

# Medicaid Accountable Care: Accountable Care Organizations, Medicaid, and Medicaid Health Plans Briefing for MHPA

**John Pourciau and Kip Piper**  
Sellers Dorsey

Webinar

October 24, 2011



**SELLERS DORSEY**

Redefining the possibilities™

# Webinar Agenda

- 1. ACO Background**
- 2. Medicaid Health Plans vs. ACOs**
- 3. Medicaid Health Plan ACO Participation**
- 4. Q & A**

# Accountable Care Background

- **What is an ACO?**
- **History**
- **Critical Success Factors**
- **Current ACO Developments**
- **Potential Threats and Opportunities for Medicaid Health Plans**

# What is an ACO?

## Key Principles:

- Clear aims: better overall health through higher-quality and lower costs with a focus on patients.
- Establish provider organizations accountable for achieving better results for all of their patients at a lower cost.
- Align financial, regulatory, and professional incentives with the aims of better health through higher-quality care, lower costs.

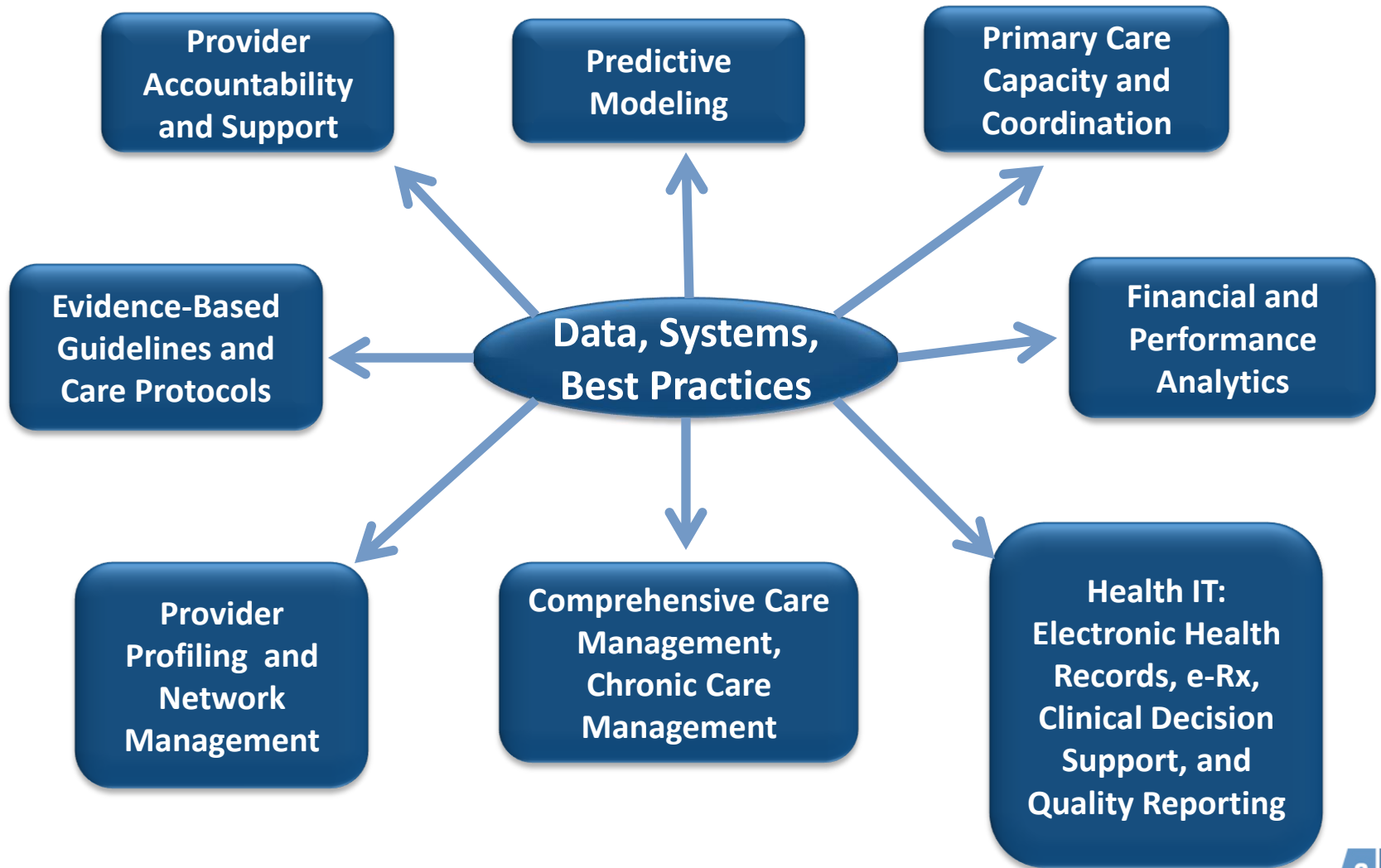
## History: Physician Group Practice Demonstration

