ACOs as Risk-Bearing Organizations

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Agenda

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2. Characteristics of RBOs that Trigger Regulatory Oversight
3. Federal and State Regulatory Approaches to ACOs
4. Case Studies in State RBO/ACO Regulation:
   - California
   - New York
   - Massachusetts
5. Business and Structural Considerations for Risk-Bearing ACOs

ACOs as Risk-Bearing Organizations

Introduction: ACOs and State Regulation of Risk-Bearing Organizations

ACOs and State Regulation of Risk-Bearing Organizations

Is an ACO a risk-bearing organization ("RBO")?

- By virtue of…
  - Participating in the Medicare Shared Savings Program (MSSP)
  - Accepting financial risk for services provided by ACO participants under arrangements with commercial insurers or managed care organizations (MCOs)
- Organizations that bear financial risk are typically regulated by state insurance departments

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- CMS recognizes possibility that state regulatory bodies will treat ACOs as risk-bearing entities:
  - "[W]e emphasize that, under our proposal for a two-sided model under the Shared Savings Program, the Medicare program retains the insurance risk and responsibility for paying claims for the services furnished to Medicare beneficiaries."
  - CMS requested comments on whether "any of our proposals for the two-sided model in particular, or the Shared Savings Program in general, would trigger the application of any State insurance laws."
- State-by-state analysis – will depend on Department of Insurance application of state insurance laws
- Will ACOs be able/willing to comply with state regulatory framework?
  - Could include licensure; financial filings; financial solvency requirements, including minimum operating reserves

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Characteristics of RBOs that Trigger Regulatory Oversight

Characteristics of an RBO

What is an RBO?

- Generally: an organization that assumes financial responsibility for the provision of a defined set of benefits in exchange for fixed, periodic payments
- Performance risk: risk of being unable to treat an illness cost-effectively (*i.e.,* cannot control controllable costs)
- Insurance risk: the risk that a patient will become sick or that a group of patients will have higher than estimated care needs
- Assumption of performance risk alone typically does not make an entity subject to state insurance regulation
- At what point does performance risk become insurance risk?

Types of Insurance Risk

Risks borne by insurers, managed care organizations (MCOs) and other RBOs

- Affiliate Risk: risk that the financial condition of an affiliate causes an adverse change in capital
- Asset Risk: risk of adverse fluctuation in the value of assets
- Underwriting Risk: risk that premiums will not be sufficient to pay claims
- Credit Risk: risk that providers and plan intermediaries paid under alternative payment arrangements will not be able to provide the services contracted as well as the recoverability of amounts due from reinsurers
- Business Risk: general risk of conducting business, including the risk that actual expenses will exceed amounts budgeted (*e.g.*, through overrun of administrative expenses)

ACOs under the Medicare Shared Savings Program – Track 1 vs. Track 2

	ACO Upside Only (Track 1, CYs 1 &2)	ACO Upside/Downside (Track 1, CY3; Track 2, all yrs)
Minimum Savings Rate	2% to 3.9%	2%
Shared Savings	Amount is net of MSR	First dollar savings
Shared Savings Rate	Maximum 52.5%	Maximum 65%
Shared Savings Cap	7.5% of benchmark	10% of benchmark
Minimum Loss Rate	N/A	2% of benchmark
Shared Losses	N/A	First dollar shared losses
Shared Loss Rate	N/A	1 minus Shared Savings Rate
Shared Losses Cap	N/A	Track 1: 5% in CY3 Track 2: 5% in CY1; 7.5% in CY2; 10% in CY3
Shared Savings Withhold	25%	25%

CMMI Initiative – Pioneer ACO Model

- Pioneer ACO Model is designed for ACOs experienced in coordinating care across care settings (Pioneer ACOs)
  - Pioneer ACO Model works parallel to the MSSP
  - During first two years of the Pioneer ACO Model, Pioneer ACOs would have higher levels of shared savings and risk than ACOs in the MSSP
  - During third year of the Pioneer ACO Model, a substantial portion of Pioneer ACO's payments would be made under a "population-based model" (*i.e.*, a PMPM rate)

CMMI Initiative – Proposed Advanced Payment Initiative

- CMMI is considering prepaying a portion of future shared savings to ACOs participating in the MSSP
  - Prepayment provides ACOs capital to invest in infrastructure and staff necessary to participate in the MSSP
  - ACOs would need to submit a plan that outlines how funds will be used
  - Prepayments would be deducted from future shared savings

ACOs under Arrangements with Commercial Payors

Under what types of commercial alternative payment arrangements will (or do) ACOs bear insurance risk?

