# ACOs and Medicaid: Challenges and Opportunities

## March 23, 2011

**Barbara Eyman**
Ropes & Gray
*Barbara.Eyman@ropesgray.com*
202.508.4762

**Charles Luband**
Ropes & Gray
*Charles.Luband@ropesgray.com*
212.596.9217

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# Ropes & Gray ACO Teleconference Series

- Sixth Ropes & Gray teleconference on the legal, policy, and practical issues surrounding the creation of ACOs
- Presentations and other helpful materials available at www.healthreformresourcecenter.ropesgray.com

# Agenda

I. Background

II. What Makes Medicaid Unique?

III. ACO Concepts in Medicaid

IV. ACA Tools for Creating Medicaid ACOs

V. Challenges & Options for Creating a Medicaid ACO Program

VI. State Efforts to Establish Medicaid ACOs

# I. Background

# What is an ACO?

- Group of providers and organizations responsible for the overall costs and quality of care for a defined patient population
- Goal is to improve care management and quality through integrated delivery of care, while reducing overall cost of care to the population
  - Better coordination of care among primary care providers, specialists, and hospitals
  - Improved quality through coordination and enhanced performance measurement
  - Shared savings for providers and payers

# Significant Focus on Medicare Shared Savings Program

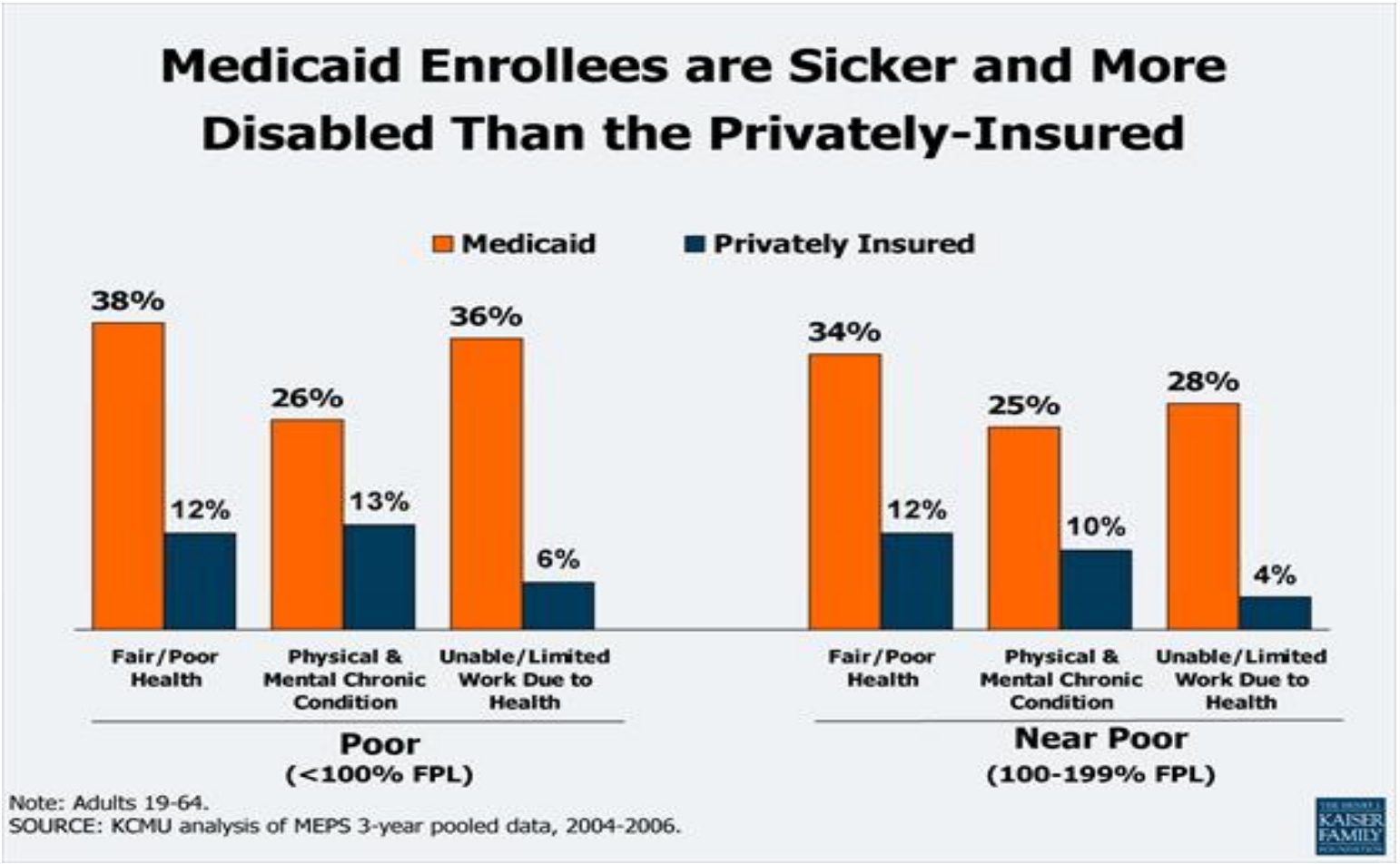
- Section 3022 of Affordable Care Act
  - Establishes Medicare ACO program
  - To begin no later than 1/1/2012
  - Providers receive share of Medicare savings if meet quality-of-care targets and reduce costs relative to benchmark
  - HHS Secretary has significant flexibility to structure payment
- Proposed rule expected any day

# Private Payers Anxious to Move Forward

- Premier's ACO Implementation Collaborative and ACO Readiness Collaborative
- Brookings-Dartmouth ACO Pilot