- One of the first examples of the accountable care model is the Physician Group Practice (PGP) demonstration.
- The Centers for Medicare and Medicaid Services (CMS) created PGP in April of 2005.
- The demonstration incentivizes physician groups to increase quality and lower costs.
- Providers receive payments based on the estimated savings they generate for Medicare, as long as they also meet quality performance standards.

## History: Medicare Shared Savings Program

- Affordable Care Act (ACA) created Medicare Shared Savings Program (MSSP) in s. 1899 of Social Security Act.
- Creates the option for Medicare providers to form Accountable Care Organizations (ACOs).
- Through an ACO, physicians, hospitals, and other providers take responsibility for quality and overall care of their Medicare patients.
- If ACO meets minimum quality standards, ACO may receive 50%-60% of Medicare savings from elimination of unnecessary costs, avoided hospitalization, etc.

# ACO Critical Success Factors



## Current ACO Developments: State ACOs

- Some States have already begun to consider implementation of the ACO concept for Medicaid.
- Legislators in 24 States and the District of Columbia filed bills that address ACOs.
- States, like Utah, have submitted an Accountable Care Organization Section 1115 Waiver demonstration.

## Current ACO Developments: State ACOs: Utah

- Utah submitted a Section 1115 waiver to CMS in July to transform its Medicaid managed care program to an accountable care model.
- ACOs will receive capitated payments per member.
- Utah will only renew contracts with ACOs that meet minimum quality standards.
- Shared savings is not a required component of the Utah waiver, however Utah will allow ACOs to use both patient and provider incentives.

## Current ACO Developments: Dual Eligible Demonstration

- CMS created a demonstration project for the dual-eligible population.
- States can partner with Medicaid health plans and providers to reduce Medicare and Medicaid health costs.
- If States reduce health costs, then they get a percentage of the savings.
- The dual-eligible demonstration shows the flexibility of the ACO concept.

# Current ACO Developments: Dual Eligible Demonstration

## Demonstration States

- |                  |                  |
|------------------|------------------|
| ▪ California     | ▪ Oklahoma       |
| ▪ Colorado       | ▪ Oregon         |
| ▪ Connecticut    | ▪ South Carolina |
| ▪ Massachusetts  | ▪ Tennessee      |
| ▪ Michigan       | ▪ Vermont        |
| ▪ Minnesota      | ▪ Washington     |
| ▪ New York       | ▪ Wisconsin      |
| ▪ North Carolina |                  |

## Current ACO Developments: Private ACOs

- Private insurers have also begun to experiment with ACOs.
- The Brookings Institute and the Dartmouth Institute for Health Policy and Clinical Evaluation created a pilot program for provider shared savings contracts with private insurers.
  - 5 providers in 4 States: Arizona, California, Kentucky, and Virginia.
  - 3 insurance companies: Anthem, United Health, and Humana.
- If ACOs reduce costs, then they will be eligible for shared savings, like the Medicare ACO program.

