and market intervention tools to protect competitive markets and price regulation relative to the transition to ACOs
- Includes provisions, procedures and rules relating to appeals by consumers from ACOs.
- Establishes recommendations for the formation of ACOs relevant to the development of fair, effective, efficient and sustainable global payment or other alternative payment methodologies.
- Also established parameters by which entities must follow in the establishment and facilitation of ACOs

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MAINE

2011 LD 540 – An Act to implement the insurance payment reform recommendations of the advisory council on health systems development

*Status: **SIGNED BY GOVERNOR** – 6/9/2011*

- Allows the superintendent to approve pilot projects between a carrier and an ACO that utilizes payment methodologies and purchasing strategies.

MINNESOTA

2011 HF 1204 – Minnesota Health Benefit Exchange Created

Status: Referred to House Health & Human Services Reform Committee – 3/21/2011

Although the legislature adjourned, this measure will carry over to the 2012 legislative session.

- Establishes the Minnesota Health Benefit Exchange to facilitate the purchase and sale of qualified health plans.
- Requires the exchange, in negotiating with health plan companies, to consider the extent to which a health plan incorporates alternative health care delivery models, including but not limited to health care homes and accountable care organizations, that provide incentives for the efficient and coordinated delivery of high-quality care.
- Requires the commissioner to include alternative health care delivery models in the public plan required to be offered in the exchange.

2011 SF 917 – Minnesota Health Benefit Exchange Act

Status: Referred to Senate Commerce & Consumer Protection Committee – 3/21/2011

Although the legislature adjourned, this measure will carry over to the 2012 legislative session.

- This measure is a companion to above 2011 HF 1204, and the current versions have the same bill summary.

2011 SF 1467 – Managed Care Plans and County-Based Purchasing Plans Administrative Costs Reduction

Status: Referred to Senate Health & Human Services Committee – 5/22/2011

Although the legislature adjourned, this measure will carry over to the 2012 legislative session.

- Amends current state statutes (43A.State Personnel Management. 23 Contracting Authority).
- Requires the Human Services Commissioner to develop and authorize a demonstration project to test alternative and innovative health care systems, including accountable care organizations, that provide services to a specified patient population for an agreed-upon total cost of care payment arrangement.
- Requires the commissioner to establish a total cost of care benchmark, which shall not exceed payments made in FY 2011 under fee-for-service or managed care.

MONTANA

2011 HB 124 (drafted as LC 270) **– An Act Creating a Montana Health Insurance Exchange Authority**

*Status: **FAILED** **Died in Standing Committee – 4/28/2011***

- Creates a Montana Health Insurance Exchange Authority and establishes an oversight board.
- Charges the board and the Commissioner of Insurance with jointly researching, investigating and producing reports by August 31, 2010 on strategies—to reduce health care costs and an assessment of how implementation of such strategies would affect health care costs and health insurance premiums for exchange enrollees—which must include (but are not limited to) encouraging the use of accountable care organizations and patient-centered medical homes.

2011 SB 221 (drafted as LC 886) **– Provide Waiver for Accountable Care Organizations in HMO Laws**

*Status: **SIGNED BY GOVERNOR** – 5/6/2011*

- Amends state statutes (33-31-102, 33-31-201, 53-6-702).
- Defines “Accountable Care Organization” as a group of health care providers that are willing and capable of accepting accountability for the total cost and quality of care for a defined population.
- Allows the Commissioner of Insurance to waive the health maintenance organization requirements for ACOs to be renewed every three years, based on the financial condition of the ACO, consumer complaints against the ACO, and length of time the ACO has been in business.

- Requires ACOs applying for a waiver to submit an audited financial statement and any other additional information requested by the commissioner.
- Requires waivers to automatically expire if certification of the ACO under the Medicare Shared Savings Program or the Department of Public Health and Human Services expires or is terminated.

NEW HAMPSHIRE

2011 HB 2 – Relative to State Fees, Funds, Revenues, and Expenditures

Status: Amended, passed Senate and returned to House for concurrence. Remainder effective 7/1/2011

The amended version no longer provides a definition of "ACO."