# II. What Makes Medicaid Unique?

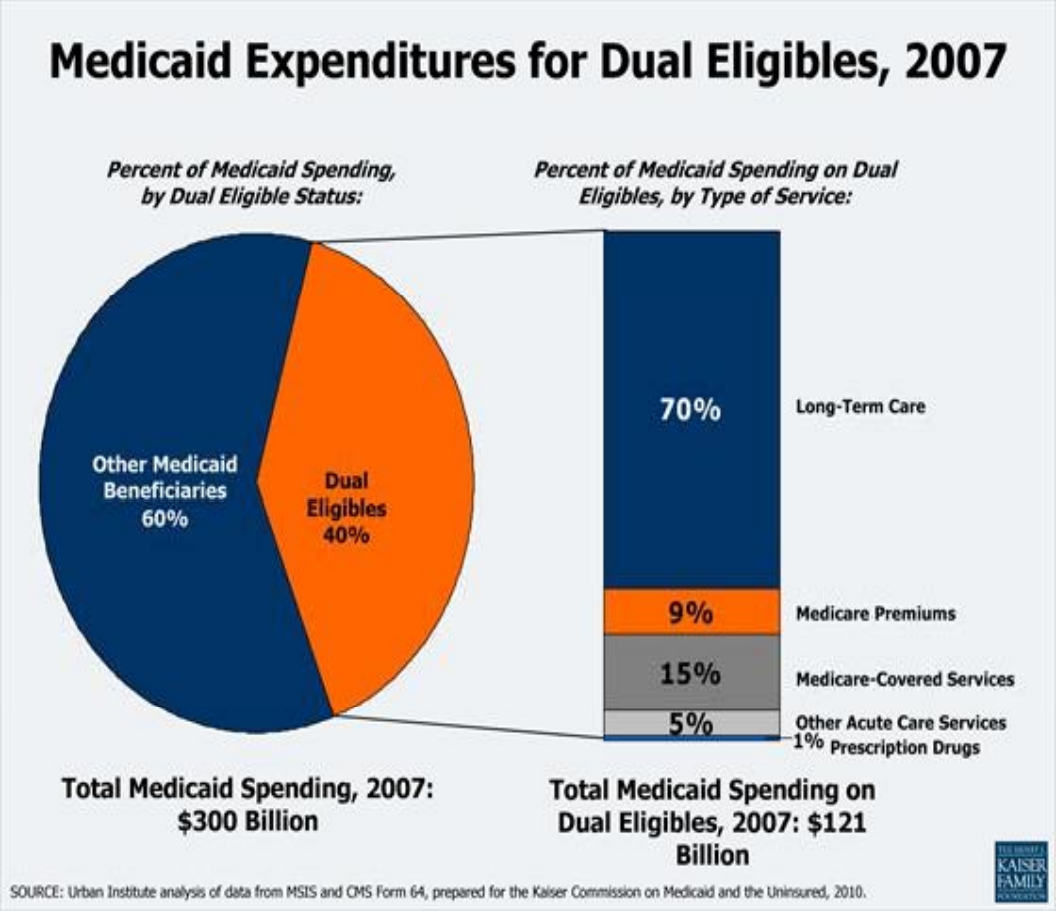
# Population is Sicker and More Disabled



# Enrollment Is Unstable

- "Churning" is common
  - Cycling on and off Medicaid disrupts coverage and leads to periods of uninsurance
  - Examples:
    - One in four RI Medicaid enrollees had gap in coverage over 12 month period
    - 35% of children in WA whose coverage was terminated were reenrolled over 3-month period
    - 1/3 of enrolled children in VA lost coverage at some point
  - Churning complicates patient assignment and attribution period

# Dual Eligibles Account for Significant Spending




- 9 million dual eligibles
- 15% of Medicaid population, but 40% of costs

# Medicaid's Unique Financing

- Providers rely on supplemental payments with no private sector counterparts:
  - Disproportionate Share Hospital payments ("DSH")
  - Upper Payment Limit payments ("UPL")
- Providers participate in funding payments
  - Provider taxes
  - Intergovernmental transfers ("IGTs")
  - Certified public expenditures ("CPEs")
- Dependence on unstable state budgets and changing politics

# III. ACO Concepts in Medicaid

# Medicaid Provides ACO Building Blocks

- ACA provides new opportunities for developing ACO models, which build off models already embedded in the programs
- Existing building blocks
  - Medicaid Managed Care
    - Primary Care Case Management
    - Prepaid Health Plans
    - Comprehensive Risk Contracts
  - Disease Management
  - Medicaid Pay-for-Performance Programs
  - Safety-Net Innovations

# Medicaid Managed Care

- State may contract with a non-provider Managed Care Entity that subcontracts with providers to deliver care
  - Primary Care Case Management
  - Prepaid Inpatient Health Plans
  - Prepaid Ambulatory Health Plan
  - Managed Care Organization
- Managed care regulations at 42 CFR Part 438 apply

# Primary Care Case Management (PCCM)

- State contracts with PCCM to coordinate care
  - Monthly case management fee
  - Must provide adequate hours of operation, including 24/7 availability of emergency information, referrals, and services
  - PCCM generally does not assume risk
  - May serve as gatekeeper
- PCCM may be a PCP or an entity that contracts with PCPs
- As of 2010, 30 states operating PCCM programs
- Blend of FFS and managed care

# Primary Care Case Management (PCCM)

- Creation and Evolution of PCCMs
  - First authorized in OBRA 1981
    - Stepping stone to risk-based managed care
    - Goal of early PCCMs to increase access to care
  - Balanced Budget Act of 1997
    - Permitted states to require enrollment in managed care through state plan amendments
  - PCCM programs now shifting toward a medical home model with focus on improving care management and quality

# States Implementing ACO-Type Reforms through PCCMs

- Incentive Payments
  - Maine's Primary Care Incentive Payment Program
    - Providers receive scores on select measures (reducing inappropriate ER use, increasing use of preventive services)
    - Quarterly payments to physicians within top 20th percentile of provider group
  - Louisiana's Enhanced PCCM Program
    - Started 1/1/11
    - Providers receive $1.50/child and $3 per SSI per child
    - Can earn up to additional $3 per member per month for achieving certain quality measurements

# States Implementing ACO-Type Reforms through PCCMs

- Shared Savings
  - Alabama's Patient 1st PCCM program shares a portion of savings with PCCM providers
    - Shared savings based on actual amount spent compared to expected expenditures
    - Performance based on generic dispensing rate, non-certified ER visits, and office visits
  - South Carolina's Medical Homes Network (MHN)
    - MHN composed of PCCM organization (provides care management infrastructure) and PCPs
    - MHN paid administrative fee and "shared savings"
    - If actual costs exceed expected costs, MHN at risk for up to all administrative fees received

