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Accountable Care as a Health Reform Tool in Oregon and Massachusetts

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Introduction

Over the past few years, Oregon and Massachusetts both established accountable care programs to help improve health care quality and reduce costs. However, some analysts remain skeptical regarding the ability of Accountable Care Organizations (ACOs) or other accountable care entities to rein in costs.¹ Oregon and Massachusetts provide a laboratory for evaluating whether ACOs deliver the outcomes desired, which is especially important as millions of Americans gain access to health insurance under the Affordable Care Act (ACA) next year. This analysis will examine each state's approach.

As the nation grapples with health care policy challenges, accountable care emerged as a possible tool to give providers more responsibility for health care quality and cost. In ACOs, groups of providers come together to give coordinated, high quality care to their patient population. ACO participating providers may be paid in a variety of different ways, including fee-for-service, global payments, quality incentives, and shared savings.

¹ See, e.g., Eric Stecker. *The Oregon ACO Experiment—Bold Design, Challenging Execution* NEW ENG. J. OF MED. 368: 11 (Mar. 14, 2013).

Policymakers envision that by giving providers the tools and incentives to manage their patient populations, ACOs will improve the patient experience, improve population health, and reduce costs. The ACA boosted the accountable care movement by creating the Medicare Shared Savings Program (MSSP).² Several states, including Oregon and Massachusetts, followed suit with their own initiatives.³

Oregon established ACO-like Coordinated Care Organizations (CCOs).⁴ Massachusetts, meanwhile, established a newly formed agency, the Health Policy Commission, charged with establishing certification requirements for all ACOs in the Commonwealth, consistent with statutory criteria.⁵ This analysis examines both states' initiatives, and includes the following topics: (1) a description of accountable entities, (2) how these entities fit within the state's health reform efforts, (3) who is taking the lead to establish the accountable entities in each state, (4) governance requirements, and (5) financial oversight.

Oregon Coordinated Care Organizations

In 2011, Oregon faced a \$1.9 billion Medicaid budget shortfall and may have been forced to cut provider rates or reduce Medicaid benefits.⁶ Instead, Oregon made a deal with the federal government as part of its 1115 Medicaid waiver.⁷ The federal government agreed to shore up Oregon's Medicaid program in exchange for a promise by the state to slow Medicaid spending by two percentage points—roughly \$11 billion over the next decade.⁸

² 42 U.S.C. §1395jjj.

³ For a list of state accountable care efforts, see the National Academy for State Health Policy's State Accountable Care Activity Map, <http://nashp.org/state-accountable-care-activity-map>

⁴ Oregon Health Authority. Request for Applications for Coordinated Care Organizations at 6 (Mar. 19, 2012).

⁵ MASS. GEN. LAW c. 6D § 15.

⁶ Sarah Kliff. *Can Oregon save American Health Care?* WASH. POST (Wonkblog), Jan. 18, 2013.

⁷ *Id.*; Joe Rojas-Burke, *Inside Oregon's Medicaid Lab*. MODERN HEALTHCARE (Sept 7, 2013).

⁸ *Id.* Long-term services and supports are not included in the 2% reduction. Oregon Health Authority. Transforming Healthcare in Oregon: Coordinated Care Organizations and Patient-Centered Primary Care

Oregon plans to slow the rate of Medicaid spending growth through the use of CCOs, entities created by 2011 state legislation (the Oregon Statute) to integrate and coordinate care in regions across the state.⁹ CCOs are described as “risk-bearing entities with prescribed governance.”¹⁰ In 2012, Oregon’s Medicaid agency released a Request for Application and contracted with 16 CCOs.¹¹ These CCOs are, in turn, responsible for contracting with health care providers in their region to provide care to Medicaid beneficiaries.

What Is an Oregon Coordinated Care Organization?

A CCO, described as a “local network of all types of health care providers,” takes responsibility for Medicaid beneficiaries in its region.¹² A CCO is tasked with bringing fragmented care together as it contracts with physical, behavioral health, and dental care providers to ensure its members receive appropriate care.¹³ CCOs must demonstrate capacity to coordinate care, meet financial requirements, operate within a global budget, and develop alternative payment methodologies to use with their contracted providers.¹⁴ CCOs may be local or statewide, and can be nonprofit or for-profit.¹⁵

Homes. PowerPoint presentation (Dec. 2012);

<http://bluecrossmafoundation.org/sites/default/files/download/related/Oregon%20Slides%202012.5.12.pdf>.