- Alternative Payment Arrangement Models
  - Partial Risk: Budget set between plan and provider; Provider shares in deviations from budget/cost-sharing within set parameters; Reductions on increases in payments based on quality or other performance measures
  - Full Risk (for health care provider's own services): fixed or capitated payment per episode of care or other set of services

ACOs under Arrangements with Commercial Payors (cont'd)

- Risk-Sharing Models (Cont'd)
  - Global Risk (for a defined set of services to a defined population): fixed payment, financial risk and/or responsibility for paying claims for physician services and inpatient and outpatient institutional care
    - Assumption of global risk typically requires state licensure as a managed care plan, health care services plans or provider-service organization
    - Many variants of risk-based payment – time period covered, types of care covered

Concerns of Regulatory Agencies Vis-à-vis RBOs

- Financial solvency to protect creditors – enrollees and health care providers
  - Timeliness of health care provider reimbursement
  - Concerns extend to “downstream entities”
  - Adequacy of health care provider reimbursement
- Accountability to consumers – disruptions in care caused by health plan or provider insolvency
- Consumer protection – quality of care and access to care

ACOs as Risk-Bearing Organizations

Federal and State Regulatory Approaches to RBOs

Who Regulates RBOs – Federal vs. State

- Federal regulation of managed care plans and providers participating in federal health care payment programs
- Federal government establishes minimum requirements for insurers and managed care plans in order to regulate market for insurance
- State insurance departments have jurisdiction over licensing and solvency
- States also typically oversee quality assurance, enrollee grievance procedures, utilization review standards, provider network adequacy
- Insolvent insurers are subject to state receivership laws, not federal bankruptcy code

Regulation of Risk-Bearing in Federal Health Care Programs – Historical Experience

- State insurance regulation over RBOs in federal programs has been addressed before
- Medicare + Choice and Part D Prescription Drug Plans
  - Provider-Sponsored Organizations under Medicare + Choice
  - Participation in Part D by pharmacies and pharmacy benefit managers as PDP sponsors
  - Federal preemption, except over licensure and solvency
- Temporary waivers of state licensure
- Federal regulators likely to defer to the states on organizational and solvency issues

Typical State Regulatory Requirements for RBOs

- Licensure
- Minimum capital reserves
- Insolvency protections
  - Reinsurance or stop-loss insurance requirements
  - Deposits/surety bonds
  - Contribution to state guaranty funds
- Financial reporting – submission to regulators of audited financial statements, projected financial statements
- Financial monitoring and examinations

Typical State Regulatory Requirements for RBOs (cont'd)

- Other disclosure: claims reimbursed, denied or contested within specified period
- Mandated internal systems to assess quality of care
- Rules for provider dispute resolution and independent medical review
- Requirements for provider network breadth and access
- Control over insolvent entities: receivership and liquidation rights, exemption from bankruptcy

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Case Studies in State RBO/ACO Regulation

ACOs as Risk-Bearing Organizations

California

California – Historical Perspective

- Pioneered the “delegated model”: capitated payments by health plans to medical groups or IPAs; delegation of utilization management and credentialing
- Two large publicly-traded physician practice management companies (FPA and MedPartners) failed in 1998-1999
  - *Source: Presentation by Director of DMHC at National ACO Congress*
- Between 1998 and 2002, the inability of providers to manage capitation resulted in closure of 147 physician organizations providing care for 4 million HMO enrollees
  - *Source: Integrated Healthcare Association White Paper*
- Creation of Department of Managed Health Care (DMHC) and the Financial Solvency Standards Board (FSSB) (1999)