# States Implementing ACO-Type Reforms through PCCMs

- Community Care of North Carolina
  - Enhanced medical home model established in 1998
    - Local non-profits provide care to enrollees and manage care
    - 14 networks of 3,200 physicians covering 67% of Medicaid population
      - Networks include physicians, case managers, hospitals, social service agencies, health departments
    - Networks receive $3-5 PMPM, PCPs receive $2.50 PMPM for serving as a medical home
  - History
    - Grew out of Carolina Access (traditional FFS PCCM program)
    - Adopted as an alternative to capitated managed care
    - Expanded to include dual eligibles in 2005, under Medicare Health Quality Demonstration

# Prepaid Health Plans

- Plan contracts with state
- Rates are not state plan rates
- Does not have a “comprehensive risk contract”
  - Prepaid Ambulatory Health Plans (PAHPs) do not provide inpatient care
  - Prepaid Inpatient Health Plans (PIHPs) provides inpatient care
- May be used for select services (e.g. behavioral health) or non-risk plans

# Managed Care Organizations

- Plan has a comprehensive risk contract
  - Provides inpatient plus other services
  - Paid on a risk-basis
  - Rates must be actuarially sound

# Flexibility Provided through Managed Care

- MCOs and PIHPs/PAHPs may provide services other than state plan services
  - Cost-effective alternative services
- Maximum flexibility in subcontracts with providers
- Risk-based payments permitted (capitation, risk corridors, stop loss, reinsurance …)

# But…

- Solvency standards
- Grievances and appeals
- Information requirements
- Disenrollment protections
- Marketing restrictions
- Access standards
- Emergency coverage
- Etc.

# Disease Management

- States may:
  - Contract with disease management organizations (as a PAHP)
  - Add disease management to PCCM responsibilities
  - Require MCOs to provide disease management
  - Provide disease management through FFS providers
  - Provide disease management for targeted populations (waiver may be required)
- State Medicaid Directors Letter 2/24/04

# Medicaid Pay-for-Performance

- State flexibility to set payment rates, subject only to aggregate upper payment limits
  - P4P, value-based purchasing, etc. may be implemented through state plan amendments
- As of 2009, 32 states had adopted a P4P program
  - Primarily managed care
- Arkansas Hospital Inpatient Quality Incentive Program
- MassHealth Hospital P4P

# Safety-Net System Innovations

- Safety net systems serve large numbers of low-income, uninsured, and Medicaid and Medicare patients
  - Low reimbursement or lack of reimbursement incentivizes efficient, coordinated care
  - Often existing integrated delivery systems providing full range of care
  - Incentives to keep care at lowest cost level
- Innovations in Medicaid context and in context of uninsured to improve care and quality while reducing costs

# Safety-Net Examples

- Virginia Coordinated Care
  - Managed care for the uninsured
  - Enrollees have a PCP and a medical home
  - System partnerships with community providers
- South Florida Community Care Network
  - Medicaid Provider Service Network
  - Managed FFS model built on top of PCCM
    - Also disease management focus
  - Receives administrative fees, shared savings, and monthly case management fee

# Safety-Net Examples

- Boston Medical Center CareNet
  - Managed care for the uninsured before Massachusetts health reform
  - Sister organization to Boston HealthNet Plan (a Medicaid MCO)
  - Financed by uncompensated care pool

# Medicaid Methods

## Through State Plan, Can:

- ✓ Implement managed care
  - Including PCCM programs
- ✓ Create flexible provider reimbursement
  - Including pay for performance
  - Payments must be within established limits

## Through Waivers, Can:

- ✓ Create regional (sub-state) programs
- ✓ Pay for non-traditional services
- ✓ Pay entity (ACO) not identified in Title XIX
- ✓ Pay for services *not* provided (shared savings)

# IV. ACA Tools for Creating Medicaid ACOs

# Medicaid Pediatric ACO Demonstration § 2706 ACA

- Permits participating states to make incentive payments to pediatric medical providers organized as an ACO
- Providers must participate for at least 3 years
- Criteria will be modeled on Medicare Shared Savings Program
- Program authorized in FFYs 2012-2016 but not funded

# Medicaid Medical Home Option § 2601 ACA

- Temporary 90% FMAP (first 8 quarters)
- Provider types:
  - Designated provider (e.g., physician, group practice, rural health clinic, CHC, etc.)
  - Health team
  - Health team linked to designated provider
- Services
  - Comprehensive care management, care coordination, transitional care, social service referral, use of HIT to link services
- Beneficiaries
  - One or more select chronic conditions
- Payment
  - May pay providers on FFS or capitated basis (CMS will consider alternatives)
  - May pay based on severity of patient condition and provider capabilities

# Medicaid Global Payment System Demo § 2705 ACA

- Demonstrations available in up to 5 states in FY 2010 to FY 2012
- States may alter Medicaid payments to a large, safety net hospital system to a capitated, global payment structure
- Program authorized, but not funded
- Awaiting CMS guidance

