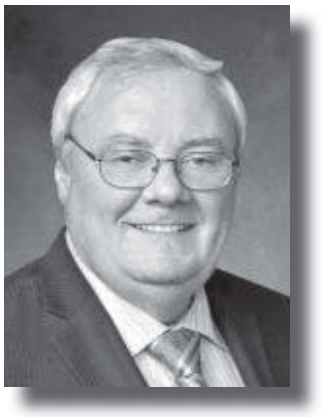
Accountable Care Organizations – The Jersey Generations



Neil M. Sullivan

by Neil M. Sullivan, Esq.

CMS issued a final rule on June 4 revising the Shared Savings Program for Accountable Care Organizations (ACOs). The rule changes several program areas, including beneficiary assignment, data sharing, available performance risk models, eligibility requirements, participation agreement renewals, and compliance and monitoring. This came on the heels of the CMS Innovation Center's introduction in March of the "Next Generation ACO Model," which built on its earlier Pioneer Model with the potential for more advanced integrated systems to take on more risk (and reward) than under the last generation.

Where have ACOs been, and where are they going in New Jersey?

ACOs mean different things to different people, but in Medicare's world, ACOs are groups of health care providers who come together to give coordinated care to their Medicare patients. They serve enrollees in traditional fee-for-service Medicare – not Medicare Advantage. Enrollees are therefore free to use any providers participating in the Medicare system without regard to their affiliation with the ACO.

For the most part, participants in the Medicare ACOs continue to get paid as under traditional Medicare fee-for-service. They are held to specific quality measures, and, if that quality care costs the Medicare Program less than CMS would have expected to pay absent the ACO, the ACO participants can share in some of the savings. Depending upon the model, they can also share in losses.

To some, ACOs are the wave of the future. In January, HHS Secretary Burwell announced a goal of basing 50 percent of Medicare payments on the quality of care provided, not on volume, by 2018. How can one sit on the sidelines? To others, they are an unsustainable flash in the pan. Rewards are based on savings that would not have occurred in the absence of the ACO for that beneficiary group. Once you have achieved a high level of efficiency, how could you continue to reap savings?

Medicare ACOs got a shot in the arm when Section 3022 of the ACA required the Secretary of HHS to establish the Medicare Shared Savings Program, to encourage the development of ACOs in Medicare. The original regulations established two tracks for ACOs – a one-sided model under which the ACO shares only in some of the gains, above a threshold, and a two-sided model under which the ACO shares in gains or losses above a specified corridor, and within limits. Of course, under either model the ACO has to make a substantial investment in infrastructure.

The stated goal was always to move ACOs to a two-sided model, and the original regulations anticipated that the one-sided model would not be available after the first agreement period. Entrants into the ACO arena stayed away from the two-sided model in droves, however. A CMS fact sheet with data as of January 1, 2015 shows 401 ACOs in the one-sided model, and only three (3) in the two-sided model. In New Jersey, 17 organizations have formed Medicare ACOs since 2012, all in the one-sided model.

Medicare ACOs have also been a springboard to commercial insurance arrangements. A Robert Wood Johnson Foundation Report released in June, "Recent Changes in Primary Care Delivery and Health Provider Systems in New Jersey," showed that 11 of the 17 New Jersey ACOs also had ACO activity with commercial plans. A CMS-sponsored study said the majority of Pioneer ACOs reported experiencing pressure from private and public purchasers to engage in risk-based payment contracts, including establishing accountable care-like delivery models. United Healthcare recently announced its intention to expand its base of accountable care contracts across its employer-sponsored, Medicare and Medicaid health benefit businesses, anticipating that, by 2017, reimbursements to hospitals, physicians and ancillary care providers will be paid through contracts linking reimbursement to quality and cost-efficiency measures will account for $50 billion in expenditures.

On the Medicaid side, in August 2011, Governor Christie signed into law P.L. 2011, Chapter 114, requiring the Division of Medical Assistance and Health Services to establish a three-year Medicaid Accountable Care Organization (ACO)

continued on page 16

continued from page 15

demonstration project. Seven coalitions of healthcare providers in different areas of the state have applied to be a part of the program. Three were approved at the end of June.

Absent a severe change in direction, then, provider organizations that want to participate in ACOs (or are nudged by changing reimbursement models) will have to look seriously at risk-bearing models, and all that entails under Federal and State rules. To understand New Jersey laws that apply to (non-insurer) risk-bearing entities, it's necessary to delve into the somewhat bumpy history of alternative health care financing and delivery models in New Jersey.

Risk-Bearing Intermediaries in New Jersey

The concept of health care providers bearing risk is as old as capitation itself. If a doctor agrees up front to accept a fixed amount per member per month to provide a level of services he or she can't predict with certainty in advance, that's a level of risk-bearing that every capitated doctor assumes. For facilities, agreeing to provide services at a fixed per diem amount or for a diagnosis-related group creates the risk that services will be required that cost more to provide than the per diem or DRG rate covers. But these are levels of risk we assume providers can handle.

