



Accountable Care Organizations and Medicaid

Overview: This white paper is designed by netlogx, an Information Risk Management and Project Management Company to assist entities in understanding Accountable Care Organizations (ACOs).



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Introduction

Accountable Care Organizations are a new concept in the medical marketplace. Public sector entities have been quick to see the benefit of these organizations as a means for providing quality healthcare in a cost effective way.

This paper focuses on providing an overview Accountable Care Organizations and their growing engagement in the public sector.

What are Accountable Care Organizations?

Accountable Care Organizations are a group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings. (HealthCare.gov, 2013)

Where did Accountable Care Organizations come from?

Drs. Elliott Fisher and Glenn Hackbarth first coined the term Accountable Care Organization at a 2006 Medicare Payment Advisory Committee (MedPAC) meeting. (Cohen, 2010) Accountable Care Organizations were further discussed by Drs. Stephen Shortell and Lawrence Casalino in the 2007 paper, "Accountable Care Systems for Comprehensive Health," (Shortell, 2007). Ultimately Accountable Care Organizations are legally defined in the Patient Protection and Affordable Care Act (ACA) that was signed into law on March 23, 2010 (Congress, 2010).

While extremely similar to the players in the alphabet soup of managed care players in the 1990s—the independent physician associations (IPAs), the physician-hospital organizations (PHOs), and the healthcare maintenance organizations (HMOs)—Accountable Care Organizations differ significantly: (1) the accountability rests with the providers, rather than the health insurers; (2) no health plan intermediary is required to contract with the provider organization; (3) Accountable Care Organizations have great flexibility in their provider composition; and (4)

About netlogx:



Founded in 1998, netlogx is an Information Risk Management company that specializes in working with our customers and consultants to solve complex business problems.

We provide Project, Security and Information Management services and products that enable our customers to get "Better, Faster, Cheaper" and thrive by effective and efficient Risk Management.



Accountable Care Organizations allow for payment under a fee-for-service arrangement. (Welch, 2012)

Can State Medicaid programs participate?

There are several opportunities for State Medicaid programs to establish and manage ACOs in the Affordable Care Act. Section 2706 provides Medicaid programs the opportunity to develop pediatric ACOs using the same incentive program described in Section 3022. Section 3021 establishes the Center for Medicare and Medicaid Innovation, to test innovative models for health care payment and delivery. (NASHP, On the Road to Better Value: State Roles in Promoting Accountable Care Organizations, 2011). Further the Center for Medicaid and CHIP Services released a State Medicaid Director Letter (Mann, 2012) that described ACOs as being authorized as an Integrated Care Models (ICM) vehicle under their authority.

How do State Medicaid programs get involved?

State Medicaid Director Letter (Mann, 2012) 12-002 describes policy considerations and relevant statutory authorities for implementing ICMs for State Medicaid programs. The following information comes directly from that State Medicaid Director Letter.

Implementing ICMs as a State Plan Option

CMS is providing states the opportunity to implement ICMs furnishing services authorized under sections 1905(a)(25) and, by reference, 1905(t)(1) of the Act. These models are consistent with the statutory description of optional Medicaid state plan PCCM services. States may use the authority under section 1905(t)(1) of the Act to offer coordinating, locating and monitoring activities broadly and create incentive payments for providers who demonstrate improved performance on quality and cost measures. Under this authority, states may opt to reimburse providers through a “per member per month” (PMPM) arrangement and/or create quality incentive payments that could be calculated as a percentage of demonstrable program savings and shared with participating providers either directly or through umbrella provider network arrangements, also known as “shared savings” (i.e., ACO or ACO-like programs).

Provider Qualifications and Service Definitions:

If the ACO is implemented as state plan option under authority at section 1905(t)(1) of the Act, the State may identify reasonable qualifications for the case managers and related providers (including an individual practitioner, physicians, nurse practitioners, certified nurse-midwives, or physician assistants; Physician group practices, or entities employing or having arrangements with physicians to provide such services.)

Comparability and Freedom of Choice:

As with any state plan benefit under this authority, ICMs must include comparable services for all Medicaid populations and allow for any provider that meets defined qualifications to participate. States can, however, set forth standards that address populations or circumstances for which primary care case management is appropriate, based on medical necessity, and set payment levels stratified to distinguish patients with high case management needs from those with low case management needs.



Beneficiary Protections Under the Statute:

When a state implements ICMs under section 1905(t)(1) of the Act, the regulations at 42 CFR 438 will not apply, although some of the provisions of those regulations merely reflect applicable statutory beneficiary protections at section 1905(t)(3) of the Act. These statutory provisions contain important beneficiary protections concerning quality and access to care. States should take care to ensure ICMs align with these access to care provisions, as well as the access requirements at section 1902(a)(30)(A) of the Act.

Reimbursing ICMs Under a State Plan Option:

States should decide whether reimbursement will be for a particular set of activities (what a provider “does”) or particular practice characteristics and incremental improvements in practice behavior (what a provider “is” or how the provider performs). (See Attachment 3 for examples.) For state plan amendments that reimburse for a particular set of activities, a state should clearly define a minimum expectation of activities that a provider would perform for each enrolled beneficiary within a defined period (e.g., a quarter). States may vary payments to providers based on the level of activity/service that will occur within a quarter and/or variations in the costs of delivering the care coordination activities.

Per member per month (PMPM) Care Coordination Payment:

While states have the option to define ICM services as a package of discrete care coordination activities to manage beneficiaries and reimburse through traditional fee-for-service payment methods, states may find that PMPM payment structures are conducive to the types of activities provided through ICMs. PMPM rates need not require an administrative action by the provider for every coordinating event or a direct contact with a beneficiary, but may reimburse providers for direct and indirect actions (e.g. monitoring patient treatment gaps or offering extended hours of operation) that aim to improve health and outcomes for all beneficiaries.

