

Accountable Care Organizations (ACOs) Work Group

March 6, 2014



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Introductions

Statutory Authorization

- Legislation enacted in 2011 (Chapter 59) created the ACO Demonstration Program, requiring the Department to establish a process for the establishment for Certificates of Authority (COAs) to be issued to entities to operate ACOs in New York.
- The statute defines an ACO as an organization of clinically integrated health care providers that work together to provide, manage and coordinate health care (including primary care) for a defined population; with a mechanism for shared governance; the ability to negotiate, receive and distribute payments; and to be accountable for the quality, cost and delivery of health care to the ACO's patients.
- Legislation enacted in 2012 (Chapter 461) made the program permanent, made the statute consistent with federal rules, and authorized certificates of authority for Medicare-only ACOs.
- The ACO law requires promulgation of regulations establishing criteria for COAs, quality standards for ACOs, reporting requirements and other matters deemed to be appropriate and necessary in the operation and evaluation of ACOs.

ACO Work Group Charge

The 2012 legislation, as amended in 2013 (Chapter 6), established a Work Group to consider whether ACOs should be enabled to serve, in place of a managed care plan, Medicaid enrollees otherwise required to participate in managed care, care management or care coordination, as well as enrollees of Family Health Plus and Child Health Plus.

Insurance Law Background

- Under NY Insurance Law, if an entity bears insurance risk, it is “doing the business of insurance” and must get an insurance license or be exempted from being licensed.
 - Statutory definition: “Insurance contract” means any agreement... whereby one party, the “insurer,” is obligated to confer benefit of pecuniary value upon another party, the “insured” or “beneficiary,” dependent upon the happening of a fortuitous event...” (Insurance Law §1101(a)(1)).
- One purpose of an insurance license: make sure insurer has money to pay claims (reserve requirements), consumer protections, etc.
- Insurers and HMOs may transfer risk to provider organizations, such as IPAs, (without an insurance license) if the provider meets certain financial requirements and consumer protections and, under the contract between the insurer and the provider, the insurer bears ultimate risk (DFS Regulation 164).
- Article 29-E of Public Health Law authorizes DOH, in consultation with DFS, to promulgate regulations to allow ACOs to enter into certain risk bearing arrangements.

Overview of Draft Regulations

Medicare-Only ACOs

- Medicare-only ACOs are those that have been accepted by CMS, have entered into an approved participation agreement with CMS and exclusively serves Medicare beneficiaries as its defined ACO population (§ 1003.2).
- Medicare-only ACOs whose shared losses may not exceed 10% will receive a COA under an expedited process and are only subject to the following provisions of the regulation (§ 1003.1):
 - Legal Structure (§ 1003.6);
 - Payment and Third Party Payers (§ 1003.11);
 - Termination (§ 1003.12);
 - Reporting (§ 1003.13); and
 - Restraint of trade, fee splitting and referrals (§1003.14).
- ❖ Shared losses are the portion of losses incurred by an ACO when its expenditures for health care services to its population are above projected benchmark expenditures (§1003.2).
- There are approximately 25 such Medicare-only ACOs certified in New York State.

Medicare-Only ACOs

- Medicare only ACOs with shared losses that exceed 10% will receive a COA under an expedited process and are subject to the following provisions of the regulation (§ 1003.1):
 - Medicare only ACOs Sharing Losses Requirements (§ 1003.5);
 - Legal Structure (§ 1003.6);
 - Payment and Third Party Payers (§ 1003.11);
 - Termination (§ 1003.12);
 - Reporting (§ 1003.13); and
 - Restraint of trade, fee splitting and referrals (§ 1003.14)
- Under the proposed regulations, ACOs are not required to be licensed under the Article 11 of the Insurance Law; however, the ACO would be required to obtain a license if they move to partial or full capitation (§1003.11).

Medicare-Only ACOs

- Medicare-only ACOs may only enter into a contract with CMS under which its shared losses **may** exceed 10% of the benchmark if they meet these additional requirements (§ 1003.5):
 - Medical claims of the ACO are paid by CMS on a Fee-for-Service (FFS) basis directly to the ACO participants;
 - Any shared savings or shared losses will be tabulated and transferred in a lump sum between CMS and the ACO at year end;
 - In lieu of a lump sum payment, the ACO may opt for reduced future FFS CMS payments; and
 - The ACO must place funds in an escrow account equal to at least 25% of the potential maximum deficit payment due from the ACO to CMS annually.