# Center for Medicare & Medicaid Innovation §§ 3921 & 10306 ACA

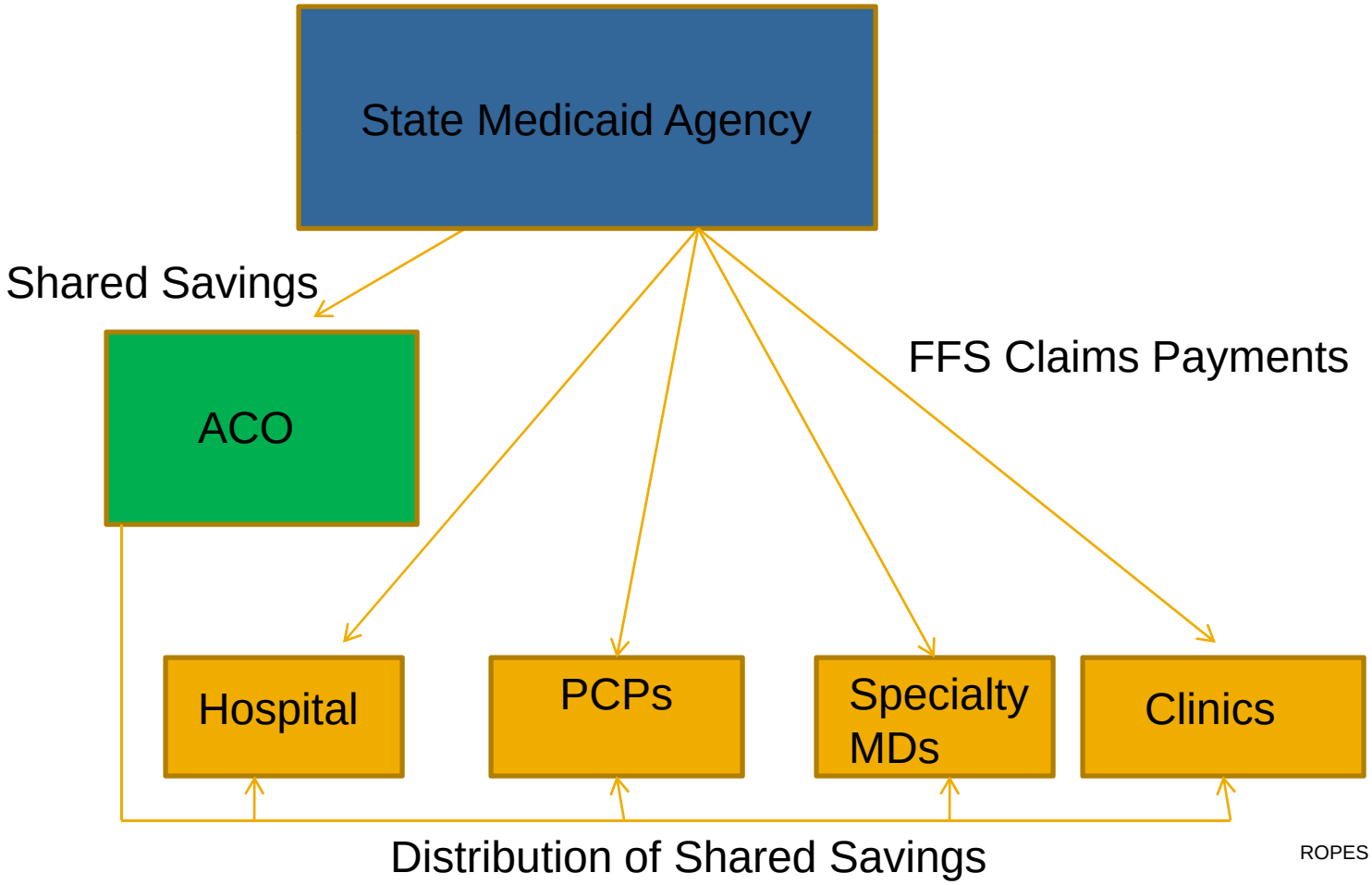
- Broad authority to design, implement, test, evaluate and expand different payment methods under Medicare, Medicaid and CHIP
- Must foster patient-centered care, improve quality, and reduce cost of care
- Models need not be budget neutral (at least initially)
- $10 billion appropriated for FYs 2011-2019
- CMMI likely has authority to implement other programs (e.g., pediatric ACO) that lack appropriations

# Additional ACA Tools

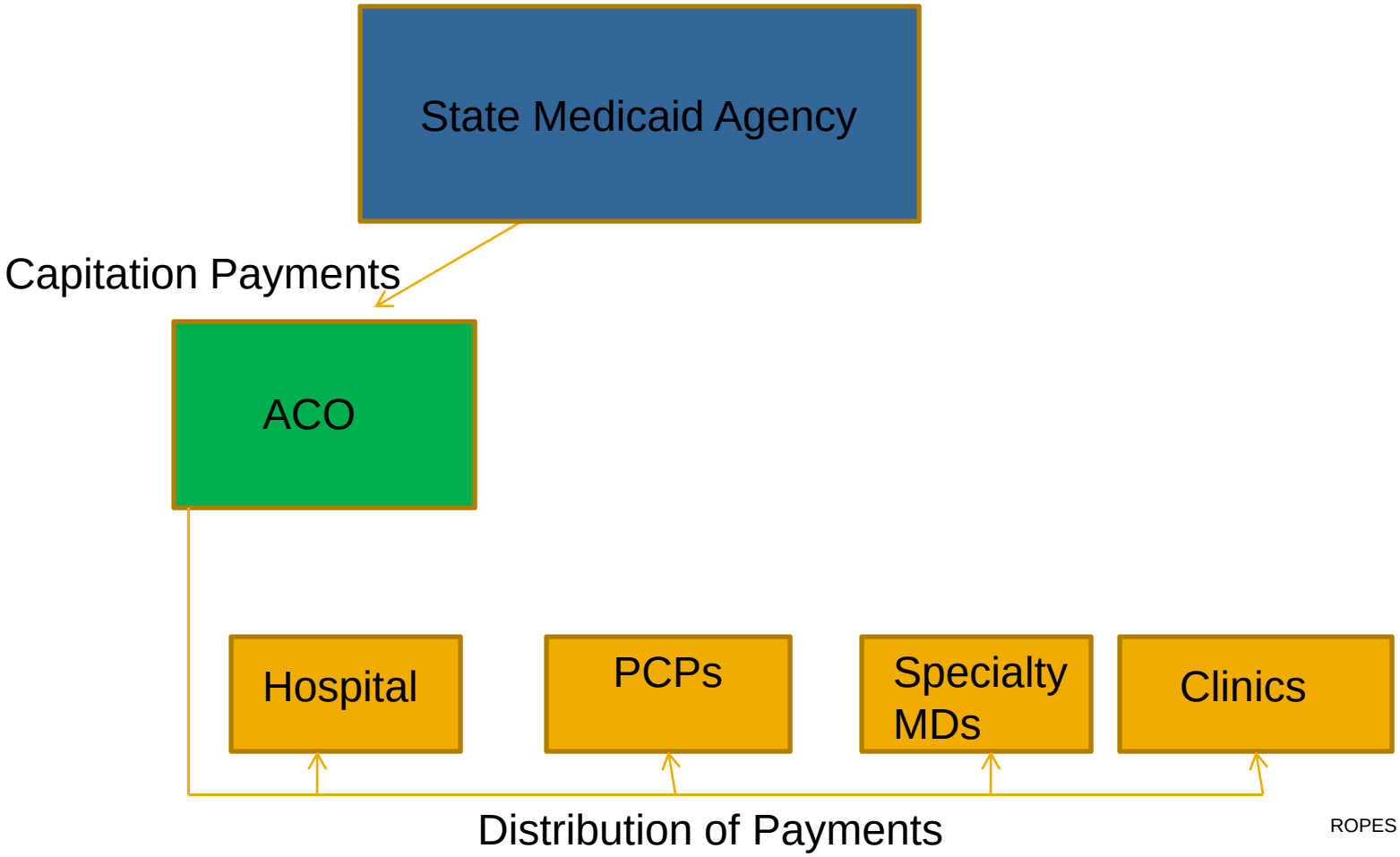
- Increased Payments for PCPs (§1202 HCERA)
  - Medicaid rates for primary care services increased to 100% Medicare Part B rates in 2013 and 2014
    - Family medicine, general internal medicine, and pediatric medicine physicians eligible
    - Applies to FFS and managed care payments, federal government to pay 100%
- Community Health Teams (§§ 3502 & 10321 ACA)
  - Grant program to support creation of community-based interdisciplinary health teams to support primary care practices
  - States and state-designated entities eligible to apply
  - Funding status unclear; Secretary directed to establish program

