



Senate

General Assembly

File No. 699

January Session, 2015

Substitute Senate Bill No. 814

Senate, April 16, 2015

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING STATE ACCOUNTABLE CARE ORGANIZATIONS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective October 1, 2015*) For purposes of this
2 section and sections 2 to 6, inclusive, of this act:

3 (1) "Accountable care organization" or "ACO" means an
4 organization of clinically integrated health care providers certified by
5 the Commissioner of Public Health in accordance with the provisions
6 of section 2 of this act;

7 (2) "ACO participant" means a health care provider that is one of the
8 health care providers that comprise the ACO;

9 (3) "Certificate of authority" means a certificate of authority issued
10 by the Commissioner of Public Health in accordance with section 2 of
11 this act;

12 (4) "Health care provider" means a person or entity licensed or

13 certified pursuant to chapters 370, 372, 373, 375, 378 and 379 of the
14 general statutes or licensed or certified pursuant to chapter 368d or
15 384d of the general statutes; and may also include, to the extent
16 provided in regulations adopted by the Commissioner of Public
17 Health under section 3 of this act, any other person or entity that
18 provides technical assistance, information systems and services, care
19 coordination and other services to health care providers and patients
20 participating in an ACO;

21 (5) "Primary care" means the medical fields of family medicine,
22 general pediatrics, primary care, internal medicine, primary care
23 obstetrics or primary care gynecology, without regard to board
24 certification, provided by a health care provider acting within the
25 health care provider's scope of practice; and

26 (6) "Health insurance carrier" means any insurer, health care center,
27 hospital service corporation, medical service corporation or other
28 entity delivering, issuing for delivery, renewing, amending or
29 continuing any individual or group health insurance policy in this
30 state providing coverage of the type specified in subdivisions (1), (2),
31 (4), (11) and (12) of section 38a-469 of the general statutes and may also
32 include any entity identified in regulations adopted by the
33 commissioner pursuant to section 3 of this act, including, but not
34 limited to, an entity such as a pharmacy benefits manager, fiscal
35 administrator, or administrative services provider that participates in
36 the administration of a health insurance system.

37 Sec. 2. (NEW) (*Effective October 1, 2015*) (a) The Commissioner of
38 Public Health shall establish a voluntary program within the
39 Department of Public Health to promote the use of ACOs to deliver
40 health care services for the purpose of improving the quality, value,
41 coordination and accountability of services provided to patients in the
42 state.

43 (b) The commissioner may issue a certificate of authority to an
44 entity that meets conditions for ACO certification as set forth in
45 regulations adopted by the commissioner pursuant to section 3 of this

46 act.

47 (c) The commissioner may limit, suspend or terminate a certificate
48 of authority if an ACO is not operating in accordance with the
49 provisions of sections 1 to 6, inclusive, of this act.

50 (d) The commissioner may seek federal approvals and waivers to
51 implement the provisions of sections 1 to 6, inclusive, of this act,
52 including, but not limited to, those approvals or waivers necessary to
53 obtain federal financial participation.

54 (e) Not later than January 1, 2016, and annually thereafter, the
55 Commissioner of Public Health shall report, in accordance with the
56 provisions of section 11-4a of the general statutes, to the joint standing
57 committee of the General Assembly having cognizance of matters
58 relating to public health concerning the program established pursuant
59 to this section. Such report shall include recommendations as to (1)
60 whether such program shall be continued, and (2) if it is recommended
61 that the program be continued, any modifications to such program.

62 Sec. 3. (NEW) (*Effective October 1, 2015*) (a) The Commissioner of
63 Public Health, in consultation with the Attorney General, health care
64 providers, health insurance carriers, advocates representing patients
65 and any other person the commissioner deems appropriate, shall
66 adopt regulations, in accordance with the provisions of chapter 54 of
67 the general statutes, to establish criteria for certificates of authority,
68 quality standards for ACOs, reporting requirements and other matters
69 deemed to be appropriate and necessary in the operation and
70 evaluation of ACOs under sections 1 to 6, inclusive, of this act. Such
71 regulations shall be consistent, to the extent practicable, with
72 regulations adopted by the federal Centers for Medicare and Medicaid
73 services for accountable care organizations under the Medicare
74 program.