- Repeals current state statutes RSA 126-A:3, VIII concerning the State Children's Health Insurance program.
- Requires the commissioner to:
  - submit a Title XXI state plan amendment, subject to the approval by the fiscal committee of the general court and the oversight committee on health and human services, to administer CHIP within the department commencing upon implementation of Medicaid managed care; and
  - operate the CHIP program utilizing the program model that demonstrates the greatest efficiency and value which includes Medicaid expansion, accountable care organization or risk-based managed care models.
- Requires the commissioner to employ a managed care model for administering the Medicaid program .
- Allows models for managed care to include a traditional capitated managed care organization contract, an administrative services organization, an accountable care organization, a primary care case management model or a combination.

2011 SB 147 – Relative to Medicaid Managed Care

*Status: **SIGNED BY GOVERNOR** – 6/2/2011*

- Defines an "accountable care organization" as an entity or group which accepts responsibility for the cost and quality of care delivered to Medicaid patients care for by its clinicians.
- Requires the commissioner to employ a managed care model for administering the Medicaid program .
- Allows models for managed care to include a traditional capitated managed care organization contract, an administrative services organization, an accountable care organization, a primary care case management model or a combination.

NEW JERSEY

2011 AB 3636 – Establishes Medicaid Accountable Care Organization Project in DHS

Status: Amended Substituted by S2443 (3R) – 6/29/2011

- Establishes a three-year Medicaid Accountable Care Organization Demonstration Project in the Department of Human Services.
- Specifies participants in the demonstration project to be nonprofit corporations organized and operated for the primary purpose of improving the quality and efficiency of care provided to Medicaid recipients residing in a designated area.
- Includes—in the specific criteria to be considered by Medicaid in approving the gain-sharing plan of a Medicaid ACO—whether the plan promotes expansion of the medical home model.
- Permits voluntary participation in the demonstration project by Medicaid managed care organizations.
- Allows a certified Medicaid ACO to be eligible to receive and distribute gain-sharing or cost-savings payments in accordance with a gain-sharing plan.
- Allows nonprofit corporations organized with the voluntary support and participation of local general hospitals, clinics, health centers, qualified primary care and behavioral health care providers, and public health and social services agencies to apply for certification and participation in the project.
- Allows Medicaid to certify as many Medicaid ACOs for participation in the demonstration project as it determines appropriate, but prohibits certifying more than one Medicaid ACO for each designated area.
- Requires applicants to be no fewer than 75 percent of primary care providers.

- Requires the gain-sharing plan to include a proposed time period with specified dates, which would be the benchmark period against which cost savings can be measured on an annual basis going forward.
- Requires the Rutgers Center for State Health Policy to assist Medicaid with:
    - the design and implementation of the application process for approval of participating Medicaid ACOs in the demonstration project;
    - the collection of data from participants in the demonstration project; and
    - the establishment of a methodology for calculation of cost savings and for monitoring of quality of care under the demonstration project;
- Requires the Commissioner of Human Services to apply for state plan amendments or waivers necessary to implement the provisions of the bill and to secure federal financial participation for state Medicaid expenditures.
- Allows the Commissioner to apply for participation in federal ACO demonstration projects that align with the goals of the bill.
- Specifies that under the demonstration project, payment shall continue to be made to providers of services and suppliers participating in the ACO under the original Medicaid reimbursement methodology in the same manner as they would otherwise be made, except the Medicaid ACO is eligible to receive gain-sharing payments.
- Requires the Commissioner to report annually to the Governor and the Legislature on the demonstration project and include in the report the findings of the evaluation of the demonstration project and such recommendations as the commissioner deems appropriate.
- Effective immediately and expires three years after the adoption of regulations by the Commissioner of Human Services.

2010 SB 2443 – Establishes Medicaid Accountable Care Organization Project in DHS

Status: Approved P.L. 2011, c.114 – 8/18/2011

- This measure is a companion of the above 2011 AB 3636, the original versions have the same bill summary, and the two are still similar.
- Committee amendments:
    - add improving health outcomes and incorporating references related to medication therapy as a component of the project;
    - replace references to Medicaid with Department of Human Services (DHS);
    - add the Department of Health and Senior Services (DHSS) involvement to the demonstration project;
    - add details to the components of the gain-sharing plan;
    - exempt from DHS approval a gain-sharing plan that provides for shared savings between general hospitals and physicians related to acute care admissions utilizing the methodological component of the Physician Hospital Collaboration Demonstration awarded by the federal Centers for Medicare and Medicaid Services to the New Jersey Care Consortium;
    - add that DHS shall consider using a portion of any savings generated to expand the nursing, primary care, behavioral health care, and dental workforces in the area served by the ACO;
    - provide that the Rutgers Center for State Health Policy shall assist DHS and DHSS in evaluation the demonstration project, and add that administrative cost savings and health outcomes shall be included in the assessment;
    - add the requirement that DHS take such additional steps to secure on behalf of participating ACOs such waivers, exemptions, or advisory opinions to ensure that such ACOs are in compliance with applicable provisions of state and federal laws related to fraud and abuse;
    - change the reporting requirement to completion of the demonstration project, rather than annually; and
    - change the effective date from immediately to 60 days following enactment.

