State Oversight of ACOs

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What are the potential goals of state oversight?

- Provide an incentive to organize a fragmented delivery system to provide better access, quality and affordability
- Create of regulatory framework for ACO financial solvency
- Protect consumers and downstream providers against ACO insolvencies

Why are ACOs important?

- Integrated and coordinated systems of health care offer advantages:
  - Overcome fragmentation of delivery system
  - Higher rate of adoption of information technology
  - …which drives capability for transparency of cost and quality = accountability
  - Expands our existing delegated model network under 13 million HMO lives to the remainder of the insured population
  - Potential for regional competition in the Exchange

Do we presently understand how ACOs will be formed and operate?

- In a word, No
- The pending federal regulation of over 470 pages is complex and will likely be amended prior to its final version
- The new Pioneer ACO program was just released a few days ago
- Likely timeline – greater clarity by early fall, 2011

The federal regulation

- Creates two kinds of ACO payment models:
  - One sided – FFS with an upside payment bonus
  - Two-sided – By year three, downside risk is imposed if quality and cost savings targets unmet
    - Risk of loss is capped at 5, 7.5 and 10 % by year 1,2 & 3
    - ACOs that show losses are dropped after 3 years
    - Stringent reserve requirements protect the CMS against the losses – ACOs must have reinsurance, surety bonds, escrow or deposits to cover ANY loss – up front
    - 25 percent of shared savings bonus is also withheld to cover potential losses, and bonus isn't paid for 2 years

The federal regulation

- Requires the ACO to publicly report shared savings and/or losses – *will this be adequate information for DMHC to monitor the market?*

What is the level of risk?

- Who would be harmed by an insolvency?
- **Payer** – CMS has fully protected itself against any loss in the MSSP
- **Patients** – Medicare FFS patients only pay at each encounter – no loss of premiums
- **Downstream Providers** – The ACO is not responsible to pay them as in a delegated model risk arrangement

What is the level of risk?

- ACO Participants:
  - The risk-sharing arrangements between all of the participants within a MSSP ACO are not specified
    - How will the reserve requirements (upfront deposit, reinsurance, surety bonding, etc.) impact the participants?
    - Will only some of the participants put up the money?
    - We do not know with certainty how risk sharing arrangements will evolve within a MSSP ACO
    - Potential area of review and comment by the DMHC

Are SB 260 standards relevant?

- Again, what is the problem that SB 260 tried to solve?
  - Enacted in an environment of massive insolvencies – over 100 groups dissolved between 1998 and 2002
  - Risk Bearing Organizations take capitation and delegation, pass risk down to other providers
  - Downstream providers didn’t get paid, payers & patients did not receive the service for the premium paid

Evaluation of DMHC jurisdiction

- Jurisdiction is over two types of entities:
  - Health plans that meet the definition under statute are subject to KKA licensure
  - RBOs that meet the SB 260 requirement are subject to monitoring oversight
- Will an ACO meet either jurisdictional trigger?
- Will statutory authority be required?

How will the ACO market compare?

- Will there be over 200 ACOs like there are RBOs in California? - Highly unlikely due to the stringent requirements of the MSSP
  - Regulation favors existing market participants that already hold KKA licenses, report financial condition regularly and have strong business in the HMO market
  - Easier for the DMHC to track new ACO players in the early years from 2012 – 2015
  - Unless new, unfamiliar players arise in the market

But what about commercial ACOs?

- Pilots exist in the commercial market in California
- No downside risk – yet
- No capitation – yet
- This is the most likely area for further study by DMHC & FSSB (if not the Legislature) to evaluate risk to the public of ACO insolvency

Will SB 260 metrics serve?

- The role of the FSSB should be to determine whether the existing SB 260 metrics are applicable for the MSSB ACOs and perhaps the Pioneer ACOs – *if* California applicants are accepted into the program
- Would commercial ACOs disclose their arrangements for study?
- Time frame for Pioneer project – Mid Summer?

Some suggestions

- Should a FFS ACO be evaluated separately or in conjunction with any existing KKA or SB 260 reporting?
- What is the ACO patient level compared to the overall patient level of the entity?
  - Example: Entity has 200,000 managed care lives and only 5,000 ACO lives – what level is significant?

CAPG Recommended Oversight

MSSP or Commercial ACO with one-sided (upside only) FFS payment model	No DMHC oversight when the ACO receives FFS payments with no downside risk
MSSP two-sided model with downside risk exposure, or any commercial model with downside risk under a FFS contract	DMHC review triggered – ACO files contracts with the DMHC for evaluation and monitoring. DMHC studies are recommends next regulatory steps
Capitated ACO payment model with professional risk only	Apply existing SB 260 reporting program for RBOs
Capitated ACO payment model with both professional and institutional risk elements	Full or restricted KKA licensure as required based on level of institutional risk assumed and type of participants in the ACO entity

Next Steps

- CAPG suggests that the FSSB continue to closely study the development of ACO models, considering the goals of public protection and the incentive to improve the delivery system through ACOs
- Make formal recommendations to the Governor and Legislature on modification of the KKA in late 2011