# V. Challenges and Options for Creating a Medicaid ACO Program

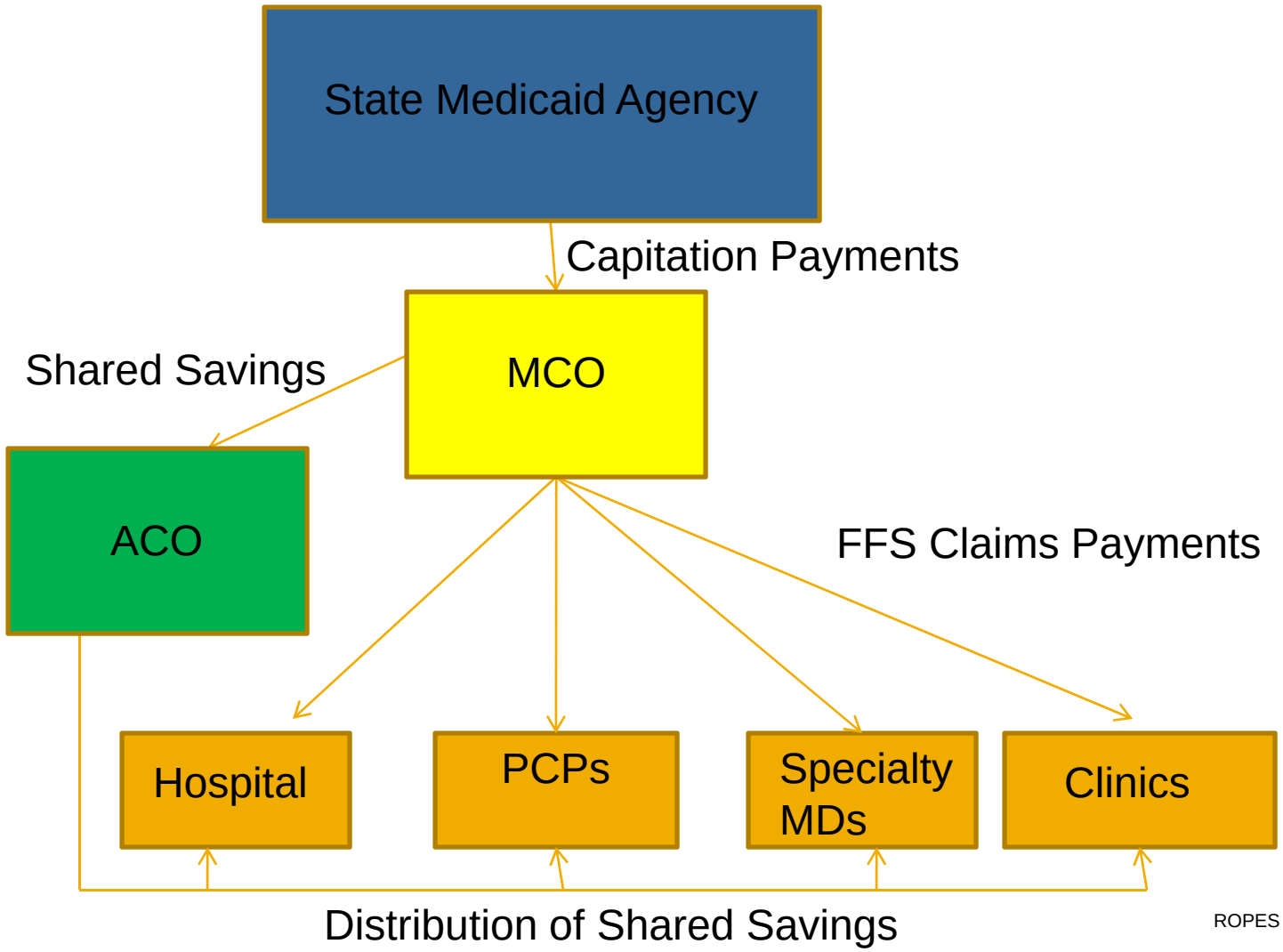
# Medicaid ACO Funds Flow: FFS Shared Savings Model



