ACOs and Medicaid:
Challenges and Opportunities
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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
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

Medicaid Enrollees are Sicker and More Disabled Than the Privately-Insured

<table>
<thead>
<tr>
<th>Poor (&lt;100% FPL)</th>
<th>Medicaid</th>
<th>Privately Insured</th>
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<tbody>
<tr>
<td>Fair/Poor Health</td>
<td>38%</td>
<td>12%</td>
</tr>
<tr>
<td>Physical &amp; Mental Chronic Condition</td>
<td>26%</td>
<td>13%</td>
</tr>
<tr>
<td>Unable/Limited Work Due to Health</td>
<td>36%</td>
<td>6%</td>
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<table>
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<tr>
<th>Near Poor (100-199% FPL)</th>
<th>Medicaid</th>
<th>Privately Insured</th>
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</thead>
<tbody>
<tr>
<td>Fair/Poor Health</td>
<td>34%</td>
<td>12%</td>
</tr>
<tr>
<td>Physical &amp; Mental Chronic Condition</td>
<td>25%</td>
<td>10%</td>
</tr>
<tr>
<td>Unable/Limited Work Due to Health</td>
<td>28%</td>
<td>4%</td>
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Note: Adults 19-64.
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
• 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

State Medicaid Agency

Shared Savings

ACO

Hospital

PCPs

Specialty MDs

Clinics

Distribution of Shared Savings

FFS Claims Payments
Medicaid ACO Funds Flow: Capitated Model

State Medicaid Agency

Capitation Payments

ACO

Hospital
PCPs
Specialty MDs
Clinics

Distribution of Payments
Medicaid ACO Funds Flow: Managed Care Model/Shared Savings

State Medicaid Agency

Capitation Payments

Shared Savings

MCO

FFS Claims Payments

ACO

Distribution of Shared Savings

Hospital

PCPs

Specialty MDs

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

State Medicaid Agency

Capitation Payments

MCO

ACO

Capitation Payments

Hospital

PCPs

Specialty MDs

Clinics

Distribution of Payments
Medicaid ACO Funds Flow: ACO as Alternative to Managed Care

State Medicaid Agency

- ACO
- Hospital
- PCPs
- Specialty MDs
- Clinics

Shared Savings

Capitation Payments

FFS Claims Payments

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Medicaid ACO Funds Flow: Supplemental Payments

- **Legislature** → **GR** → **State Medicaid Agency** → **FFP** → **CMS**

- **Shared Savings** (incorporates UPL) → **ACO**
  - **IGT/Provider Taxes**

- **Supp. (UPL) Pmts**

- **FFS Claims Payments**

- **Distribution of Shared Savings**
  - **Hospital**
  - **PCPs**
  - **Specialty MDs**
  - **Clinics**
Medicaid ACO Funds Flow: Supplemental Payments

- Legislature
- State Medicaid Agency
- ACO
- Hospital
- PCPs
- Specialty MDs
- Clinics

IGT/Provider Taxes → ACO

Capitation Payments (incorporates UPL)

Distribution of Payments (including UPL)

Legislature → GR → State Medicaid Agency → FFP → CMS

- GR
- FFP

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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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