## Current ACO Developments: Private ACOs: Alternative Quality Contract

- Blue Cross Blue Shield Massachusetts (BCBS MA) launched the Alternative Quality Contract program in 2009.
- BCBS MA negotiates five year contracts with eligible providers.
- The contract sets a per member per month budget for the initial year and annual budget increases for the remaining years.
- Providers may assume between 50% and 100% of the risk of the contract.
- Providers with 100% of the risk receive all savings and are liable for all losses.

## Potential Threats for Medicaid Health Plans

- ACOs could evolve into a competitive alternative to the capitated health plan model in some States.
- Providers in some States may be eager to supplant health plans in marketplace.
- ACO model is expected to encourage further provider consolidation, with adverse effects on prices and choice.
- Competitive threat intensifies as providers consolidate and redesign care delivery.

# Potential Opportunities for Medicaid Health Plans

- Shared savings is a means to address cost pressures and reward efficient providers, all while protecting quality.
- ACOs provide a new market for administrative services from Medicaid health plans:
  - Data collection and quality reporting
  - Data warehouses, analytics, and predictive models
  - Administrative services
  - Access to an extensive Medicaid provider network
- ACOs are a means to compete for Medicaid expansion and health exchange market.

# Medicaid Health Plans vs. ACOs

- **Health Plans Accomplish the Goals of ACOs**
  - Performance Measurement
  - Accountability
  - Financial Incentives
- **Proven Track Record of Lower Costs and High Quality**
- **Potential for Future Improvement**

# Performance Measurement

- HEDIS measures provide adequate quality measurements for Medicaid beneficiaries.
- Cultural competency regulations require proper care environments for all races and ethnicities.
- Performance standards tie quality measurements to care requirements to maintain health quality.

# Accountability

- Managed care contracts hold Medicaid health plans accountable for the cost and quality of care.
- States pay Medicaid health plans through payment methods, like capitation, that encourage cost-effective care.
- Existing State managed care financial viability and accountability standards ensure that Medicaid health plans are able capable of providing care.

## Financial Incentives

- Medicaid health plans are experienced innovators in the use of care improvement incentives.
- Providers: Medicaid health plans use incentives to increase the quality of provider performance.
- Patients: Medicaid health plans also use incentives to encourage patient participation in disease management programs.

# Proven Track Record of Lower Costs and High Quality

## ■ Lower Costs

- Medicaid health plans reduce costs for States.
- In 2004, the Lewin Group synthesized the results of 14 studies on the effect of Medicaid managed care on costs.
- They found that Medicaid managed care reduced costs for their patient population in nearly all instances.
- Cost reduction varied from 2% to 19%.

## ■ Higher Quality

- While Medicaid health plan performance may vary from plan to plan, many Medicaid plans have demonstrated a continued commitment to increase the quality of care for Medicaid beneficiaries.
- Through increased care coordination, beneficiary outreach, and the use of information technology, Medicaid health plans have improved care for millions.

## Potential for Future Improvement

- Medicaid health plans have the potential to further reduce costs and improve quality for States.
- Fully capitating Medicaid costs could result in a total savings of up to \$87 billion over ten years.
- Medicaid health plans also provide an excellent format for continued quality improvements like the implementation of Patient-Centered Medical Homes (PCMH).

# Medicaid Health Plan ACO Participation

- **Essential for Successful Medicaid ACOs**
- **Benefits of Medicaid Health Plan Participation in Medicaid ACOs**
- **Possible ACO Model Variation**
- **Policy Prescriptions**

## Essential for Success

- Medicaid health plans have the capabilities, systems, and financial resources to help States and providers implement Medicaid ACOs.
- Medicaid health plans understand the unique needs of Medicaid enrollees and have established working relationships with Medicaid providers, particularly safety-net providers.
- Most States have an actualized strategy regarding Medicaid health plans that can be applied to ACOs.