⁹ Chapter 60 of the Oregon Acts of 2011, codified in various sections of the Oregon revised statute. Other statutes, including Chapters 8 and 80 of the Oregon Acts of 2012 and Chapters 534 and 535 of the Oregon Acts of 2013 amend the authorizing statutes.

¹⁰ Oregon Health Authority. Transforming Healthcare in Oregon: Coordinated Care Organizations and Patient-Centered Primary Care Homes. PowerPoint presentation (Dec. 2012).

¹¹ Oregon Request for Application for Coordinated Care Organizations (Mar. 2012). List of CCOs, Oregon website; <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx>.

¹² Oregon Health Authority. Transforming Healthcare in Oregon: Coordinated Care Organizations and Patient-Centered Primary Care Homes. PowerPoint presentation (Dec. 2012); see OR. REV. STAT. § 414.625.

¹³ Oregon Health Authority. Request for Applications for Coordinated Care Organizations, at 6 (Mar. 19, 2012).

¹⁴ OR. REV. STAT. § 414.625

¹⁵ OR. REV. STAT. § 414.625(1). List of CCOs, Oregon website;

<http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx>.

Oregon's Medicaid agency pays CCOs with a global budget for its population's physical health, behavioral health, and oral care needs.¹⁶ CCOs are given flexibility regarding how to use this money, but must maintain quality care as evidenced by quality and outcome measures.¹⁷

The Oregon Statute declares its intent to exempt CCOs from state antitrust law, and invokes the state action immunity doctrine to attempt to protect CCOs from federal antitrust law.¹⁸ The Oregon Statute does not appear, however, to address federal fraud and abuse laws that may impede CCO formation.

How do CCOs Fit into the Larger Health Reform Effort in Oregon?

Oregon implemented managed care in the mid-1980s.¹⁹ Despite the fact that managed care organizations covered a large majority of Oregon Medicaid recipients, concerns regarding cost, coordination, and inequalities remain.²⁰ Oregon is moving away from a managed care model for its Medicaid recipients, and towards a CCO model.²¹

Oregon's CCO program builds on past efforts to increase patient-centered care in the state. In 2009, Oregon created its Patient-Centered Primary Care Home (PCPCH) program.²² To date, more than 400 entities have been recognized as PCPCHs.²³ CCOs are expected to contract with PCPCHs to the greatest extent possible.²⁴

¹⁶ OR. REV. STAT. §§ 414.620; 414.651

¹⁷ Oregon Health Authority. Request for Applications for Coordinated Care Organizations, at 6 (Mar. 19, 2012).

¹⁸ Or. Rev. Stat. § 646.735.

¹⁹ Oregon 1115 Medicaid Demonstration Waiver, at 172 (July 2012).

²⁰ *Id.*

²¹ *Id.*

²² National Academy of State Health Policy. Medical Home Map: Oregon, <http://www.nashp.org/med-home-states/oregon>.

²³ Oregon PCPCH List of Recognized Clinics, <http://www.oregon.gov/oha/OHPR/pages/HEALTHREFORM/PCPCH/recognized-clinics.aspx>.

²⁴ OR. REV. STAT. § 414.625.

Oregon is leveraging federal health reform, using monies from the Health Homes State Plan Option and the State Innovation Model Initiative to fund growth of PCPCHs and CCOs.²⁵

Who is Taking the Lead to Establish CCOs in Oregon?

All 16 CCOs that contracted with Medicaid stated a connection with former Medicaid managed care organizations in their CCO applications.²⁶ CCOs cover different regions of the state, with one to three CCOs per area.²⁷ CCOs plan to use their financial flexibility to focus on certain interventions to improve quality and reduce cost, including tobacco cessation programs for pregnant women and mold reduction in low-income housing.²⁸

The largest CCO, Health Share, covers Portland and surrounding areas. According to its CCO application, Health Share was created by health plans, counties, community health centers, and a university.²⁹ As part of its strategy, Health Share planned to use coordinated care for individuals with high needs, establish primary care providers at mental health clinics to help integrate care, and engage with community members to respond to community needs.³⁰

²⁵ National Academy of State Health Policy. Medical Home Map: Oregon, <http://www.nashp.org/med-home-states/oregon>.