75 (b) (1) Regulations adopted by the commissioner pursuant to this
76 section shall allow independent practice associations to obtain a
77 certificate of authority and may otherwise promote and support the

78 participation of independent community health care providers and
79 community hospitals in ACOs by means, including, but not limited to,
80 (A) creating an expedited or streamlined process for ACOs formed by,
81 or that include a significant number of such health care providers or
82 hospitals, to obtain a certificate of authority, and (B) providing
83 technical and administrative assistance to such ACOs during and after
84 issuance of a certificate of authority.

85 (2) To the extent that it is consistent with the provisions of sections 1
86 to 6, inclusive, of this act, the commissioner may adopt regulations to
87 allow an ACO certified or accredited by an independent organization,
88 including, but not limited to, URAC, to obtain a certificate of authority.

89 (c) Regulations adopted by the commissioner pursuant to this
90 section may address matters including, but not limited to:

91 (1) The governance, leadership and management structure of the
92 ACO that reasonably and equitably represents the ACO's participants
93 and the ACO's patients, including the manner in which clinical and
94 administrative systems and clinical participation shall be managed;

95 (2) A description of the population proposed to be served by the
96 ACO, that may include reference to a geographical area and patient
97 characteristics;

98 (3) The character, competence, and fiscal responsibility and
99 soundness of an ACO and its principals;

100 (4) Governance standards that address financial conflicts of interest
101 and promote transparency;

102 (5) The adequacy of an ACO's network of participating health care
103 providers, including primary care health care providers;

104 (6) Mechanisms by which an ACO is to provide, manage and
105 coordinate quality health care for its patients including improving
106 access to primary care services and, where practicable, elevating the
107 services of primary care health care providers to meet patient-centered

108 medical home standards, coordinating services for complex high-need
109 patients, and providing access to health care providers that are not
110 ACO participants;

111 (7) Mechanisms by which the ACO shall receive and distribute
112 payments to its participating health care providers, that may include
113 incentive payments, such as medical home payments, or mechanisms
114 for combining payments received by participating health care
115 providers from health insurance carriers and patients, provided any
116 such payment mechanism shall not create an incentive to deny or limit
117 medically necessary care;

118 (8) Mechanisms and criteria for accepting health care providers to
119 participate in the ACO that are related to the needs of the patient
120 population to be served and needs and purposes of the ACO, and
121 preventing unreasonable discrimination;

122 (9) Mechanisms for quality assurance and grievance procedures for
123 patients or health care providers where appropriate, and procedures
124 for reviewing and appealing patient care decisions;

125 (10) Mechanisms that promote evidence-based health care, patient
126 engagement, coordination of care, electronic health records, other
127 enabling technologies and integrated, efficient and effective health care
128 services;

129 (11) Performance standards for, and measures to assess, the quality
130 and utilization of care provided by an ACO;

131 (12) Mechanisms to evaluate patient satisfaction regarding the
132 patient's access to care and the quality and cost of care;

133 (13) Appropriate requirements for ACOs to promote compliance
134 with the purposes of sections 1 to 6, inclusive, of this act;

135 (14) Posting on the Department of Public Health's Internet web site
136 information about ACOs that would be useful to health care providers
137 and patients, including similar metrics;

138 (15) Requirements for the submission of information and data by
139 ACOs and their participating and affiliated health care providers as
140 necessary for the evaluation of the success of ACOs;

141 (16) Protection of patient rights as appropriate;

142 (17) The impact of the establishment and operation of an ACO,
143 including providing that it shall not diminish access to any health care
144 service for the population served and in the area served; and

145 (18) Establishment of standards to promote the ability of an ACO to
146 participate in applicable federal programs for ACOs.

147 (d) An ACO shall provide for meaningful participation in the
148 composition and control of the ACO's governing body for ACO
149 participants or their designated representatives.

150 (e) The ACO governing body shall include an administrative officer,
151 medical director and not less than one representative of: (1) Medicaid
152 or HUSKY plan recipients; and (2) other patients and consumers. Such
153 representatives shall have no conflict of interest with the ACO and no
154 immediate family member with a conflict of interest with the ACO.