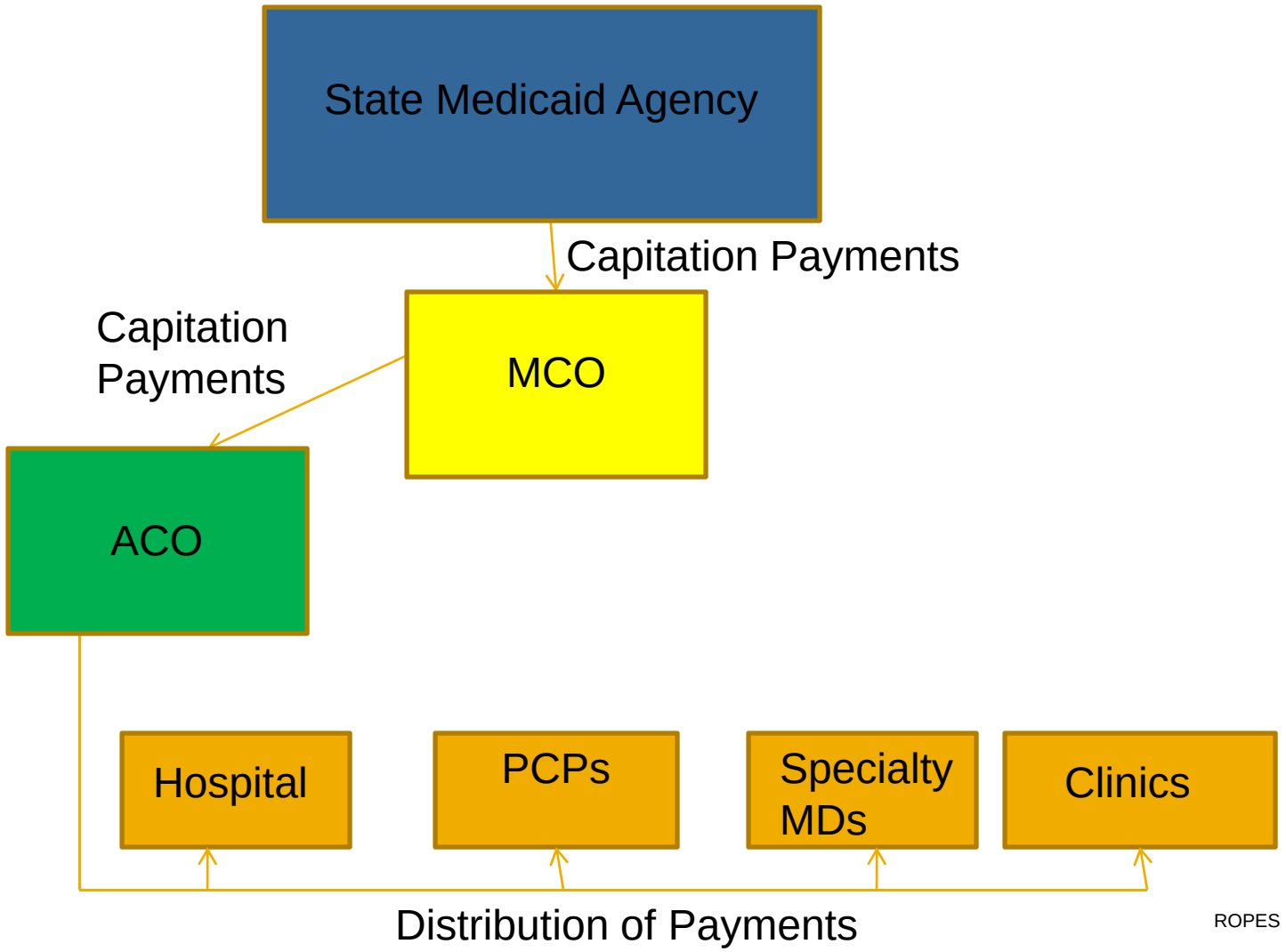
# Medicaid ACO Funds Flow: Capitated Model



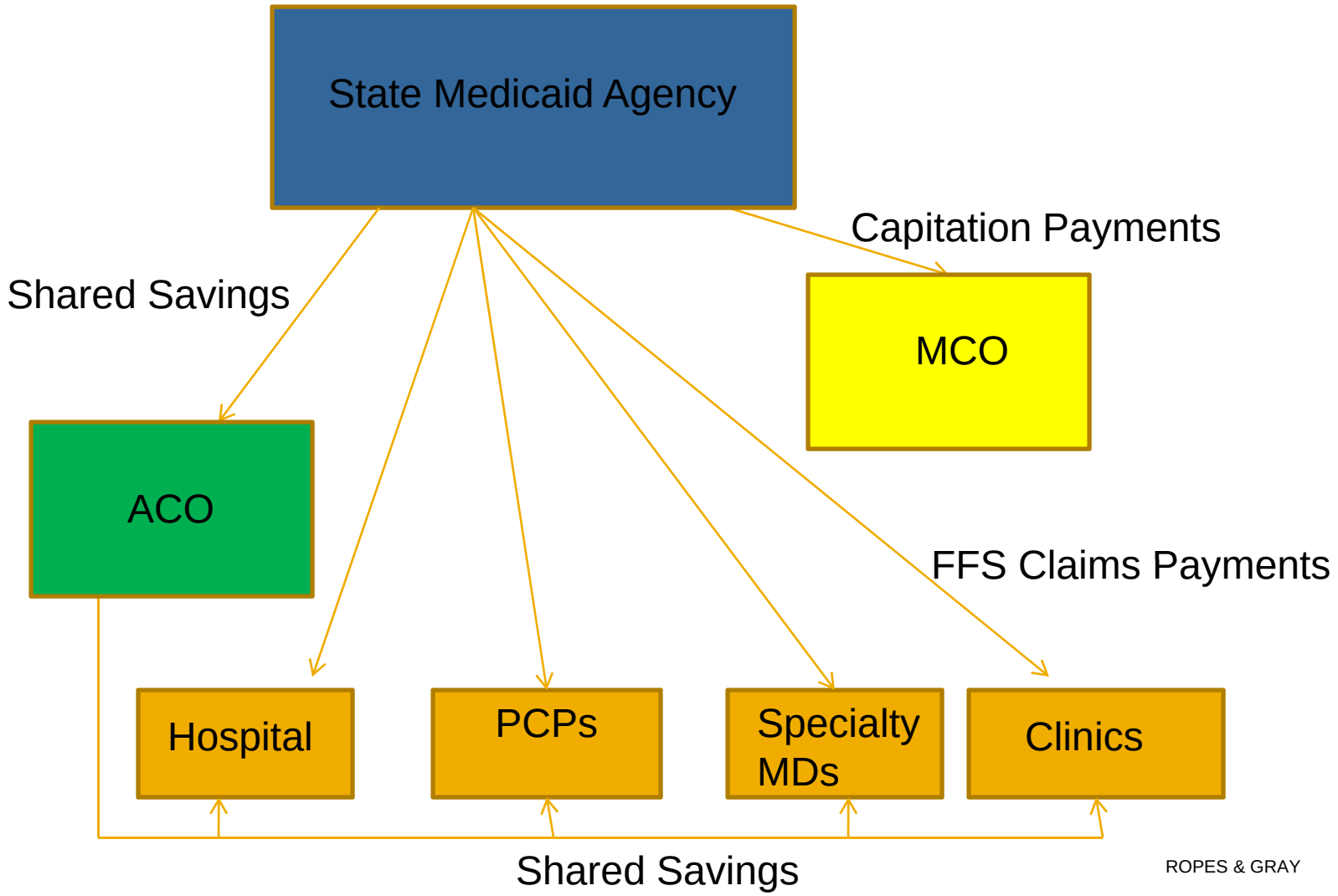
# Medicaid ACO Funds Flow: Managed Care Model/Shared Savings



