Whole Person Care Integration Workgroup

Questions and Answers to Date about Different Models

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GENERAL/OVERVIEW QUESTIONS

WHAT ARE THE PRIMARY DIFFERENCES BETWEEN ACCOUNTABLE CARE ORGANIZATIONS (ACOs) AND CAPITATED PAYMENT MODELS (Managed Care Organizations, "MCOs")

ACOs are based on fee-for-service payment with the addition of gain/loss sharing. MCOs are based on capitation payment, which is full prepayment, not fee-for-service. The MCO therefore has full risk, whereas the ACO's risk is limited.

And with ACOs, the state is still processing providers' claims. MCOs are true intermediaries and process claims themselves.

Under ACOs, Beneficiaries would be assigned to ACOs based on which PCP they've selected ... and that PCP's affiliation with an ACO. This differs from how MCOs work: beneficiaries must formally enroll in an MCO, or be assigned to an MCO by the state if they don't choose on their own.

QUESTIONS ABOUT ACCOUNTABLE CARE ORGANIZATION MODELS

Are there administrative payments made to ACOs?

The DHHS plan does not contemplate making administrative payments to ACOs. The plan was modeled on Medicare's ACO design for the Medicare Shared Savings Program. In that program, ACOs are expected to bear their own administrative costs, with the expectation of recovering such costs out of health cost savings awards.

What happens if the ACOs end up with lots of folks with expensive needs?

Our plan for ACO payment includes a number of risk buffers. First, the benchmark cost for each ACO – that is, the health cost budget – will be risk adjusted based on the health profile of the ACO-associated population. ACOs with patients having higher needs will have higher benchmarks. Second, there will be what is called "specific stop-loss," under which the ACO budget will be charged only 10% of costs any beneficiary incurs above $50,000 in any year. Third, there will be "aggregate stop-loss" that will cap an ACO's payback to the state should total health spending for the ACO population be very high.

QUESTIONS RELATED TO CAPITATED MODELS:

What is the difference between a Comprehensive Plan and a Non Comprehensive Plan?

A comprehensive plan covers all services that a beneficiary may use, while a non-comprehensive plan covers a limited set, possibly only one type of service. The LME-MCOs are an example of a non-comprehensive plan.

Can ACO model evolve into a capitated model?

Yes, ACO payment can shift from fee-for-service with shared gains/losses to full capitation. The DHSS Medicaid reform plan includes a glide path to nearly full risk for ACOs. The House version of HB 1181 says ACOs (called "provider led health plans" in the bill) will have limited risk in the beginning but then be capitated after several years.

Other states have done this. Florida's provider service networks (PSNs) started out with fee-for-service payment and a shared risk feature, then shifted to capitation. Illinois recently started up accountable care entities (ACEs) that will shift to capitation within two years. Other states with ACO-type programs, such as Colorado, also envision moving to capitation.

Can a capitated model be provider-led?

Yes. Capitated plans do not have to be managed by insurance companies. States have also used not-for-profit health plans and sometimes local counties have created a plan. That said, a capitated plan truly does bear risk for its enrollees' health costs. It must demonstrate both the financial capacity and the know-how to manage that risk.

What happens if a person requires additional services above set limit?

Plans can have the ability to waive the limit but may be required to do so within their existing payment.

Ongoing Observations and Additional Questions

Domain	Carrie's Group	Lee's Group
Questions about FFS with enhancements		Hospitals are starting to coordinate more strongly with home health agencies (ACA).
Observations about FFS with enhancement	• LTSS partnership with CCNC and MCO inconsistent and difficult to coordinate • Unified assessment and usher function can't exist without stronger contractual requirements	
Questions About ACOs		•

Observations About ACOs	Sandra state research: ACOs require heavy lift with IT • Important to fix what we have	
Questions About MLTSS	Has FL experienced cost savings? A: Florida builds projected savings into the capitated payment model.	• How do Special Needs Plans handle overlap if person has to transition to a service not covered by plan (i.e. CAP C to Innovations)? • How does SNP cover transitions to services where there is a significant change in service limit, but not a change in need? (CAP C to CAP DA). • How does care coordination work if responsible for all ages/needs within a population [TF: we have some info on this]/. • How do we ensure folks aren't offloaded onto state services that already have waiting lists? • How are waiting lists managed under a capitated model? • What are some examples of how MLTSS plans have supported family caregivers, both under the waivers and outside the waivers? • How are individuals with high needs but limited family support treated? • How do plans build networks in low population areas? In remote locations? • How do you ensure a robust provider network? • What steps are taken re: fraud

		prevention?
Observations About MLTSS		• NJ has experienced cuts • In FL, less than 3% of HCBS provider provide Medicaid • Importance of strong planning
About Quality Measures		
Other		• Discussion of rate setting and risk adjustment: need additional information about how process works