NEW MEXICO

2011 HB 35 – Hidalgo County Health Demonstration Project

- Directs the Secretary of Human Services, by July 1, 2011, to establish an Accountable Care Organization Demonstration Project Task Force to study the feasibility and parameters of an ACO demo project for Medicaid, State Children's Health Insurance Program, and State Coverage Insurance Program in Hidalgo County.
- Defines "accountable care organization" as a set of providers associated with a defined population of patients that is accountable for the quality and cost of care delivered to that population.
- Defines "managed care contractor" as a managed care organization that provides the health care benefits, items and services to recipients in Hidalgo county under the state's Medicaid program, state children's health insurance program or state coverage insurance program.
- Defines "primary care provider" as a nonprofit community-based entity that provides, or commits to provide, comprehensive primary health care services for residents of Hidalgo county, including a federally qualified health center or a facility serving primarily low-income populations.
- Directs the task force to devise a two-year strategic plan and report to the legislative health and human services committee and the legislative finance committee by August 1, 2012.
- Requires the strategic plan to contain recommendations regarding:
    - the feasibility of implementing a financial model for an accountable care organization in Hidalgo county that provides incentives to improve health outcomes and reduce per capita costs in the accountable care organization;
    - the parameters of risk in a regional or community-based accountable care organization in Hidalgo county;
    - the role of managed care contractors in providing administrative and other services to successfully implement the demonstration project;
    - the utilization of care and case management, whereby the demonstration project incorporates:
        - incentives for the promotion of a comprehensive health care system in which a recipient has a primary health care or social service provider who advocates for and provides ongoing support, oversight and guidance to implement an integrated, coherent, cross-discipline plan for ongoing health care and service delivery that is developed in partnership with the recipient and that includes all other health care and social service providers furnishing care to the recipient;
        - health system utilization management that is designed to assure appropriate access and utilization of services, including specialty and hospital care and utilization of prescription drugs;
        - health risk or functional needs assessments for recipients;
        - a method for reporting on the effectiveness of the demonstration project and its effect upon recipients' utilization of health care services and the associated costs of utilization of those services;
        - mechanisms to reduce inappropriate emergency department utilization by recipients;
        - mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating and monitoring recipients with complex, chronic or high-cost health care or social support needs, including attendant care and other services needed to enable recipients to remain in the community;
        - a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system, including the use of community health workers or promoters;
        - strategies to prevent or delay institutionalization of recipients through the effective utilization of home- and community-based support services; and
        - any other components that the task force determines will improve a recipient's health outcome and that are cost-effective;
    - promotion of the health commons model of integrated primary care, specialty, behavioral and dental health care services, including telehealth services;
    - incentives for encouraging longer hours for primary care services, including weekend and evening hours; and

- recommendations for designing and implementing a comprehensive incentive and risk system whereby providers of care in an accountable care organization in Hidalgo county receive financial incentives for measurable improvements in the health of their patients, including recommendations for quality evaluation and measurement protocols and for increasing community support for improving health care outcomes while addressing the social determinants of health.