²⁶ Oregon Health Authority, List of CCOs, <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx>.

²⁷ Oregon Health Authority, Coordinated Care Organization Service Area Density, <http://www.oregon.gov/oha/OHPB/Documents/CCOs%20by%20county.pdf>.

²⁸ Kirk Johnson, *Experiment in Oregon gives Medicaid Very Local Roots*, N.Y. TIMES, Apr. 12, 2013).

²⁹ Health Share's CCO application, <http://www.oregon.gov/oha/OHPB/Documents/tricounty-medicaid-collabtricounty-medicaid-collab.pdf>.

³⁰ *Id.*

The state moved almost all Oregon Medicaid and Children’s Health Insurance Program beneficiaries to Coordinated Care Organizations.³¹ Certain populations, including individuals dually eligible for Medicaid and Medicare, can opt out.³²

How are Oregon CCOs Paid?

Oregon Medicaid pays CCOs a global budget for their enrolled members.³³ This budget covers primary care, behavioral health, dental care, and other services.³⁴ These other services could be outside the scope of services for which Medicaid typically pays.³⁵ For example, they could include an air conditioner that prevents hospitalizations for a woman with congestive heart failure.³⁶ Oregon also pays its CCOs quality incentive payments, which may include shared savings.³⁷

What Are the Governance Requirements for Oregon CCOs?

The amount of money and power that Oregon is bestowing upon CCOs heightens the importance of a healthy and representative CCO governance structure. The Oregon Statute specifies the representation that must be on each CCO governing body, including a majority consisting of “persons that share in the financial risk of the organization,” health care providers, and members from the community at large.³⁸ In addition to its governing body, CCOs must convene a Community Advisory Council

³¹ Joe Rojas-Burke, *Inside Oregon’s Medicaid Lab*, MODERN HEALTHCARE (Sept. 7, 2013).

³² *Id.*; 1115 Waiver, at 45.

³³ OR. REV. STAT. § 414.620.

³⁴ Oregon Health Authority. Request for Applications for Coordinated Care Organizations, Appendix F (Mar. 19, 2012); see OR. REV. STAT. § 414.065(5).

³⁵ Oregon Health Authority. Request for Applications for Coordinated Care Organizations, Appendix F (Mar. 19, 2012).

³⁶ Kirk Johnson, *Experiment in Oregon gives Medicaid Very Local Roots*, N.Y. TIMES, Apr. 12, 2013.

³⁷ Oregon Health Authority. Request for Applications for Coordinated Care Organizations, Appendix F (Mar. 19, 2012).

³⁸ OR. REV. STAT. § 414.625(2)(o).

primarily composed of community members who will assess the health needs of the community and adopt a community health improvement plan.³⁹

A dispute recently erupted between Willamette Valley CCO and Salem Hospital. Salem Hospital's parent company filed suit, claiming that the CCO backed out of a payment arrangement.⁴⁰ This lawsuit spurred lawmakers to draft a bill to prevent such lawsuits in the future.⁴¹ Earlier versions of the bill would have allowed a CCO to remove "bad actors" from its governing board. The latest version of the bill would punish "bad actors" by "having their payments reduced" by "4 to 8 points."⁴² The suit was settled this year, but the episode highlights the importance of governance in the implementation of health reform.⁴³

How is Oregon Managing Provider Risk?

There is concern that as organizations take on financial risk, they face greater risk of insolvency that may, in turn, restrict access to health care for vulnerable populations. In response to this concern, Oregon implemented a number of measures to protect from the risk of CCO insolvency. The Oregon Statute requires CCOs to keep financial reserves and maintain a certain net worth level.⁴⁴ In addition, the CCO contract requires financial reporting, record reviews, and insurance protection.⁴⁵ Sanctions may be imposed if these requirements are not met, including "[i]ncreased reinsurance requirements; increased reserve requirements; market conduct constraints; and financial examinations."⁴⁶

³⁹ OR. REV. STAT. § 414.625(2)(i).