California – Regulation of Health Plans and RBOs

- Knox-Keene license required to arrange for the provision of health care services in return for prepaid or periodic payment (*e.g.*, HMO or provider bearing global risk)
  - Risk pool participation may trigger need for license
- Limited or Restricted Knox-Keene license
  - May only contract with an HMO for global risk; may not contract with employers or other purchasers as if full HMO; relieved of certain regulatory requirements for Knox-Keene plans
  - Limited licenses are not explicitly authorized by Knox-Keene Act
- Providers operating within the scope of their licenses (*e.g.*, physicians bearing risk for services they provide) are exempt from Knox-Keene licensure

California – Regulation of RBOs (SB 260)

- Regulation of RBOs is indirect – requirements apply to arrangements between health care service plans and RBOs
- Applies to health care providers (*e.g.,* IPAs) who accept "non-global" risk from health care service plans and do not require Knox-Keene license
- Requirements:
  - Positive Tangible Net Equity
  - Positive Working Capital
  - Minimum Cash-to-Claims Ratio (minimum 0.75 requirement)
  - Claims Payment Timeliness – 95% of complete claims reimbursed over any 3 months
  - RBO must estimate and documents their IBNR claims liability on a monthly basis
  - All RBOs required to submit annual audited financial statements

California – Regulation of RBOs and Application to ACOs

- FSSB is considering requiring ACOs that bear global risk to obtain "restricted" license – revival of limited licensure approach under Knox-Keene
- Application requirement with 6-month review period; provide information about:
  - Contracts with providers, administrative service providers and creditors
  - Quality of care review system
  - Enrollment projections
  - Projected financial statements for 2 years

California – Regulation of RBOs and Application to ACOs in MSSP

Recent pronouncements from DMHC on ACO oversight:

- Participation in MSSP does not appear to trigger requirement for DMHC licensure as health plan
  - Compensation to providers under MSSP based on original Medicare FFS schedule
- Position could change if compensation under MSSP is changed to capitation or other form of prepaid or periodic payment

- Source: Presentation by DMHC, May 19, 2010

ACOs as Risk-Bearing Organizations

New York

New York – Historical Perspective

- MCOs and IPAs grew rapidly in New York from 1995-2000
- State legislature active during that period in passing laws governing MCOs, IPAs and insurers
  - Focus on consumer protections (e.g., coverage portability, guaranteed issue, grievance and appeal processes)
- Dual regulation developed
  - State Insurance Department ("SID") – oversees solvency of managed care plans, monitors markets
  - Department of Health ("DOH") – oversees quality of care, evaluates network adequacy, tracks complaints
- Temporary legislation governing provider risk contracting
  - In 1996, with introduction of PSOs under Medicare + Choice, provisions enacted in Public Health Law to permit direct risk contracting between providers and Medicare, Medicaid and other health care purchasers
  - Certificate of Authority from Health Commissioner and other requirements
  - Legislation sunset in 2002 without adoption by providers
- Market shift away from provider risk contracting after 2000

New York – Regulation of RBOs

- MCOs are certified by DOH; insurers are licensed by SID
- Any agreement between an MCO and another entity that transfers financial risk is subject DOH financial review and approval
  - Except for prepaid capitation agreements, which require separate SID financial approval under SID Regulation 164 (“Reg 164”)
  - If there is transfer of risk through other provisions (e.g., withhold, pooling, postpaid), DOH financial review and approval is also required
- DOH “Part 98”regulations
  - Imposes contingency reserve and escrow requirements for MCOs
  - Allows an IPA to share risk for provision of medical services with MCOs, subject to approval from DOH or SID, as applicable
    - IPAs do not provide services directly but must subcontract with providers

New York – Regulation of RBOs (cont'd)

- DOH assigns every risk-sharing arrangement to one of five risk levels
- Each risk level involves different financial review criteria, which could include
  - Demonstration that provider/IPA is financially responsible, capable of assuming risk, has satisfactory insurance, reserves or other arrangements, and has sufficient capital and solvency evidenced by submission of financial statements
  - Establishment by provider/IPA of a financial security deposit equal to 12.5% of the estimated annual medical costs covered by the arrangement and paid to the provider/IPA
  - Establishment of out-of-network reserve account if the risk arrangement covers services not provided directly by non-participating providers
  - Additional requirements for IPA risk sharing