155 (f) Not less than seventy-five per cent control of the ACO's
156 governing body shall be held by ACO participants. Members of the
157 ACO governing body shall have a fiduciary relationship with the ACO
158 and shall be subject to conflict of interest requirements adopted by the
159 ACO and set forth in regulations adopted by the commissioner. The
160 ACO's finances, including dividends and other return on capital, debt
161 structure, executive compensation, and ACO participant
162 compensation, shall be arranged and conducted to maximize the
163 achievement of the purposes of sections 1 to 6, inclusive, of this act.

164 (g) An ACO shall use its best efforts to include among the ACO
165 participants, on reasonable terms and conditions, any federally-
166 qualified health center that is willing to be an ACO participant and
167 that serves the area and population served by the ACO.

168 (h) An ACO may focus its efforts on providing health care services
169 to patients with one or more chronic conditions or special needs.
170 However, an ACO shall not otherwise, on the basis of a person's
171 medical or demographic characteristics, discriminate for or against or
172 discourage or encourage any person with respect to enrolling or
173 participating in the ACO.

174 (i) An ACO shall not, by incentives or otherwise, discourage a
175 health care provider from providing, or an enrollee or patient from
176 seeking, appropriate health care services.

177 (j) An ACO shall not discriminate against or disadvantage a patient
178 or patient's representative for the exercise of patient autonomy.

179 (k) An ACO shall not limit or restrict patients' use of health care
180 providers contracted or affiliated with the ACO. An ACO shall not
181 require a patient to obtain the prior approval, from a primary care
182 gatekeeper or otherwise, before utilizing the services of other
183 providers. An ACO shall not make adverse determinations as defined
184 in section 38a-591a of the general statutes.

185 (l) An ACO shall not prevent ACO participants from disclosing
186 price information to patients, state agencies or the public and shall
187 encourage ACO participants to provide patients with relevant price
188 information to support informed value-based care decisions.

189 (m) An ACO shall provide care coordination for its participating
190 patients, that includes, but need not be limited to, managing, referring,
191 locating, coordinating, and monitoring health care services for the
192 patient to ensure that all medically necessary health care services are
193 made available to, and are effectively used by, the patient in a timely
194 manner, consistent with patient autonomy and is not a requirement for
195 prior authorization for health care services. Referral shall not be
196 required for a patient to receive a health care service.

197 Sec. 4. (NEW) (*Effective October 1, 2015*) (a) Subject to regulations
198 adopted by the Commissioner of Public Health pursuant to section 3 of

199 this act, an ACO may: (1) Enter into arrangements with one or more
200 health insurance carriers to establish payment methodologies for
201 health care services for the health insurance carrier's enrollees
202 provided by the ACO or for which the ACO is responsible, such as full
203 or partial capitation or other arrangements. Such arrangements may
204 include provision for the ACO to receive and distribute payments to
205 the ACO's participating health care providers, including incentive
206 payments and payments for health care services from health insurance
207 carriers and patients; and (2) include mechanisms for combining
208 payments received by participating health care providers from health
209 insurance carriers and patients.

210 (b) Notwithstanding any provision of the general statutes, the
211 Commissioner of Public Health may, in consultation with the Attorney
212 General, authorize a health insurance carrier to participate in payment
213 methodologies with an ACO under this subsection, provided the
214 payment methodology is consistent with the purposes of sections 1 to
215 6, inclusive, of this act.

216 (c) An ACO may contract with a health insurance carrier to serve as
217 all or part of the health insurance carrier's provider network or care
218 coordination agent, provided the ACO shall be subject to all provisions
219 of title 38a of the general statutes that are applicable to the provider
220 network of the health insurance carrier.

221 (d) The provision of health care services directly or indirectly by an
222 ACO through health care providers shall not be considered the
223 practice of a profession by the ACO under title 20 of the general
224 statutes.

225 Sec. 5. (NEW) (*Effective October 1, 2015*) (a) The Commissioner of
226 Public Health, in regulations adopted pursuant to section 3 of this act,
227 shall permit and encourage cooperative, collaborative and integrative
228 arrangements among health insurance carriers and health care
229 providers who might otherwise be competitors. To the extent that it is
230 necessary to accomplish the purposes of sections 1 to 6, inclusive, of
231 this act, competition may be supplanted and the state may provide

232 state action immunity under state and federal antitrust laws to health
233 insurance carriers and health care providers.