NEW YORK

2011 AB 4009 – An Act to Amend the Public Health Law

*Status: **SIGNED BY GOVERNOR** – 3/31/2011*

- Defines "health care provider" to include, in addition to ordinary meanings, an entity that is an integrated organization of health care providers or an Accountable Care Organization of health care providers.
- Defines an ACO as a not-for-profit or governmental entity that is:
  - an organization of health care providers that work together to manage, and coordinate health care (including primary care) for a defined population with a mechanism for shared governance, the ability to negotiate, receive and distribute payments, and accountability for quality, cost, and delivery of health care; and
  - has been issued by a certificate of authority by the Insurance Commissioner.
- Requires an ACO to:
  - have a governance system that reasonably, equitably and democratically represents the ACO providers, employees of participating providers, enrollees and the general public;
  - define the population proposed to be served, which may include reference to a geographical area and patient characteristics;
  - include an adequate network of participating providers to provide care for which the ACO is accountable, including primary care providers, and at least one Federally Qualified Health Center – a requirement that the Commissioner may waive;
  - have defined mechanisms for providing, managing, and coordinating high quality health care, elevating primary care services to meet Patient-Centered Medical Home standards, coordinating intensive services for complex high-needs patients, providing access to providers that are not ACO participants, and providing access to the full range of reproductive health care for the population served;
  - have defined mechanisms for receiving and distributing payments to ACO providers, including incentive payments and payments for health care services from third-party health care payers and patients;
  - have reasonable mechanisms and criteria for accepting providers to participate related to the needs of the patient population;
  - have a leadership and management structure that includes clinical and administrative systems and clinical participation;
  - have appropriate quality assurance mechanisms, grievance procedures for providers and patients;
  - provide satisfactory evidence of the character and competence of the ACO; and
  - have mechanisms to promote evidence-based health care, patient engagement, coordination of care, electronic health records and other enabling technologies.
- Charges the Insurance Commissioner, in consultation with providers, third-party payers, advocates representing patients, the Superintendent of Insurance, and other appropriate parties, to:
  - establish appropriate requirements for ACOs;
  - establish appropriate performance standards for, and measures to access, the quality of care provided by an ACO; and
  - make regulations, set standards, and take other actions to promote the ability of an ACO to participate in applicable federal programs.
- Provides immunity from state and federal antitrust laws with respect to planning, implementing and operating ACOs.
- Allows the Commissioner to:
  - seek to promote the establishment of ACOs;
  - promote use of risk-adjustment and stop-loss methodologies; and

- establish payment methodologies, including for Medicaid fee-for-service and Medicaid managed care.

2011 AB 6261 – An Act to Amend the Public Health Law

Status: Referred to Assembly Health Committee – 3/11/2011

- The ACO provisions of this measure are similar to those in above AB 4009. The current versions have the same bill summary.

2011 AB 7518 – An Act to Amend the Social Services Law

Status: Referred to Rules Committee – 6/13/2011

- Amends 364J of current Social Services statutes.
- Adds "accountable care organization" to the definition of a managed care provider with in the state medical assistance program.

2011 SB 2809 – An Act to Amend the Elder Law

*Status: **SIGNED BY GOVERNOR** – 3/31/2011*

- Defines "Accountable Care Organization" as a clinically integrated network of providers certified by the Insurance Commissioner that is clinically and fiscally accountable for the entire continuum of care that a given population of patients may need and may include other entities that provide technical assistance, information systems and services, care coordination and other services to providers and patients.
- Authorizes the Commissioner to:
  - issue a certificate of authority to an entity that meets conditions for ACO certification;
  - engage in state supervision to promote immunity under state and federal antitrust laws to payers and providers with respect to planning, implementing and operating ACOs; and
  - seek federal grants, approvals, and waivers.
- Requires certified ACOs to have:
  - the ability to be accountable for the quality, cost and overall care of its patients;
  - a formal legal structure that allows it to receive and distribute innovative payments;
  - a leadership and management structure that supports clinical and administrative systems;
  - processes to promote evidence-based medicine, collect information on quality and cost measures, and coordinate care; and
  - a clinically integrated network of providers.
- Directs the Commissioner to establish a Medicaid ACO program.

OREGON

2011 HB 3650 – Relating to Health

*Status: **SIGNED BY GOVERNOR** – 7/1/2011*

- Establishes the Oregon Integrated and Coordinated Health Care Delivery System to replace managed care systems for recipients of medical assistance.
- States that the Legislative Assembly finds that achieving its goals of improving health, increasing the quality, reliability, availability and continuity of care and reducing the cost of care requires an integrated and coordinated health care system in which
  - Individuals who are fully eligible for both Medicare and Medicaid participate;
  - Health care services are delivered through coordinated care contracts that use alternative payment methodologies to focus on prevention, improving health equity and reducing health disparities, utilizing patient-centered primary care homes, evidence-based practices and HIT to improve health and health care;
  - High quality information is collected and used to measure health outcomes, health care quality and costs and clinical health information;
  - Communities and regions are accountable for improving he health of their communities and regions, reducing avoidable health gaps among different cultural groups and managing health care resources;

- Care and services emphasize preventive services and services supporting individuals to live independently at home or in their community; and
- Services are person centered and provide choice, independence and dignity reflected in individual plans provide assistance in accessing care and services.