New York – Regulation of RBOs and Application to ACOs

- No comments yet from SID or DOH on ACOs under MSSP
- ACO Demonstration Project – separate from the MSSP
  - Adopted in March 2011 as part of 2011/2012 budget following recommendation by the Medicaid Redesign Team
  - Limited to 7 ACOs
  - Unrestricted payment methodologies, notwithstanding any contrary provisions of the Public Health Law or Insurance Law
  - Applies to all third-party payors
  - Requirements related to financial solvency likely to appear in future DOH regulations
- Do ACOs fit into the current regulatory scheme for MCOs and IPAs?

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Massachusetts

Massachusetts – Historical Perspective

- Massachusetts HMO Enabling Act
  - Authorizes and regulates the establishment and operation of HMOs
  - Division of Insurance ("MA DOI") has exclusive jurisdiction over HMO licensure
  - MA DOI regulates premiums charged by HMO and imposes financial standards

- Law in 2000 establishing new requirements for HMOs
  - For licensure renewal, submission to DOI of the following:
    - Financial statements and projections of results of operations for the next 3 years
    - Financial plan including description of mechanisms to monitor financial solvency
    - Reinsurance contracts
  - Created Managed Care Bureau in MA DOI and a Managed Care Oversight Board within the Executive Office of HHS
  - Silent as to applicability to intermediary provider contracting organizations, such as IPAs
  - Certification requirements to perform utilization review and medical management

Massachusetts – Regulation of RBOs

- MA health insurance reform - individual mandate (2006)
  - Numerous effects on state insurance market
  - Review by state regulators of risk-based capital ratios for insurance carriers in the merged individual/small group market
- Escalation in health care costs has led to calls for more regulation of health plan rates
  - Effects on solvency?

Massachusetts – Proposed ACO Legislation and MSSP

- Special Commission on the Health Care Payment System and investigations by Office of Attorney General
  - Report of Special Commission (July 2009) – recommendation of payment method alternatives to FFS
  - Attorney General investigation of provider reimbursement and insurance premium rate increases
- Legislation strengthening DOI's authority over merged market and limiting premium rate increases (August 2010)
- Health plan litigation over MA DOI's caps on premium rate increases caps and price controls in merged market
- Proposed health care payment reform legislation
  Mass. Bill H01849 (2011)

Comparison of Key Terms of Proposed Massachusetts Payment Reform Legislation and Proposed Medicare Shared Savings Program Regulations

	Proposed Massachusetts Payment Reform Legislation	Proposed Medicare Shared Savings Program Regulations
General Goals	General goals include: • Encouraging the formation of ACOs that will achieve improved health outcomes and lower the costs of care • Fostering payment methods that decrease total per capita expenditures and the rate of growth in expenditures and improve the efficiency, effectiveness and quality of health care delivery systems • Transitioning payments from fee-for-service to global and other alternative payment methodologies for all public and private payers so that payment is based on quality rather than volume	General goals include: • Achieving better health for individuals, better health for populations, and reduced growth in expenditures • Promoting accountability for patient populations • Coordinating items and services under Medicare Parts A and B • Encouraging investment in infrastructure and redesigned care processes for high quality and efficient delivery of care

Comparison of Key Terms of Proposed Massachusetts Payment Reform Legislation and Proposed Medicare Shared Savings Program Regulations (cont'd)

	Proposed Massachusetts Payment Reform Legislation	Proposed Medicare Shared Savings Program Regulations
Definition of ACO	An entity that: • Is comprised of provider groups and operates as a single integrated organization; • Accepts primary responsibility for the quality, and at least shared responsibility for the cost, of care delivered to a specific population of patients; • Operates consistent with the principles of a patient centered medical home; • Has a formal legal structure to receive and distribute savings; and • Complies with any federal requirements for ACOs, however named, enacted or adopted in law or regulation	An entity that: • Is comprised of an eligible group of ACO participants that: o Work together to manage and coordinate care for Medicare fee-for-service beneficiaries; o Have a mechanism for shared governance that provides all ACO participants with appropriate proportionate control over the ACO's decision-making process; and • Is recognized and authorized under state law, as identified by a Taxpayer Identification Number