234 (b) The commissioner shall engage in state supervision to promote
235 state action immunity under state and federal antitrust laws and may
236 inspect, require or request additional documentation and take other
237 actions under sections 1 to 6, inclusive, of this act to verify and ensure
238 that the provisions of sections 1 to 6, inclusive, of this act are
239 implemented in accordance with their intent and purpose.

240 (c) With respect to the planning, implementation and operation of
241 ACOs, the commissioner shall, by regulation, specify safe harbors that
242 exempt ACOs from the application of arrangements and agreements in
243 restraint of trade, fee-splitting arrangements and health care provider
244 referrals.

245 (d) The commissioner may seek federal grants, approvals and
246 waivers to implement the provisions of sections 1 to 6, inclusive, of this
247 act, including federal financial participation under public health
248 coverage. The commissioner shall provide copies of applications and
249 other documents, including drafts, submitted to the federal
250 government seeking such federal grants, approvals and waivers to the
251 joint standing committee of the General Assembly having cognizance
252 of matters relating to public health simultaneously with the
253 submission of such documents to the federal government.

254 (e) The commissioner may directly, or by contract with nonprofit
255 organizations, provide: (1) Consumer assistance to patients served by
256 an ACO as to matters relating to ACOs; (2) technical and other
257 assistance to health care providers participating in an ACO as to
258 matters relating to the ACO; (3) assistance to ACOs to promote their
259 formation and improve their operation; and (4) information sharing
260 and other assistance among ACOs to improve the operation of ACOs.

261 Sec. 6. (NEW) (*Effective October 1, 2015*) Notwithstanding any
262 provision of sections 1 to 5, inclusive, of this act, each ACO operating
263 in the state shall submit to the Commissioner of Public Health: (1) Its

264 articles of incorporation and bylaws; (2) annual financial reports as
 265 requested by the commissioner; (3) a description of (A) the standards
 266 used by the ACO to determine which hospitals and health care
 267 providers are permitted to participate in the ACO, (B) the process for
 268 hospitals and health care providers to apply to participate in the ACO,
 269 and (C) any related appeal or grievance procedures.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2015	New section
Sec. 2	October 1, 2015	New section
Sec. 3	October 1, 2015	New section
Sec. 4	October 1, 2015	New section
Sec. 5	October 1, 2015	New section
Sec. 6	October 1, 2015	New section

Statement of Legislative Commissioners:

In Section 3(a), the word "shall" was moved to be immediately before "adopt", for clarity; in Section 3(c)(13), "this article" was changed to "sections 1 to 6, inclusive, of this act", for accuracy; in Section 3(c)(14), "department's" was changed to "Department of Public Health's", for clarity; in Sections 3(h) and (k), "may not" was changed to "shall not" for internal consistency; in Section 3(l), "participants" was changed to "ACO participants" for conformity with the defined term; in Section 3(m), "member" was changed to "patient" for consistency; in Section 5(a), "this section and sections 1 to 6" was changed to "sections 1 to 6" for internal consistency, and "health care insurers" was changed to "health insurance carriers" for conformity with the defined term.

PH *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 16 \$	FY 17 \$
Public Health, Dept.	GF - Cost	119,745	177,220
Comptroller- Fringe Benefits ¹	GF - Cost	45,230	68,496

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in a Department of Public Health (DPH) cost of \$119,745 in FY 16 and \$177,220 in FY 17 by requiring DPH to promote and regulate Accountable Care Organizations (ACOs). The department does not have expertise in the area of ACOs and requires two staff persons to fulfill the responsibilities of the bill.

DPH will incur Personal Services costs of \$117,025 in FY 16 and \$177,220 in FY 17 to employ a Health Program Associate position and a Staff Attorney 2 position (effective 10/1/15). The Staff Attorney position is necessary to oversee DPH efforts outlined in the bill by providing knowledge of health care systems, insurance and antitrust laws. The Health Program Associate will be responsible for seeking federal grants, approvals and waivers to implement the provisions of the bill. Additionally, \$2,720 is necessary in Other Expenses in FY 16 for associated equipment.

The State Comptroller fringe benefits cost for the Special

¹The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 38.65% of payroll in FY 16 and FY 17.