⁴⁰ Christopher David Gray, *Legislators Pinpoint Salem Health in Bad Actor Bill*, The Lund Report (June 11, 2013). As of the end of the 2013 regular legislative session, the bill had not passed.

⁴¹ *Id.*

⁴² *Id.*

⁴³ See Joe Rojas-Burke, *Inside Oregon's Medicaid Lab*, MODERN HEALTHCARE (Sept. 7, 2013).

⁴⁴ OR. REV. STAT. § 414.625.

⁴⁵ Oregon Health Authority. Request for Applications for Coordinated Care Organizations, Appendix G, at 56, 76-78 (Mar. 19, 2012) (CCO Contract).

⁴⁶ *Id.* at 104.

Massachusetts Accountable Care Organizations

Massachusetts led the nation in expanding health insurance coverage to over 95% of its residents, but the Commonwealth continues to struggle with high health care costs. On August 6, 2012, Governor Deval Patrick signed into law Chapter 224 of the Acts of 2012, entitled “An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation” (Chapter 224). Chapter 224 is an effort to bring health care spending in line with economic growth.

As its title suggests, Chapter 224 contains comprehensive reforms in the areas of transparency, system delivery, payment methodologies, and other categories designed to promote cost containment. Most provisions of Chapter 224 became effective November 5, 2012; therefore, implementation is in the early stages. The Health Policy Commission has begun holding public hearings and issuing interim guidance through agency bulletins.⁴⁷ Chapter 224 establishes benchmarks for cost growth as well as a process for monitoring and some degree of regulation of consolidation and other transactions in the health care market that are within its jurisdiction.⁴⁸

This groundbreaking legislation was the result of several years of public engagement in Massachusetts on the issue of cost and system and payment reform. Ambitious in scope and substance, Chapter 224 came six years after Massachusetts enacted Chapter 58, referred to as “Health Reform Part I,” the seminal law that resulted in close to universal health care coverage for the state’s residents.⁴⁹

Along the way to enacting Chapter 224, the Commonwealth implemented a series of laws and other key guiding documents relating to cost containment, or “Health Reform

⁴⁷ *E.g.*, Massachusetts Health Policy Commission. Interim Guidance for Providers and Provider Organizations Relative to Notice of Material Change, Policy Bulletin 2013-01 (Mar. 2013).

⁴⁸ MASS. GEN. LAW c. 6D.

⁴⁹ Chapter 58 of the Massachusetts Acts of 2006.

Part II.”⁵⁰ These included the pivotal Special Commission Report, issued in 2009 by a designated team of stakeholders from all sectors of the health care community, which recommended for the first time the adoption of ACOs and global payment methodologies, and a shift away from fee for service payments.⁵¹

These state reforms were adopted in parallel with federal reforms, including the ACA and subsequent implementing regulations, including those applicable to the MSSP. In this complex state and federal reform environment, Massachusetts has introduced ACOs as a new system delivery mechanism to help achieve the Commonwealth’s cost containment goals.

What Is a Massachusetts Accountable Care Organization?

Chapter 224 sets forth criteria entities must satisfy to qualify as an ACO. The legislation envisions ACOs as including both medical and behavioral health care.⁵² ACOs are defined as a “provider organization” certified by the Health Policy Commission.⁵³ All “provider organizations,” including ACOs, must now register with the Health Policy Commission.⁵⁴ ACO certification is designed as an additional step; all ACOs (including those participating in the MSSP) must be certified as such by the Health Policy Commission to qualify as ACOs under state law.⁵⁵

Additionally, the Health Policy Commission is mandated to establish criteria and designate certain entities as “Model ACOs,” those ACOs that “have demonstrated excellence in adopting the best practices for quality improvement, cost containment,

⁵⁰ Chapter 305 of the Massachusetts Acts of 2008; Chapter 288 of the Massachusetts Acts of 2010; and Chapter 224 of the Acts of 2012.

⁵¹ Recommendations of the Special Commission on Health Care Payment (July 2009).

⁵² MASS. GEN. LAW c. 6D; § 1, definition of ACO patient.

⁵³ MASS. GEN. LAW c. 6D § 1.

⁵⁴ MASS. GEN. LAW c. 6D § 11.