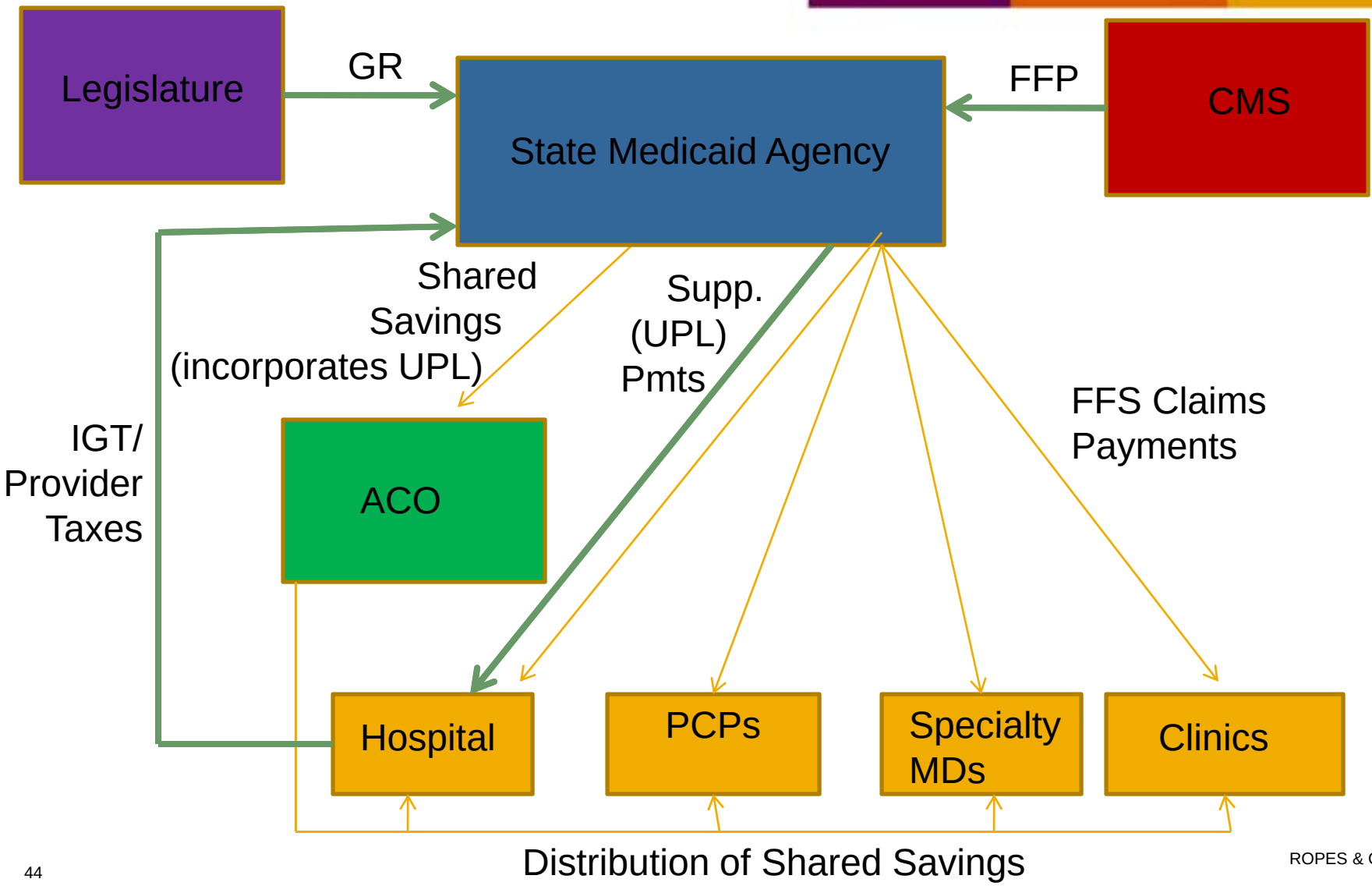
# Medicaid ACO Funds Flow: Managed Care Model/Sub-Capitation