Investigator and Staff Attorney positions is \$45,230 in FY 16 and \$68,496 in FY 17.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**sSB 814****AN ACT CONCERNING STATE ACCOUNTABLE CARE ORGANIZATIONS.****SUMMARY:**

This bill requires the public health (DPH) commissioner to establish a voluntary certification program for accountable care organizations (ACOs) (i.e., organizations of clinically integrated health care providers). The program must promote the use of ACOs to improve the quality, value, coordination, and accountability of health care services.

The bill establishes various requirements and conditions for certified ACOs, and it requires or allows the DPH commissioner to adopt regulations on numerous related matters. For example, it sets conditions regarding ACOs' governance structure, care coordination, and relationships with insurers. It allows the commissioner to (1) issue certificates of authority to entities that meet the certification conditions set forth in regulations and (2) limit, suspend, or terminate a certificate of authority if an ACO is not operating in accordance with the bill.

While the bill does not require ACOs to become certified, it provides certain protections for certified ACOs, such as possible immunity from antitrust laws.

Among other things, the bill also (1) allows the DPH commissioner to seek federal grants or other federal financial participation to implement the program and (2) requires the commissioner to annually report to the Public Health Committee on the program.

EFFECTIVE DATE: October 1, 2015

§ 1 – DEFINITIONS AND APPLICABILITY

The bill defines an ACO as a DPH-certified organization of clinically integrated health care providers. ACO participants are the health care providers that comprise the ACO.

Under the bill, the providers who may be ACO participants include licensed physicians, physician assistants, chiropractors, naturopaths, podiatrists, advanced practice registered nurses, registered nurses, practical nurses, and dentists, as well as licensed or certified emergency medical services providers and organizations (e.g., paramedics, emergency medical technicians, ambulance services). Participating providers may also include, to the extent provided in regulations adopted by the DPH commissioner under the bill, any other person or entity that provides technical assistance, information systems and services, care coordination, and other services to ACO participants and patients.

§ 3 – ACO CERTIFICATES OF AUTHORITY AND STANDARDS

The bill requires the commissioner to adopt regulations to establish criteria for ACO certificates of authority, ACO quality standards, reporting requirements, and other appropriate and necessary matters for ACO operation and evaluation. In doing so, she must consult with the attorney general, providers, insurance carriers, patient advocates, and anyone else she deems appropriate. When practical, the regulations must be consistent with the Centers for Medicare and Medicaid Services' regulations under the Medicare ACO program (see BACKGROUND).

As explained below, the bill allows or requires the commissioner to adopt regulations on various other matters.

Governance

Under the bill, an ACO must provide for meaningful participation by ACO participants, or their designated representatives, in the composition and control of the ACO's governing body. ACO participants must hold at least 75% control of an ACO's governing body.

An ACO's governing body must include (1) an administrative officer, (2) a medical director, and (3) at least one representative of (a) Medicaid or HUSKY plan recipients and (b) other patients and consumers. These representatives and their immediate family members must not have a conflict of interest with the ACO.

Governing body members have a fiduciary relationship with the ACO and are subject to conflict of interest requirements adopted by the ACO and set forth in regulations. An ACO's finances, including dividends and other return on capital, debt structure, and executive and ACO participant compensation, must be arranged and conducted to maximally achieve the bill's purposes.

The bill allows the DPH commissioner to adopt regulations on:

1. ACO governance, leadership, and management structure that reasonably and equitably represents ACO participants and patients, including how clinical and administrative systems and clinical participation will be managed;
2. the character, competence, fiscal responsibility, and soundness of an ACO and its principals; and
3. governance standards that address financial conflicts of interest and promote transparency.

Participating Providers and Patient Population

The bill allows an ACO to focus on providing health care to patients with chronic conditions or special needs. It otherwise prohibits an ACO, on the basis of a person's medical or demographic characteristics, from discriminating for or against, or discouraging or encouraging, him or her with respect to enrolling or participating in the ACO.

It requires an ACO to use its best efforts to include among its providers, on reasonable terms and conditions, any federally qualified health center that (1) is willing to participate and (2) serves the ACO's

area and patient population.

Under the bill, the regulations must allow independent practice associations (IPAs) to obtain a certificate of authority. (Generally, an IPA is a group of physicians who come together to negotiate with payers, without fully integrating into a medical group practice.)

The regulations may otherwise promote and support the participation of independent community providers and community hospitals in ACOs. Among other things, the regulations may:

1. create an expedited or streamlined certification process for ACOs formed by, or that include a significant number of, these providers or hospitals, and
2. provide for technical and administrative assistance to these ACOs, when applying for certification and after becoming certified.