Comparison of Key Terms of Proposed Massachusetts Payment Reform Legislation and Proposed Medicare Shared Savings Program Regulations (cont'd)

	Proposed Massachusetts Payment Reform Legislation	Proposed Medicare Shared Savings Program Regulations
Eligible ACO Participants	A provider that by contract or corporate structure participates in the ACO Provider means a provider of medical or health services and any other person or organization that furnishes, bills for or is paid for health care services in the normal course of business	The following providers and suppliers are eligible separately or in combination to form ACOs: • ACO professionals in group practice arrangements • Networks of individual practices of ACO professionals • Partnerships or joint venture arrangements between hospitals and ACO professionals • Hospitals employing ACO professionals ACO professionals include doctors of medicine or osteopathy, physician assistants, nurse practitioners, and clinical nurse specialists

Comparison of Key Terms of Proposed Massachusetts Payment Reform Legislation and Proposed Medicare Shared Savings Program Regulations

	Proposed Massachusetts Payment Reform Legislation	Proposed Medicare Shared Savings Program Regulations
Legal Structure of ACO	ACO must have a formal legal structure to receive and distribute savings	ACO must be constituted as a legal entity for: • Receiving and distributing shared savings • Repaying shared losses • Establishing, reporting, and ensuring provider compliance with health care quality criteria (e.g., quality performance standards) • Performing other ACO functions
Exclusivity of ACO Participants	Primary care physicians may participate in only one ACO (except as permitted in regulations)	Primary care physicians used as basis for assigning beneficiaries to an ACO must be exclusive to the ACO

Comparison of Key Terms of Proposed Massachusetts Payment Reform Legislation and Proposed Medicare Shared Savings Program Regulations (cont'd)

	Proposed Massachusetts Payment Reform Legislation	Proposed Medicare Shared Savings Program Regulations
Key Legal Agreement	Alternative Payment Contract between a payer and an ACO or other provider under which reimbursement is pursuant to an alternative payment methodology	Medicare Shared Savings Program Agreement between an ACO and CMS
Quality Measurement	Division of Health Care Finance and Policy will develop quality measures to be used in evaluating ACO performance Alternative Payment Contract between ACO and payer must contain at least "some" performance based quality measures with associated financial rewards and/or penalties	Extensive quality measurement system, based substantially on other CMS programs, that assesses an ACO's quality performance on 65 quality measures

Comparison of Key Terms of Proposed Massachusetts Payment Reform Legislation and Proposed Medicare Shared Savings Program Regulations (cont'd)

	Proposed Massachusetts Payment Reform Legislation	Proposed Medicare Shared Savings Program Regulations
Payment Methodology	"Alternative payment methodologies" that are not fee-for-service based, including shared savings arrangements, bundled payments, episode based payments, and global payments No payment "based on" the fee-for-service methodology will be considered an alternative payment methodology	Fee-for-service payments with opportunity for shared savings and liability for losses
Payment of Shared Savings and Performance Incentive Payments	Performance incentive payments and performance penalties depend on agreement negotiated between ACO and payer and on the alternative payment methodology used	ACOs that exceed a minimum savings rate, meet minimum quality performance standards, and otherwise maintain eligibility to participate in the Shared Savings Program are eligible to receive payments for shared savings

Comparison of Key Terms of Proposed Massachusetts Payment Reform Legislation and Proposed Medicare Shared Savings Program Regulations