Medicare-Only ACOs

- Medicare-only ACOs whose shared losses may exceed 10% and meet the previous requirements must also include with their COA application (§ 1003.5):
 - Financial statements and CPA certification that represents whether the liabilities of the ACO make adequate provision for additional liability that may result by its assumption of risk; and
 - An actuarial certification that the ACO has the ability to meet its financial responsibilities and the financial risk assumed by it does not threaten its financial solvency.
- Annual reports providing the same financial information and certifications described above must be submitted to the Commissioner.
- Such ACOs and its participating providers may not collect from a patient any amounts owed for covered services (excluding amounts owed under the patient's subscriber contract).
- The Commissioner may examine the affairs of such ACOs as often as seems prudent.

All Other ACOs

- All other ACOs are subject to the “full” application process for issuing a COA (§1003.1).
- ACOs that enter into payment arrangements with a third party health care payer for health care services provided to the third party’s enrollees that require the ACO to contractually assume the liability for the delivery of health care services (e.g., full or partial capitation, shared losses) must (§1003.11):
 - Be licensed under Article 11 of the the Insurance Law (if the ACO seeks to enter into a risk bearing arrangement with DOH, a self-funded entity or an insurer not licensed in NY, it must get an insurance license); or
 - Contract with a managed care organization certified under the Article 44 of the PHL, an insurer authorized under the Insurance Law or a corporation licensed under Article 43 of the Insurance Law.
- Insurance Regulation 164 is also being amended to include ACOs among the providers that may enter into capitation arrangements provided that they meet certain financial standards and only when entering into agreements with certain insurers licensed under the New York Insurance Law or certified under Article 44 of the Public Health Law. However, Regulation 164 does not govern arrangements involving Medicare or Medicaid.

Other Entities that May be ACOs

- Health Homes may be certified as ACOs or serve as Administrative Support Organizations to provide care management (§ 1003.2 and § 1003.6).
 - Health Homes are a Care Management Model and are an optional State Plan benefit authorized under the ACA.
 - There are currently 48 Health Homes (32 unique entities) that provide care management to Medicaid enrollees with at least two chronic conditions, or HIV, or Serious Mental Illness (SMI).

Other Entities Authorized to Become ACOs

- Independent Practice Associations (IPAs) may be certified as ACOs (§1003.6).
 - An IPA is a corporation, limited liability company, or professional services limited liability company, other than a corporation or limited liability company established pursuant to Articles 28, 36, 40, 44 or 47 of the Public Health Law, which contracts directly with providers of medical or medically related services or another IPA in order that it may then contract with one or more MCOs and/or workers' compensation preferred provider organizations to make the services of such providers available to the enrollees of an MCO and/or to injured workers participating in a workers' compensation preferred provider arrangement.
 - Part 98 of the Managed Care regulations (which defines and specifies the entities with which IPAs are allowed to contract) is being amended to include the broader ACO powers and purposes.

ACO Contracts

- ACOs and IPAs that become ACOs that meet the provisions of this regulation may contract with (§1003.6):
 - Insurers licensed under NY law or other state's laws;
 - Centers for Medicare and Medicaid Services (CMS);
 - The Department of Health;
 - Other entities doing an insurance business that are subject to New York Insurance Law; or
 - Self-funded insurers that are exempt from being licensed under the NY Insurance Law pursuant to the Employee Retirement and Income Security Act (“ERISA”) or other law.

ACO Application Criteria for Certificate of Authority

- ACOs must meet the following conditions or criteria for the Commissioner to Approve an Application (§1003.3):
 - Demonstrate the ability to provide, manage, and coordinate health care, including where practical, elevating the services of primary health care providers to meet patient centered medical home standards, coordinating services for complex high needs patients and providing access to health care providers that are not part of the ACO;
 - Include participation of clinically integrated health care providers and administrative support organizations that are accountable for the quality, cost and delivery of health care to a defined geographic area of ACO participants;
 - Provide a governance, leadership, and management structure that is representative of its of its ACO participants and patients; and
 - Document satisfactory character and competence.

Application Requirements

- Applications must include (§1003.4):
 - Information about ACO participants, certification that ACO and its participants have agreed to become accountable for the quality, cost and overall care of individuals in the ACO;
 - Qualifications for participating in the ACO, plans detailing how the ACO will use its best efforts to include Federally Qualified Health Centers among its participants;
 - Copies of organizational documents, financial statements of the ACO, and documents related to character and competence of ACO and its participants;
 - Identification of participants that are providers or suppliers in the Federal Medicare Shared Savings Program;
 - Documents (participation agreements, employment contracts, operating policies) and how the opportunity to receive shared savings or other financial arrangements will encourage ACO participants and ACO providers to adhere to the quality assurance and improvement program and evidenced based clinical guidelines; and
 - Description of the population to be served and geographic area to be served, and if applicable patient characteristics to be served.