⁵⁵ MASS. GEN. LAW c. 6D § 15.

and patient protections.”⁵⁶ Chapter 224 encourages state purchasers for publicly insured individuals (including the state’s Medicaid agency, MassHealth⁵⁷), to take the lead in ACO contracting by prioritizing Model ACOs in their procurements.⁵⁸ This directive to have the Commonwealth lead the way to promote ACO development through preferential contracting while allowing ACO formation to be completely voluntary is one of the unique aspects of Chapter 224, reflecting a balance between allowing market forces to flourish and state law and regulation to move the market in the direction of more integrated organization of care delivery systems.

There are ten core requirements for ACOs, addressing interoperable health records, price transparency, internal appeals, provider risk, and patient engagement in shared decision-making.⁵⁹ The Health Policy Commission is authorized to establish “additional standards” for ACOs consistent with Chapter 224’s “goals.”⁶⁰ These goals are spelled out in Chapter 224, and include reducing the Commonwealth’s overall health cost growth, behavioral health integration, and improving quality.⁶¹

In contrast to the MSSP, which was accompanied by five contemporaneous waivers and notices from CMS and sister agencies, no federal waivers or other guidance accompanied the Massachusetts legislation addressing antitrust, fraud, or abuse laws. This absence may potentially restrain ACO formation, especially regarding compliance with federal fraud and abuse law.⁶²

⁵⁶ MASS. GEN. LAW c. 6D § 15(e).

⁵⁷ Executive Office of Health and Human Services, MassHealth Office.

⁵⁸ Chapter 224 of the Massachusetts Acts of 2012 § 268.

⁵⁹ MASS. GEN. LAW c. 6D § 15(b).

⁶⁰ MASS. GEN. LAW c. 6D § 15(c).

⁶¹ MASS. GEN. LAW c. 6D §15(c); c. 12C § 14.

⁶² Fraud and abuse laws include 42 U.S.C. § 1320a-7a (Civil Monetary Penalties); 42 U.S.C. § 1320a-7b (Anti-kickback); and 42 U.S.C. § 1395nn (Stark).

How do ACOs Fit into the Larger Health Reform Effort in Massachusetts?

ACOs are established as part of a broad restructuring of health care delivery systems and payment methodologies that form the basis of health reform “Part II,” Massachusetts’ effort to follow increased health insurance access with improved quality and cost containment. Chapter 224 took a multi-faceted approach in reaching these goals.

All major providers and payers in the Commonwealth are now subject to cost-growth benchmarks, established and overseen by the Health Policy Commission.⁶³ Entities that do not meet these benchmarks and who fail to implement “performance improvement plans” may be subject to fines.⁶⁴ ACOs are offered as a tool to help entities control costs and meet their health care cost-growth benchmarks. Though ACOs are not mandatory, Chapter 224 encourages entities to include them as part of delivery and payment system reforms.⁶⁵

With the emergence of large accountable care entities, concerns about market consolidation have arisen. Chapter 224 addresses these considerations and sets up a scheme for review. Under this scheme, ACOs and other provider organizations must now submit notice of any “material change” to its operations or governance structure.⁶⁶ This notice must be delivered to the Health Policy Commission, which will conduct a review and make recommendations to the Massachusetts Attorney General.⁶⁷

⁶³ MASS. GEN. LAW c. 6D § 10.

⁶⁴ *Id.*

⁶⁵ See Chapter 224 of the Massachusetts Acts of 2012 § 268.

⁶⁶ MASS. GEN. LAW c. 6D § 13.

⁶⁷ *Id.*

The Health Policy Commission has issued interim guidance on the nature of the material change notice and the cost and market impact review under Chapter 224.⁶⁸ The agency plans to issue final regulations in the next few months.

Who is Taking the Lead to Establish ACOs in Massachusetts?

While the Health Policy Commission has not yet commenced ACO certification, delivery and payment reform continues. In addition to private efforts and selected participation in the federal MSSP and Pioneer ACO programs, the Commonwealth has undertaken several recent health care payment and system reform initiatives in its Medicaid program, contemporaneous with the enactment of Chapter 224 and consistent with its goals and mandates.