- Requires the System to consist of state policies and actions that make coordinated care organizations accountable for care management and provision of integrated and coordinated health care for each organization's members, managed within fixed global budgets, by providing care so that efficiency and quality improvements reduce medical cost inflation while supporting the development of regional and community accountability for the health of the residents of each region and community, and while maintain regulatory controls necessary to ensure quality and affordable care for all Oregonians.
- Requires the Oregon Health Authority to adopt by rule the criteria for a coordinated care organization and to integrate the criteria into each contract with a coordinated care organization, ensuring that each serves members who are dually eligible for Medicare and Medicaid meets the requirements for an accountable care organizations.
- Requires the Authority to establish alternative payment methodologies, including global budgets, that
  - Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;
  - Hold organizations and providers responsible for the efficient delivery of quality care;
  - Reward good performance;
  - Limit increases in medical costs; and
  - Use payment structures that create incentives to promote prevention, provide person-centered care; and reward comprehensive care coordination using delivery models such as patient centered primary care homes.
- Requires the Authority to identify objective outcome and quality measures and benchmarks, including measures of outcome and quality for ambulatory care, inpatient care, behavioral health care, oral health care and all other health services provided, holding the organizations accountable for performance and customer satisfaction requirements.

TENNESSEE

2011 HB 1158 – Hospitals and Health Care Facilities

Status: Substituted for companion SB 484 – 3/28/2011

- Amends current state statutes Title 68, Chapter 11, Part 2 and Title 63, Chapter 1, Part 1.
- Includes ACOs in the definition of "health care organization."
- Prohibits a health care organization officer or director, health care provider staff, administrative staff, employees or other committee members or attendees from being held liable in any action for damages or other relief arising from the provision of information to a Quality Improvement Committee or in any judicial or administrative proceeding.

2011 SB 484 – Hospitals and Health Care Facilities

*Status: **SIGNED BY GOVERNOR** – 4/12/2011*

- This measure is a companion of the above 2011 HB 1158, and the current versions have the same bill summary.

UTAH

2011 HB 450 – Hospital Provider Tax Amendments

*Status: **SIGNED BY GOVERNOR** – 3/21/2011*

- Amends current state statutes (26-36a-208) that provides circumstances for which the hospital assessment can be repealed.
- Adds to such circumstances the effective date of approval of any change in the state Medicaid plan that requires a greater percentage of Medicaid patients to enroll in managed care plans than what is required:
  - to implement accountable care organizations in the state plan; and

- by other managed care enrollment requirements in effect on or before January 1, 2012.

VERMONT

2011 HB 202 – An Act Relating to a Single-Payer and Unified System

*Status: **SIGNED BY GOVERNOR** – 5/6/2011*

- Sets forth a strategic plan to create a single-payer and unified health system that is transparent in design, efficient in operation, and accountable to the people it serves, requiring the state to ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system.
- Establishes a board of directors to ensure cost-containment in health care, create a system-wide budget and pursue payment reform.
- Requires the board, by July 1, 2013, to review and approve plans on various issues, including global payments or capitated payments to accountable care organizations, health care professionals, or other provider arrangements.

2011 SB 57 – An Act Relating to a Single-Payer and Unified System

Status: Referred to Senate Health & Welfare Committee – 2/8/2011

Although the legislature adjourned and this measure will technically carry over to the 2012 legislative session, because its companion bill was enacted, this measure will not receive further consideration.

- This measure is a companion of the above 2011 HB 202, and the current versions have the same bill summary.

WASHINGTON

2011 HB 1086 – Making 2011 supplemental operating appropriations

*Status: **SIGNED BY GOVERNOR (PARTIALLY VETOED)** – 2/18/2011*

- $20,000 appropriated for fiscal 20 year 2010, and $63,000 of the general fund—state appropriation for fiscal year 2011 are provided solely for the implementation of chapter 12 220, laws of 2010 (ACOs)

2011 HB 1087 – Making 2011-2013 operating appropriations

*Status: **SIGNED BY GOVERNOR (PARTIALLY VETOED)** – 6/15/2011*

- Similar to HB 1086 & S 5094, but for 2011-2013 operating appropriations.