	Proposed Massachusetts Payment Reform Legislation	Proposed Medicare Shared Savings Program Regulations
Financial Solvency and Mitigation of Risk	Division of Insurance is charged with: • Monitoring risk arrangements between payers and ACOs • Establishing benchmarks to facilitate the transition of providers to integrated care delivery systems that accept risk • Developing methodologies for risk adjustments, risk corridors, outliers and reinsurance to protect ACOs from assuming excess risk • As it determines necessary after January 1, 2014, adopting regulations establishing risk adjusters that must be used by payers when implementing alternative payment methodologies • Adopting regulations as necessary to establish financial oversight provisions for ACOs and other providers that take on risk ACOs must be members of the Massachusetts ACO Reinsurance Plan	In two-sided model, first dollar shared losses once minimum loss rate of 2% is exceeded Cap on losses phased in: • 5% cap in year one • 7.5% cap in year two • 10% cap in year three CMS withholds 25% of shared savings earned to ensure that ACO can repay Medicare for future losses HHS and other agencies may audit ACO to assess the ability of ACO to bear the risk of potential losses and to repay any losses to CMS

Comparison of Key Terms of Proposed Massachusetts Payment Reform Legislation and Proposed Medicare Shared Savings Program Regulations (cont'd)

	Proposed Massachusetts Payment Reform Legislation	Proposed Medicare Shared Savings Program Regulations
Population Covered	Goal is all public and private beneficiaries	Medicare fee-for-service beneficiaries
Payers Participating	Goal is participation by all public and private payers Executive Office of Health and Human Services must try to obtain a waiver of federal statutory provisions to allow Medicare to participate in alternative payment methodologies State-funded health programs (*e.g.*, Medicaid and the Connector) must implement alternative payment methodologies and use ACOs by January 1, 2014	Medicare Parts A and B
Program Term	Long-lasting system reform	3 year program term

Comparison of Key Terms of Proposed Massachusetts Payment Reform Legislation and Proposed Medicare Shared Savings Program Regulations (cont'd)

	Proposed Massachusetts Payment Reform Legislation	Proposed Medicare Shared Savings Program Regulations
Oversight Agencies	Division of Health Care Finance and Policy facilitates the establishment of ACOs and the transition to alternative payment methodologies and drafts key implementing regulations Attorney General oversees: • Market competition • Obtaining waivers from federal fraud and abuse laws • Provider compliance with market conduct laws, such as prohibition on recouping lower payer reimbursement by increasing charges to other payers or health benefit plans • Impact of other state and federal laws on implementation of legislation Division of Insurance oversees: • Premium increases and rates in contracts between payers and providers • Risk arrangements between payers and ACOs • Carrier compliance with market conduct laws, such as prohibition on entering into a contract with a hospital or inpatient facility that requires carrier to contract with the affiliates of the hospital or inpatient facility	CMS oversees implementation of the Shared Savings Program, distribution of shared savings and assessment of ACO quality OIG oversees waivers of federal fraud and abuse laws for ACOs participating in the Shared Savings Program FTC and DOJ oversee ACO compliance with federal antitrust laws IRS oversees ACO compliance with federal laws governing tax-exempt organizations

ACOs as Risk-Bearing Organizations

Business and Structural Considerations for Risk-Bearing ACOs

Skills Required for an ACO to Function as an RBO

- Ability to project different types of revenues (*e.g.,* expected earnings on shared risk pools) and costs (*e.g.,* IBNR)
- Bonus settlement and/or claims adjudication and payment distribution within the ACO
- Medical management for care delivered by others – monitor and influence specialty referrals, ambulatory care (*e.g.,* diagnostic tests), inpatient admissions and length of stay
- Legal and business knowledge to negotiate risk-bearing contracts (*e.g.,* implementing risk corridors, setting up risk pools)
- Specific challenges under MSSP
  - Managing risk in an open network with patient choice

Considerations for Becoming or Participating in a Risk-Bearing ACO

- Is licensure required? What type of license? Prerequisites to obtaining license and conditions to maintaining license?
- Is financial risk management a competency the organization possesses or wants to develop?
- What are the skills of other potential ACO participants?
- How to obtain the skills necessary to function as an RBO?
  - Build
  - Buy
  - Contract or Partner

Considerations for Becoming or Participating in a Risk-Bearing ACO (cont'd)

- How to protect the organization in an ACO if organization has minority control or delegates payment-related operational functions to ACO?
- How should risk pools be structured?
- What criteria for fiscal health or ability to manage risk should be established as prerequisites for participation in ACO?

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