Specifically, procurements for the Medicaid pediatric-asthma bundled payment pilot, primary care payment reform initiative, and dual-eligibles program for receiving care through integrated care organizations (ICOs) have all recently been launched, and call for the use of alternative payment methodologies and some measures of delivery reform. These programs, once underway, are designed to meet the Chapter 224 requirement that Medicaid achieve certain percentages of members enrolled in alternative payment arrangements,⁶⁹ as well as the broader goals of system reform contemplated by Chapter 224. In their infancy, they remain as of yet untested experiments in the public sector's next steps toward implementing Chapter 224.

⁶⁸ Massachusetts Health Policy Commission. Interim Guidance for Providers and Provider Organizations Relative to Notice of Material Change, Policy Bulletin 2013-01 (Mar. 2013).

⁶⁹ Chapter 224 of the Massachusetts Acts of 2012 § 261. The section directs MassHealth (state Medicaid program) to pay for health care utilizing alternative payment methods for no fewer than: 25% of its members by July 2, 2013; 50% of its members by July 1, 2014; and 80% of its members by July 1 2015.

How are Massachusetts ACOs Paid?

ACOs must “receive reimbursements or compensation from alternative payment methodologies” (broadly defined),⁷⁰ reflecting the overarching approach of the legislation to view system delivery reform and payment reform as joint requirements in order to meet the ambitious new cost-containment goals. An ACO might receive shared savings, bundled payments, global payments, or some other payment methodology that is an alternative to fee for service, consistent with the statutory requirements.

What Are the Governance Requirements for Massachusetts ACOs?

A Massachusetts ACO must “be organized or registered as a separate legal entity from its ACO participants.”⁷¹ The ACO must have a “governance structure that includes an administrative officer, a medical officer, and patient or consumer representation,” reflecting the nature of interests that must be included in the governing body, but stopping short of prescribing the exact structure.⁷² Overall, the governance rules for ACOs under Chapter 224 strike a balance between establishing some minimum requirements for the way in which ACOs are governed and leaving considerable flexibility as to how those requirements are implemented.

How is Massachusetts Regulating Provider Risk?

Provider organizations seeking to be certified as ACOs must obtain a “risk certificate” from the Commonwealth’s Division of Insurance.⁷³ Chapter 224 directs the Division of Insurance to establish a process for certifying providers taking on “downside risk”

⁷⁰ MASS. GEN. LAW c. 6D §15(b)(iii).

⁷¹ MASS. GEN. LAW c. 6D §15(b)(i). These requirements are slightly more proscriptive than the MSSP regulations, which permit ACOs to be either a separate entity or a participant in the ACO, if it meets certain requirements. See 42 C.F.R. § 425.104.

⁷² MASS. GEN. LAW c. 6D § 15(b)(i).

⁷³ MASS. GEN. LAW c. 6D § 15(b)(ix).

(referred to as “risk-bearing provider organizations”). Providers taking on downside risk, including ACOs, must now either obtain a risk certificate or a waiver from the Division of Insurance in order to enter into or continue contracts under which they bear “downside risk.”⁷⁴

The Division of Insurance and the Health Policy Commission have been jointly leading special sessions to discuss the process of, and issues raised by, the Health Policy Commission mandate to certify provider organizations, and the Division of Insurance mandate to certify provider organizations that take on downside risk.⁷⁵ Issues raised at these sessions have in some sense gone right to the heart of the structure of Chapter 224, and the purpose of regulation of provider organizations, ACOs, and provider risk.

For example, Chapter 224 mandates enormous information gathering by the Division of Insurance and Health Policy Commission, as well as transparency of that information. Additionally, Chapter 224 is quite prescriptive about the types of financial information and reports risk-bearing provider organizations must provide to the Division of Insurance. Stakeholders have raised issues with making all such information public, as well as how that information is to be used to regulate them. The lack of confidentiality and the breadth and use of the information required to be submitted remain issues the Division of Insurance will need to address in the coming months through regulations

Conclusion

Both Oregon and Massachusetts are engaging in bold experiments to improve health care quality while containing costs. These initiatives will increase in national importance as health insurance coverage expands as part of the ACA. What happens in Oregon and Massachusetts could well influence state reform efforts nationwide.

⁷⁴ MASS. GEN. LAW c. 176T.

⁷⁵ MASS. GEN. LAW c. 6D § 11; c. 176T.

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