2011 SB 5095 – Making 2011 supplemental operating appropriations

Status: by resolution, reintroduced and retained in present status – 4/26/2011

- *Similar to HB 1086 & HB 1087*

2011 HB 1686 – Concerning Long-Term Disability for Injured Workers

Status: Referred to House Labor & Workforce Development Committee, retained in present status– 4/26/2011

Although the legislature adjourned and this measure will technically carry over to the 2012 legislative session, because similar legislation (SB 5596) was enacted, this measure will not receive further consideration.

- Amends current state statutes (RCW 51.36.010).
- Determines that high quality medical treatment and adherence to occupation health best practices can prevent disability, reduce loss of family income for workers, and lower labor and insurance costs for employers.
- Directs the Department of Labor and Industries to establish a health care provider network to treat injured workers and to accept providers into the network who meet established minimum standards.
- Requires the department to convene an advisory group to consider and advise the department related to implementation, including developing best practice treatment guidelines for providers in the network.
- Finds that the department and its business and labor partners have collaborated in establishing centers for occupational health and education—to promote best practices and prevent preventable disability by focusing additional provider-based resources during the first 12 weeks following an injury—representing

innovative accountable care systems in an early state of development consistent with national health care reform efforts.

- Requires the department, in order to expand evidence based occupation health best practices, to:
  - establish additional centers for occupational health and education, with the goal of extending access to at least 50 percent of injured and ill workers by December 2013 and to all injured workers by December 2015;
  - develop additional best practices and incentives that span the entire period of recovery, not only the first 12 weeks; and
  - certify and decertify centers for occupational health and education.

2011 HB 1869 – Addressing Occupational Health Best Practices in Industrial Insurance through Creation of a State-Approved Medical Provider Network

Status: By resolution, reintroduced and retained in present status – 4/26/2011

Although the legislature adjourned and this measure will technically carry over to the 2012 legislative session, because similar legislation (SB 5596) was enacted, this measure will not receive further consideration.

- This measure is similar to the above 2011 HB 1686, and the current versions have the same bill summary.

2011 SB 5566 – Concerning Long-Term Disability for Injured Workers

Status: By resolution, reintroduced and retained in present status– 4/26/2011

Although the legislature adjourned, this measure will carry over to the 2012 legislative session.

- This measure is a companion of the above 2011 HB 1686; however, an adopted Senate Committee amendment removed the provisions concerning accountable care organizations.

2011 SB 5596 – Requiring the Department of Social and Health Services to Submit a Demonstration Waiver to Revise the Federal Medicaid Program

*Status: **SIGNED BY GOVERNOR** – 5/31/2011*

- Directs the Department of Social and Health Services, by October 1, 2011, to submit a request to the Centers for Medicare and Medicaid Services' Innovation Center, and if needed, a section 1115 demonstration waiver request to the federal Department of Health and Human Services to revise the medical assistance program.
- Requires the "Medicaid modernization" demonstration to:
  - be designed to ensure the broadest federal financial participation under Titles XIX and XXI of the federal Social Security Act;
  - include a variety of components including the flexibility to adopt innovative reimbursement methods such as bundled, global, and risk-bearing payment arrangements that promote effective purchasing, efficient use of health services, and support health homes, accountable care organizations, and other innovations intended to contain costs, improve health, and incest smart consumer decision making.

2011 SB 5801 – Establishing Medical Provider Networks and Expanding Centers for Occupational Health and Education in the Industrial Insurance System

*Status: **SIGNED BY GOVERNOR** – 3/14/2011*

- This measure is a similar to the above 2011 HB 1686, and the current versions have the same bill summary.

WYOMING

2011 SF 50 – Medicaid Options Study

*Status: **SIGNED BY GOVERNOR** – 3/10/2011*

- Requires the governor to designate a study oversight committee—which may be a state agency, more than one agency, or an ad hoc committee—to conduct a study to develop estimates of the cost of redesigning the Medicaid programs currently operated and those mandated by the *Patient Protection and Affordable Care Act,* (P.L. 111-1148) and the *Health Care and Education Reconciliation Act of 2010,* (P.L. 111-152).

- Requires the study to evaluate options including the establishment of innovative service delivery systems and models such as healthy frontiers and accountable care organizations.