If consistent with the bill, the commissioner may adopt regulations to allow ACOs certified or accredited by independent organizations, including URAC, to obtain a certificate of authority. (URAC, formerly known as the Utilization Review Accreditation Commission, is a nonprofit health quality organization that has several accreditation programs, including for ACOs.)

The bill allows the commissioner to adopt regulations on:

1. the population an ACO proposes to serve, by geographical area and patient characteristics, and
2. mechanisms and criteria for accepting providers to participate in the ACO that (a) are related to the patient population's needs and ACO's needs and purposes and (b) prevent unreasonable discrimination.

Provision of Care and Related Matters

The bill requires an ACO to provide care coordination for its

patients. This at least includes managing, referring, locating, coordinating, and monitoring health care services for patients to ensure that all medically necessary services are available to and effectively used by them in a timely manner, consistent with patient autonomy. These provisions do not require prior authorization for services. The bill prohibits an ACO from requiring a referral for a patient to receive health care services.

Under the bill, an ACO must encourage its participants to provide patients with relevant price information to support informed value-based care decisions. The bill prohibits an ACO from preventing participants from disclosing price information to patients, state agencies, or the public.

It also prohibits an ACO from:

1. discriminating against or disadvantaging a patient or patient's representative for exercising patient autonomy;
2. limiting or restricting patients' use of providers contracted or affiliated with the ACO;
3. requiring patients to obtain prior approval, from a primary care gatekeeper or otherwise, before using other providers' services; or
4. using incentives or otherwise discouraging a provider from providing or an enrollee or patient from seeking appropriate health care.

The bill allows the commissioner to adopt regulations on:

1. how an ACO will provide, manage, and coordinate quality health care, including (a) improving access to primary care and (b) where practicable, elevating the services of primary care providers to meet patient-centered medical home standards, coordinating services for complex high-need patients, and providing access to providers who are not ACO participants;

2. mechanisms promoting evidence-based health care, patient engagement, care coordination, electronic health records, other enabling technologies, and integrated, efficient, and effective health care services;
3. protection of patient rights as appropriate; and
4. the impact of an ACO's establishment and operation, including that it must not diminish access to any health care service for the population and area served.

Quality Assurance and Evaluation

The bill allows the commissioner to adopt regulations on:

1. quality assurance mechanisms and grievance procedures for patients or providers as appropriate, and procedures for reviewing and appealing patient care decisions;
2. performance standards and assessment measures for ACO care quality and utilization;
3. ways to evaluate patient satisfaction as to care accessibility, quality, and cost;
4. appropriate requirements for ACOs to promote compliance with the bill; and
5. posting on DPH's website information about ACOs that would be useful to providers and patients, including similar metrics.

§§ 3 & 4 – PAYMENT METHODOLOGIES AND RELATIONSHIPS WITH INSURANCE CARRIERS

Health Care Service Payment Methodologies

The bill allows an ACO, subject to regulations adopted by the commissioner, to enter into arrangements with health insurance carriers to establish payment methodologies for health care services the ACO provides to the carriers' enrollees or for which the ACO is responsible.

These arrangements may include full or partial capitation, among other things. (Capitation arrangements provide payments per patient rather than per service provided.) These arrangements may also allow an ACO to receive and distribute payments to participating providers, including incentive payments and payments from carriers or patients for health care services.

Subject to regulations, the bill allows ACOs to establish mechanisms to combine payments received by participating providers from carriers and patients. The bill allows the commissioner to adopt regulations on how an ACO will receive and distribute payments to participating providers, such as (1) medical home payments and other incentive payments or (2) ways to combine payments, as long as these payment mechanisms do not create incentives to deny or limit necessary care.

The bill allows the DPH commissioner, in consultation with the attorney general and despite any contrary law, to authorize a carrier to participate in payment methodologies with an ACO, as long as that methodology is consistent with the bill's purposes.

Under the bill, "health insurance carriers" are insurers, HMOs, hospital or medical service corporations, or other entities delivering, issuing, renewing, amending, or continuing any individual or group health insurance policies in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan.

The DPH commissioner, through regulations, may also identify other entities as carriers under the bill, such as pharmacy benefits managers, fiscal administrators, or administrative services providers that help to administer a health insurance system.