## Benefits of Medicaid Health Plan Participation in Medicaid ACOs

States	Beneficiaries	Providers
<ul style="list-style-type: none"><li>▪ Quality measures are already in place.</li><li>▪ Accountability safeguards</li><li>▪ Can administer Medicaid ACOs without significant State administrative or financial resources.</li><li>▪ Flexible enough to cater ACO capabilities to State needs.</li></ul>	<ul style="list-style-type: none"><li>▪ Existing provider networks ensure adequate health access.</li><li>▪ Knowledge of patient population.</li><li>▪ Experienced outreach and enrollment practices.</li><li>▪ Already required to account for linguistic and cultural capacity.</li></ul>	<ul style="list-style-type: none"><li>▪ Capable of paying upfront ACO implementation costs.</li><li>▪ Experienced risk modeling.</li><li>▪ Established relationships with primary care providers.</li><li>▪ Can provide assistance in partnership with or as a service to providers.</li></ul>

# ACO Model Variation: Weak Managed Care States

Weak Managed Care	
<b>Payment</b>	<ul style="list-style-type: none"><li>▪ ACO Bonus Only</li></ul>
<b>Responsibility</b>	<ul style="list-style-type: none"><li>▪ Bonus for low spending</li><li>▪ Bonus contingent on quality scores</li><li>▪ No insurance or performance risk</li></ul>
<b>Operation</b>	<ul style="list-style-type: none"><li>▪ FFS claiming as usual</li><li>▪ Distribute bonus payments to ACO providers</li><li>▪ Coordinate care</li></ul>
<b>Incentives</b>	<ul style="list-style-type: none"><li>▪ Incentive to reduce volume, redesign care</li><li>▪ Enough to compensate for lower FFS volume?</li></ul>