Payment for Quality Improvement and Shared Program Savings:

An additional approach to reimbursing ICMs under this state plan option is through payments to the ICM provider for improvements in health care quality. States may offer these payments as the base reimbursement methodology for the ICM provider, or as deferred compensation to a care coordination base rate.

Implementing ICMs through a 1915(b) Waiver

States that seek to limit freedom of choice, and/or vary the amount, duration, and scope of services amongst different populations, and/or that selectively contracts with a defined set of providers, among a broader pool of qualified providers, may do so under waiver authority of section 1915(b) of the Act.

Implementing ICMs through an 1115 Demonstration

A state that targets specific populations and/or limits geographic scope may do so as a demonstration under section 1115(a) of the Act.



Which States are participating?

Thus far Arkansas, Hawaii, Illinois, Maine, Massachusetts, Minnesota, New Jersey, New York, Oregon, Texas, and Utah have either implemented or applied to participate under these authorities. (NASHP, 2013)

Arkansas

Arkansas received CMS approval for their State Plan Amendment in August of 2012.

Hawaii

The Accountable Healthcare Alliance of Rural Oahu (AHARO) was established via interagency agreement between the three participating Federally Qualified Health Centers in 2010. The AHARO contracts with the two participating Medicaid managed care plans support “health care home” standards (additional standards, beyond NCQA patient-centered medical home recognition, for care enabling services, cultural proficiency, community involvement, and workforce and economic development), performance-based reimbursement, and shared savings partnerships.

Illinois

The Care Coordination Innovations Project is an initiative within the Illinois Department of Healthcare and Family Services to meet a legislative mandate that 50 percent of Medicaid beneficiaries be enrolled in coordinated care by 2015. This mandate—and the definition of “coordinated care”—was passed as part of Public Act 096-1501 in 2011.

Maine

MaineCare is developing a State Plan Amendment to authorize the Accountable Communities Initiative.

Minnesota

In 2010, the Minnesota Legislature passed a bill (Minnesota Statutes § 256B.0755) requiring that the Commissioner of Human Services “develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement.” The Department of Human Services released a Request for Proposals from Health Care Delivery Systems (HCDSs) in the state in September 2011. Minnesota received federal approval to implement the demonstration’s payment reforms under its Medicaid state plan in August 2012.

New Jersey

The New Jersey Medicaid Accountable Care Organization (ACO) Demonstration Project was authorized by the passage of P.L. 2011, Ch. 114. The statute specifies that the New Jersey Department of Human Services will establish the demonstration in consultation with the state’s Department of Health and Senior Services.



In the authorizing legislation, New Jersey’s legislature announced its intent to “exempt activities undertaken pursuant to the Medicaid ACO Demonstration Project that might otherwise be constrained by State antitrust laws and to provide immunity for such activities from federal antitrust laws through the state action immunity doctrine.”

In early October 2012, the Centers for Medicare & Medicaid Services approved New Jersey’s Comprehensive Medicaid Waiver, an 1115 demonstration waiver. The delivery system reforms covered in the waiver include the Medicaid Accountable Care Organization Demonstration Project.

New York

The certification of Accountable Care Organizations by the New York Department of Health was authorized in March 2011 with the enactment of Chapter 59 of the Chapter Laws of 2011, which created NYS Public Health Code Article 29-E. This law was revised by Chapter 461 of the Chapter Laws of 2012 in October 2012 to better align the state program with the federal Medicare Shared Savings Program and to expand the ACO initiative from a demonstration to a full program.

The law also authorizes the New York Department of Health to seek federal approvals and waivers to implement ACOs, including waivers needed to obtain federal financial participation.

Oregon

The Oregon Integrated and Coordinated Health Care Delivery System was authorized by the Oregon legislature in 2011 through House Bill 3650. A second piece of legislation passed in 2012, SB 1580, approved follow-up proposals for Coordinated Care Organization qualification criteria and global budgeting processes developed by the Oregon Health Authority.

Section 15 of House Bill 3650 declared the Oregon Legislature’s intent to exempt CCOs from state antitrust laws, and to provide immunity from federal antitrust laws through the state action doctrine. Oregon submitted to the Centers for Medicare & Medicaid Services a Request for Waiver Amendment to the 1115 Demonstration Waiver under which the Oregon Health Plan operates. The state requested a three-year extension of the waiver through October 31, 2016 and sought to maintain authorities included in its existing waiver, such as the authority to contract with managed care entities and to mandatorily enroll and auto-enroll individuals within managed care. The waiver request was approved in July 2012.

Utah

Utah is pursuing Accountable Care Organizations (ACOs) in Medicaid under the mandate to introduce new payment methodologies into Medicaid established by SB 180 in 2011.

The state originally included its proposal to convert existing managed care contracts into ACO contracts in the Payment & Service Delivery Reform Proposal for an 1115 Demonstration waiver it submitted to CMS in June 2011; this waiver was submitted in accordance with a statutory requirement included in SB 180. While CMS denied this waiver request, it expressed support for the ACO model proposed by the state. The state sought to amend its existing 1915(b) managed care waiver to incorporate the ACO contracting approach.



For more information on the structure of these programs please visit the National Academy for State Health Policy's State "Accountable Care" Activity Map at <http://nashp.org/state-accountable-care-activity-map>.

netlogx services

netlogx will be delighted to offer ACO program development, ACO State Plan option development, ACO 1915(b) development, ACO 1115(a) development, and ACO Quality and Reporting development and management services.