# Medicaid ACO Funds Flow: ACO as Alternative to Managed Care



# Medicaid ACO Funds Flow: Supplemental Payments



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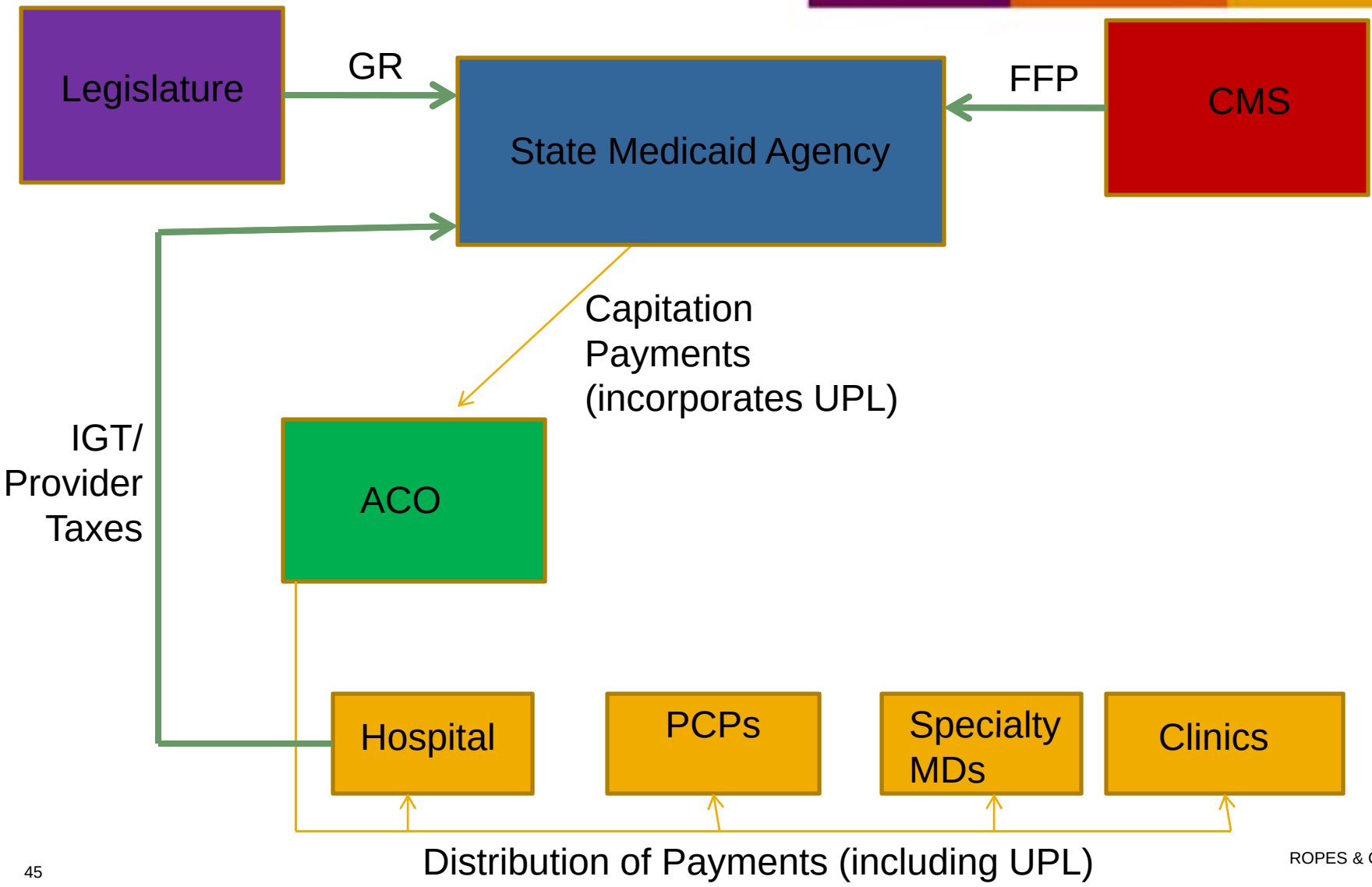

# Medicaid and the Sec. 3022 Shared Savings Program

- States may, but need not, adhere to Sec. 3022 requirements in Medicaid ACO programs
  - Waivers provide significant flexibility to design tailored programs
  - May design own programs through waivers, Innovation Center, combination
  - But … forthcoming regulations may set Medicaid parameters
- Participation in multi-payer ACOs may be facilitated by adopting Sec. 3022 model

# Eligibility Churning

- Can a Medicaid ACO have a stable patient base?
  - Instability caused by churning
  - Guaranteed Medicaid eligibility for a time period for those assigned to ACO?
  - ACO participation in Exchanges?
  - ACOs for the uninsured?

# Capital Challenges

- Medicaid providers may lack capital to create ACOs
  - Should providers with significant Medicaid populations share in first dollar savings?
  - Allow flexible funding sources to invest in ACO creation?
    - DSH
    - Waiver-based funding
    - HIT incentive payments
    - ACA funding
    - Innovation Center

# Unique Population Issues

- High-risk/high-cost population may require additional services
  - Expanding access to new services may temporarily increase costs
  - Flexible funding sources
- How to assign a difficult to reach population?
  - Prospective vs. Retrospective
  - Opt out?  Opt in?
  - Tailoring spending benchmarks/capitation payments to the populations
  - Additional (non-Medicaid) outreach

# Unique Population Issues

- Dual Eligibles
  - Coordinating Medicare and Medicaid funding
  - Coordinating Medicare and Medicaid coverage
  - Most savings accrue to Medicare; most investment in care management is by states and providers
  - Need to align incentives and consolidate program parameters

# VI. State Efforts to Establish Medicaid ACOs

# State Medicaid ACO Efforts - CO

- Colorado's Accountable Care Collaborative
  - Pilot to begin April-June 2011
  - PCPs participating in Primary Care Medical Provider network to serve as medical home
  - 7 Regional Care Coordination Organizations (RCCOs) provide management and care coordination
  - Statewide Data and Analytics Organization provides data and IT support
  - Care Coordination and Disease Management
  - Payment
    - FFS with PMPM payment to RCCO and PCMP
    - Incentive payments for achieving utilization targets

# State Medicaid ACO Efforts - NC

- North Carolina
  - Enacted legislation in July 2010 to transform Community Care program into ACO-type program
  - By October 2012, NC Community Care Network to release plan detailing:
    - Quality of care, access, utilization measures, performance incentives, and shared-savings models

# State Medicaid ACO Efforts - OR

- Oregon
  - Enacted health reform legislation in 2009
  - Broad range of initiatives essential to establish multi-payer ACOs
    - Consolidation of most state health programs in new Oregon Health Authority (OHA) to maximize purchasing power and align programs
    - Development of uniform, statewide health care quality standards for use by all purchasers
    - Standardization of certain provider payments to Medicare methodology
      - Goal of statewide implementation by 2013

# State Medicaid ACO Efforts - VT

- ACO Pilot to begin in 2011
- All-payer model
  - State's 3 commercial payers and state Medicaid agency
  - Hope to expand to Medicare through ACA Shared Savings program
- 3 community hospital sites participating by mid-2012
- Outgrowth of VT's Enhanced Medical Home Pilot

# Other States

- Massachusetts considering payment reform legislation
  - Encourages formation of ACOs
  - Requires all payers to develop alternative payment methodologies to compensate ACOs
  - MassHealth must implement alternative payment methodologies and contract with ACOs “to the maximum extent feasible” by January 1, 2014
- New Jersey legislature considering legislation to create Medicaid ACO demonstration project

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