# ACO Model Variation: Moderate Managed Care States

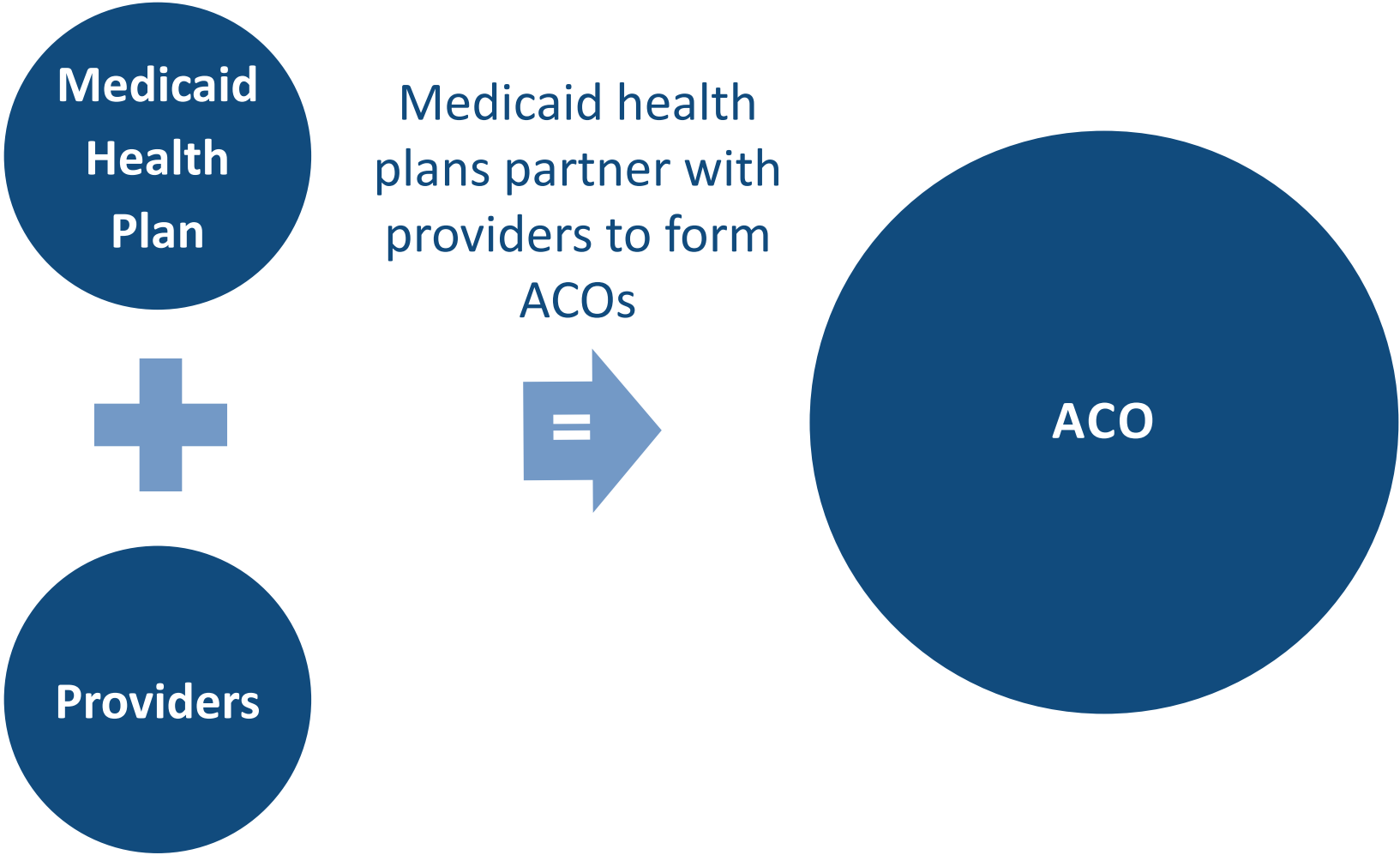
Moderate Managed Care	
<b>Payment</b>	<ul style="list-style-type: none"><li>▪ ACO Bonus and Penalty</li></ul>
<b>Responsibility</b>	<ul style="list-style-type: none"><li>▪ Bonus for low spending</li><li>▪ Penalty for higher spending</li><li>▪ Partial performance risk but no insurance risk</li></ul>
<b>Operation</b>	<ul style="list-style-type: none"><li>▪ FFS claiming as usual</li><li>▪ Distribute bonuses and pay penalties</li><li>▪ Coordinate care</li></ul>
<b>Incentives</b>	<ul style="list-style-type: none"><li>▪ Strong incentive to constrain utilization and redesign care</li><li>▪ But will provider volunteer for down-side risk? Especially poor performers?</li></ul>

# ACO Model Variation: Strong Managed Care States

Strong Managed Care	
<b>Payment</b>	<ul style="list-style-type: none"><li>▪ Global Fee, Partial Cap</li></ul>
<b>Responsibility</b>	<ul style="list-style-type: none"><li>▪ Retain savings from low spending</li><li>▪ Absorb cost of higher spending</li><li>▪ Bonuses for quality</li><li>▪ Partial insurance and performance risk</li></ul>
<b>Operation</b>	<ul style="list-style-type: none"><li>▪ Receive global payment or partial capitation</li><li>▪ Share net savings and losses with ACO providers</li><li>▪ Coordinate care</li></ul>
<b>Incentives</b>	<ul style="list-style-type: none"><li>▪ Finances aligned with lower utilization growth and care redesign</li></ul>