Risk-bearing is taken to a whole new level, however, when another entity is created separate and apart from the health care practitioner or facility, and that entity undertakes to manage the risk of multiple health care practitioners and/or facilities. That starts to look more like the business of insurance.

New Jersey Supreme Court Justice Jaynee LaVecchia (when she was the Commissioner of the New Jersey Department of Banking and Insurance), once had this to say on the subject:

"I have a significant concern about arrangements which transfer risk to unlicensed entities. First, the unknown financial viability of the unlicensed entities exposes the public to risk of failure that may result in, among other things, a consumer losing access to health care services or being responsible for large unpaid bills. Two, the quality of care is of concern when quality assurance and utilization review functions are subcontracted to a non-licensed entity that is not subject to regulation. Three, continuity of care for an individual is not guaranteed if the unlicensed entity fails or the contract is terminated."

The Commissioner had ample cause for concern. The occasion for her remarks was the May 20, 1999 Senate Health Committee hearing on the causes of insolvency of HIP Health Plan of New Jersey (HIPNJ). HIPNJ had been the fourth largest HMO in New Jersey. The context for her remarks was an arrangement between HIPNJ and two unlicensed entities.

In July of 1997, HIPNJ sold most of its property and goodwill to PHP Healthcare Corporation (PHP), a for-profit Delaware corporation. At the same time, HIPNJ entered into a twenty year Health Service Agreement with Pinnacle Health Enterprises (PHE), a subsidiary of PHP, under which PHE undertook the delivery and administration of healthcare services. In return, HIPNJ paid PHE a capitation payment equal to 91.5% of premiums collected.

While the DOBI directly regulated the solvency of HIPNJ as a Health Maintenance Organization, it did not have the same authority over the unlicensed PHE, which maintained it didn't need a license as it was not marketing directly to the consumer.

According to the Superior Court's order liquidating HIPNJ:

"PHE failed to meet its obligations to process claims and make timely payments to healthcare providers. The amount owed by PHE for medical services and supplies rose to approximately $120,000,000 despite having received capitation payments in excess of $300,000,000. As a result of PHE's escalating debt, HIPNJ's net worth correspondingly spiraled downward and continued to hemorrhage."

Following the HIPNJ collapse, New Jersey passed a law establishing oversight by the DOBI of what the law refers to as "Organized Delivery Systems" (ODSs). In general, an ODS is an entity contracting with a carrier to provide comprehensive or limited services, but does not include any professional corporation, professional association or independent practice association (IPA), provided the shareholders are solely providers, and the entity performs no services beyond those for which its shareholders are otherwise licensed. An ODS must be either licensed or certified with the DOBI.

The question of whether an ODS needs to be certified or licensed depends upon whether the ODS assumes financial risk from the carrier. An ODS that assumes financial risk must become licensed, unless the Department determines the financial risk is de minimis, as set forth in regulation. An ODS that does not assume financial risk or that is determined to assume only a financial risk must become certified.

Whether an ODS is licensed or certified, it must meet certain minimum standards regarding the functions that the ODS intends to perform under contract with carriers. The standards are substantially similar to those that carriers would have to comply with if they were performing the specific functions themselves. For licensure, to bear risk, an ODS must satisfy minimum net worth and deposit requirements. To date, the DOBI website lists 12 licensed ODSs, and 50 certified ODSs.

During my tenure as the Assistant Commissioner for Life and Health at the New Jersey Department of Banking and Insurance, from March 2010 to March 2014, the sweet spot for ACA implementation, DOBI attempted to sort out some of this alphabet soup of State and Federal oversight of non-insurer risk-bearers by issuing a Bulletin in 2013 on the application of

state law to Alternative Health Care Financing and Delivery Models.[1]

Pursuant to P.L. 2011, c. 114 (codified at 30:4D-8.1 .), which established a Medicaid Accountable Care Organization Demonstration Project, a Medicaid ACO certified pursuant to that act is not required to obtain licensure or certification as an ODS while it is providing services to Medicaid recipients.

The First Post- ACA Generations

Two separate, but closely related CMS initiatives post-ACA were the broad-based Medicare-Shared Savings Program (MSSP), and the more narrowly-focused Pioneer Program.

On March 31, 2011, HHS released the proposed regulations for MSSP ACOs. As previously mentioned, there were two options with the MSSP: a shared savings-only model (Track 1) and a two-sided risk model (Track 2). In the Track 1 model, ACOs achieving a specified minimum savings rate can share in up to 50 percent of savings based on quality performance, and there is no downside risk for the three-year agreement period. For Track 2, ACOs that achieve a specified minimum savings rate can share in up to 60 percent of savings, but this model includes downside risk. ACOs not meeting the minimum savings rate will share in losses (also not exceeding 60 percent). Quality metrics are also required to be met.The final rules were published in the Federal Register on November 2, 2011.

On May 17, 2011, CMS announced the Pioneer Program, through its Innovation Center. CMS said this was intended for a limited number of larger organizations that already had proven risk-sharing experience. In the Pioneer Program, an ACO accepted into the program could bear greater risks and rewards than under the standard MSSP Program.