Carrier Contracts

The bill allows an ACO to contract with a carrier to serve as all or part of the carrier's provider network or care coordination agent,

provided the ACO is subject to all provisions of the insurance statutes that apply to the carrier's provider network. It allows the commissioner to adopt regulations on the adequacy of an ACO's provider network, including primary care providers.

It also prohibits ACOs from making adverse determinations (i.e., claim denials) under insurance laws.

§ 5 – ANTITRUST AND RELATED MATTERS

The bill requires the DPH commissioner, through regulations, to permit and encourage cooperative, collaborative, and integrative arrangements among carriers and providers who might otherwise be competitors. To the extent needed to accomplish the bill's purposes, competition may be supplanted and the state may provide state action immunity under state and federal antitrust laws to carriers and providers (see BACKGROUND).

The bill requires the commissioner to engage in state supervision to promote this immunity. She may inspect, require, or request additional documentation and take other actions under the bill to verify and ensure that it is implemented in accordance with its intent and purpose.

The bill also requires the commissioner, by regulation, to specify safe harbors exempting ACOs from the application of arrangements and agreements in restraint of trade, fee-splitting arrangements, and provider referrals. These safe harbors apply to ACO planning, implementation, and operation.

OTHER PROVISIONS

§§ 2, 3, & 5 – *Federal Financial Assistance or Programs*

The bill allows the commissioner to seek federal grants, approvals, and waivers to implement the bill, including to obtain federal financial participation under public health coverage. If the commissioner applies for any of these, she must provide copies of the applications and other documents, including drafts, to the Public Health Committee, at the same time she submits them to the federal

government.

The commissioner may adopt regulations establishing standards to promote an ACO's ability to participate in applicable federal programs.

§ 4 – Practice of Profession

The bill specifies that an ACO's provision of health care services, directly or indirectly, through providers is not considered the practice of a profession by the ACO under the professional licensing statutes.

§ 5 – DPH Assistance

The bill allows the commissioner, directly or by contracting with nonprofit organizations, to provide:

1. consumer assistance to patients served by ACOs, on ACO-related matters;
2. technical and other assistance to participating providers on ACO-related matters;
3. assistance to ACOs to promote their formation and improve their operation; and
4. information sharing and other assistance among ACOs to improve their operation.

§§ 2, 3, & 6 – Reporting Requirements

The bill requires the commissioner, by January 1, 2016, to begin annually reporting to the Public Health Committee on the ACO certification program. The report must include recommendations on (1) whether the program should continue and, if so, (2) any modifications to it.

As noted above, the bill requires the commissioner to adopt regulations on reporting requirements. It allows her to adopt regulations on information and data submission requirements for ACOs and their participating and affiliated providers, as needed to

evaluate ACOs' success. In addition to any reporting requirements in regulations, the bill also requires ACOs to submit to DPH:

1. their articles of incorporation and bylaws;
2. annual financial reports as requested by the commissioner; and
3. a description of (a) their standards to determine which hospitals and providers can participate in the ACO, (b) the application process for hospitals and providers, and (c) any related appeal or grievance procedures.

BACKGROUND

Medicare ACOs

As authorized by the federal Affordable Care Act, Medicare ACOs are voluntary networks of doctors, hospitals, and other providers that coordinate care for certain Medicare patients. Providers may participate in a Medicare ACO and commercial payer ACO at the same time.

While Medicare ACOs still use Medicare's traditional fee-for-service payment system, they are eligible for additional payments when providers coordinate care, reduce Medicare spending, and meet specified quality of care benchmarks. Medicare currently offers three ACO programs, the most popular of which is the Medicare Shared Savings Program.

State Action Immunity

Among other things, the state action immunity doctrine (which originated with a 1943 U.S. Supreme Court decision) permits an exception to federal antitrust laws for a private actor's anticompetitive activity if (1) the activity occurs pursuant to a "clearly articulated and affirmatively expressed state policy to displace competition" and (2) the state actively supervises that policy (see, e.g., *F.T.C. v. Phoebe Putney Health System, Inc.*, 133 S.Ct. 1003 (2013)).

COMMITTEE ACTION

Public Health Committee

Joint Favorable

Yea 25 Nay 0 (03/30/2015)