Application Requirements

- Applications must include (§1003.4):
 - A plan for care coordination (ACOs must not require patients to obtain prior authorization or a referral to receive health care services);
 - Description of how ACO will use evidenced based health care, patient engagements, coordination of care, EHRs, and services that promote integrated and efficient health care;
 - Description of proposed quality assurance and improvement procedures, including how performance standards and measures will be used to assess and improve quality and utilization of care;
 - Proposed ACO policies for reviewing and responding to complaints;
 - Assurance ACO will not discourage a provider or enrollee from seeking appropriate health care service;
 - Assurance that the proposed ACO will not discriminate against or disadvantage a patient or patient's representative for the exercise of patient autonomy; and
 - Assurance that the proposed ACO will not limit or restrict beneficiaries to providers contracted or affiliated with the ACO, including not requiring patients to obtain prior approval from a primary care gatekeeper.

Legal Structure of ACOs

- Purpose and Powers of ACO (§1003.6)
 - Upon obtaining a COA, to establish, own, operate and manage an ACO of clinically integrated health care providers that work together through a shared governance structure to:
 - Provide, manage and coordinate health care including primary care, for a defined population focusing on patient centeredness, patient engagement and promoting evidence-based medicine;
 - Be accountable for quality, cost, and delivery of health care to ACO patients;
 - Negotiate, receive and distribute any shared savings or losses; and
 - Establish, report and ensure provider compliance with health care criteria including quality performance standards.

Quality Management and Improvement Program and Performance Standards

- An ACO must develop and implement a Quality Management and Improvement Program that is supervised by a medical director and that (§1003.9 and §1003.10):
 - Includes organizational arrangements and ongoing procedures for the identification, evaluation, resolution and follow up of potential and actual problems in health care administration and deliver;
 - Maintains health care information systems to collect, analyze and integrate reports to develop and implement the program, which include defined methods for the identification and selection of standardized quality measures and develop quality metrics from multiple sources (encounter and claim data, medical reviews, surveys);
 - Has a process for peer review to monitor provider performance;

Quality Management and Improvement Program and Performance Standards

- Ensures that providers are licensed, certified and/or registered health care professionals that meet and maintain standards for the practice of their profession;
- An ACO must collect performance measures and/or data consistent with national and state standards and applicable to the demographics of the ACO population; and
- An ACO's quality performance shall equal or exceed statewide and/or national benchmarks and/or demonstrate improvement over time on multiple performance measures of care to maintain participation in the program.

Annual Reports

The ACO shall submit data to the Commissioner annually or at such other times as requested and in a form prescribed by the Commissioner including, but not limited to (§ 1003.13):

- Participants of the ACO;
- Enrollee characteristics;
- Utilization of services;
- Enrollments and disenrollments;
- Complaints; and
- Grievances.

MRT Vision for Medicaid ACOs in New York

- The Medicaid Redesign Team (MRT) recommended the adoption of ACOs under MRT #243.
- ACOs are aligned with the central tenet of the MRT Vision to “Provide Care Management for All.”
 - ACOs can be used as a vehicle to deliver comprehensive, fully integrated services and care management, while providing high quality, accountable health care.
- The New York State MRT vision is that all members will eventually be enrolled in comprehensive Managed Care Plans and that these Plans would contract with ACOs for both care management and services under sub-capitated payment arrangements.
 - Approach promotes consistency, quality and member satisfaction by carefully transitioning out of the current fee-for-service payment system to a new payment system that rewards quality instead of volume.

MRT Vision for Medicaid ACOs in New York

- Under the draft ACO regulations, Health Homes can become ACOs.
- Health Homes are leading candidates to become Integrated Delivery Care Systems to combine services integration and accountability.
 - Health Homes will evolve beyond care management and navigation to become ACOs to serve Health Home members and other Medicaid Members.
- In the interim, ACOs may present an opportunity to provide care management to members that are not currently eligible for Managed Care, such as “well dual eligibles” that, for now, remain in fee-for-service.
- ACOs that accept direct risk from Medicaid or Medicare will be required to obtain insurance license.
- The draft regulations provide options for ACOs that bear minimal financial risk to provide services without obtaining a state insurance license or meeting capitalization requirements that apply to Managed Care Organizations.

Montefiore Presentation on Pioneer Experience

Next Steps

- Comments on draft regulations requested by March 17, 2014
- Presentation/Agenda for Next Session
- Initial Draft of Report