Because MSSP ACOs apply to enrollees in traditional fee-for-service Medicare, enrollees are free to use any providers participating in the Medicare system without regard to their affiliation with the ACO, which makes care management challenging. On the one hand beneficiaries are free to come and go, but the ACO is responsible for the care delivered to some fixed population. How do you define such a fluid cohort? CMS uses what it refers to as preliminary prospective beneficiary alignment, subject to a final retrospective adjustment. The beneficiaries 'aligned' with a particular ACO are identified prior to the start of a performance year on the basis of their historical utilization – those fee-for-service beneficiaries who received the larger amount of primary care services (or in certain circumstances, selected specialty care services) from physicians and other practitioners who participate with the ACO, compared to providers affiliated with any other ACO or any non-ACO-affiliated provider. To be eligible, an ACO needs at least 5,000 aligned beneficiaries. The retrospective adjustments apply when calculating the savings or loss, by removing beneficiary months from the performance period for beneficiaries who were not in the fee-for-service program the entire time.

The next step is to establish a benchmark for that cohort, to be used to measure success (or failure). The benchmark uses a formula that starts with a baseline of historic expenditures for that cohort, with some adjustments to trend claims to the last base year and remove some outlier data. Savings or losses are defined as the difference between the per capita expenditure benchmark for a year and the actual per capita expenditure for that year's aligned beneficiaries.

To qualify for shared savings under the one-sided model, savings had to exceed a minimum savings rate, established on a decreasing sliding scale between 3.95 percent on the low end and two (2) percent on the high end. For the two-sided model, the cutoff is two (2) percent above or below the benchmark for shared savings or losses to apply.

New Jersey had 11 ACOs prior to 2015. While all met the quality metrics, only three of the 11 saved enough money to qualify for a shared savings payout. According to CMS, 19 ACOs participated in the Pioneer Program nationally, but none were in New Jersey, and that program is no longer accepting applications.

2015 and the Next Generation

Just as the original regulations were proposed in 2011, followed closely by the announcement of the Pioneer Model, revisions to the rules were proposed in December 2014, followed by the March 2015 announcement of "The Next Generation."

The new rules change the program in a number of areas including:

- Allowing eligible ACOs to continue participation under the one-sided model for a second agreement period;
- Adding a new performance-based risk option (Track 3) that includes prospective beneficiary assignment and a higher sharing rate;
- Establishing a waiver of the 3-day stay SNF rule for beneficiaries who are prospectively assigned to ACOs under Track 3;
- Increasing the emphasis on primary care services in the beneficiary assignment methodology, including counting more services performed by non-physician practitioners;
- Streamlining data sharing between CMS and ACOs for beneficiaries who do not opt out of data sharing;
- Providing ACOs a menu of choices of symmetric thresholds for savings and losses under the two performance-based risk tracks;
- Refining the methodology for resetting benchmarks, including weighting the benchmark years evenly instead of giving more weight to the recent years, and crediting ACOs for savings generated in the prior agreement period.

continued on page 18

continued from page 17

In publishing the final rule CMS indicated an intent to propose another rule later this year further refining the benchmark based in part on trends in regional fee-for-service costs rather than solely on the ACO's own recent spending.

The Next Generation program would launch in January 2016 and expand the following year to reach a total of 15 to 20 accountable care organizations, according to CMS. Like the Pioneer Model, it is intended for a limited number of larger organizations that already had proven risk-sharing experience

Unlike the Pioneer Model, the Next Generation does not have a minimum savings rate. Instead, CMS applies a discount to the benchmark (after the baseline is calculated, trended, and risk adjusted). The discount is a function of the ACO's quality score, regional efficiency and national efficiency, with a total range of between .5% and 4.5%.

Two risk arrangements are available under the Model – Increased Shared Risk (80% in early years, 85% later) and 100% Risk. Both incorporate a cap on savings and losses of 15% of the benchmark. To be eligible for participation in the Next Generation Model, ACOs must maintain an aligned population of at least 10,000 Medicare beneficiaries (7,500 for designated Rural ACOs).

The Next Generation Model also offers four different payment mechanisms – capitation, fee-for-service, FFS plus a per-beneficiary per month payment, and population-based payments.

It is not necessary to have participated in the Pioneer ACO or Medicare Shared Savings Program to apply for the Next Generation Model.

The Next Generation Model will have two application rounds – the first due date was June 1, 2015 for a 2016 launch, and the second will be June 1, 2016 for a 2017 launch.

Will New Jersey health care providers and systems embrace the new ACO options, including the assumption of down-side risk? Time will tell, but prudence dictates they will have to be watched closely, and serious entrants must follow the rules for establishing risk-bearing entities in the State of New Jersey.

About the Author

Neil M. Sullivan, Esq. is a partner with McElroy, Deutsch, Mulvaney & Carpenter, LLP where he practices healthcare and insurance law. Mr. Sullivan served as Assistant Commissioner of the New Jersey Department of Banking and Insurance, overseeing the Office of Life and Health, from 2010 to 2014. Mr. Sullivan can be reached at nsullivan@mdmc-law.com.

Endote

[1] http://www.state.nj.us/dobi/bulletins/blt13_04.pdf.