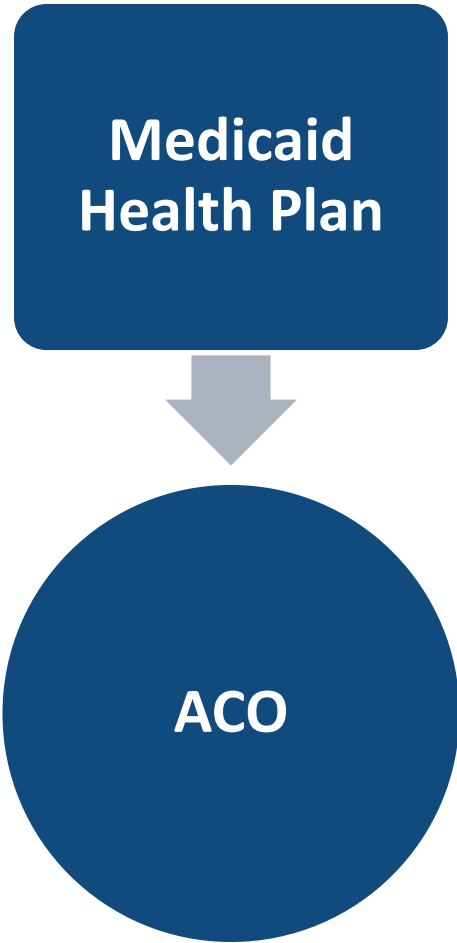


# ACO Model Variation: Medicaid Health Plans as Partners



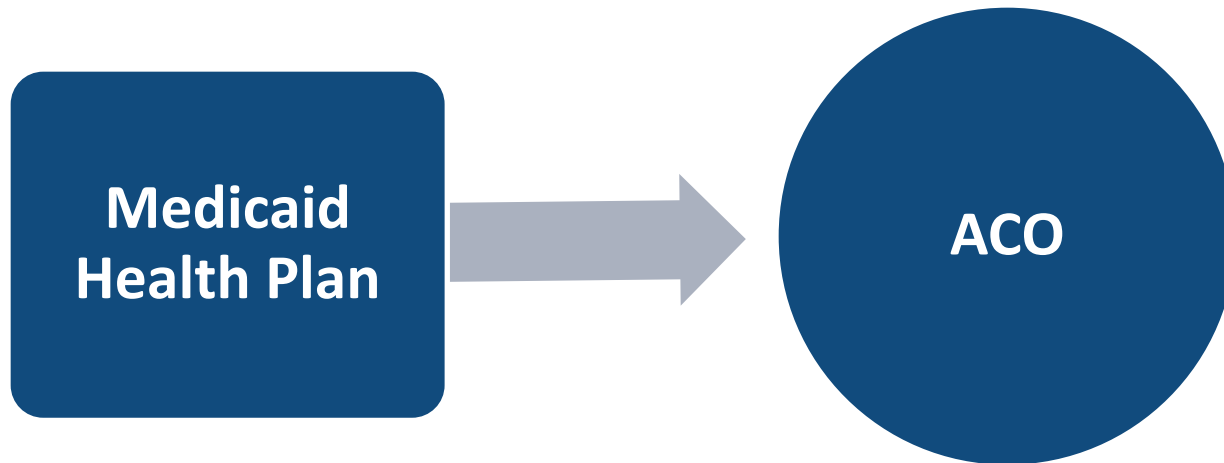
# ACO Model Variation: Medicaid Health Plans as Coordinators

Medicaid health plans coordinate ACO design and implementation



# ACO Model Variation: Medicaid Health Plans as Coordinators

Medicaid health plans provide services to provider-only ACOs



## Policy Prescriptions

- No Non-provider Participation Restrictions
- Prevent Antitrust Issues
- One-sided Shared Savings Model
- Value Improvement as Well as Quality
- Allow Targeted ACO Patient Populations
- Require HEDIS Quality Metrics and Managed Care Performance Standards to ACOs
- Allow for Automatic Beneficiary Assignment and Limited Out-of-Network Access

# Questions and Discussion



## SELLERS DORSEY

Redefining the possibilities

### **John Pourciau**

Consultant

Sellers Dorsey

225-247-2833

[jpourciau@sellersdorsey.com](mailto:jpourciau@sellersdorsey.com)

### **Kip Piper**

Senior Consultant

Sellers Dorsey

202-558-5658

[kpiper@sellersdorsey.com](mailto:kpiper@sellersdorsey.com)

