

# Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design

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Accountable care organizations (ACOs) are gaining momentum in Medicaid. As Medicare, commercial payers, and providers aggressively launch ACOs across the country, state Medicaid agencies, health plans, and providers have also been planning innovative initiatives for their beneficiaries. Given Medicaid's growing role as a health insurer, ACOs offer states an opportunity to drive broader delivery-system transformation for providers and systems serving low-income populations.

To help guide Medicaid stakeholders in developing safety-net ACOs, the Center for Health Care Strategies (CHCS) interviewed 26 state Medicaid leaders, ACO stakeholders, and health plan officials in states that are pursuing ACO models, as well as key officials within the Centers for Medicare & Medicaid Services (CMS), including staff from the Center for Medicaid, CHIP and Survey & Certification (CMCS) and the Center for Medicare and Medicaid Innovation (CMMI). The scan focused on:

- Understanding how ACOs can serve as innovative delivery system models for Medicaid populations;
- Assessing the state and federal policy issues related to operating ACOs; and
- Assessing the unique start-up and operational challenges for safety-net ACOs.

The interviews and a subsequent small group stakeholder session in December 2011 confirmed that ACOs offer a useful framework through which payers, providers, and communities can radically restructure care delivery to improve care for low-income patients and reduce system costs. ACOs can potentially fill existing gaps in care delivery by moving clinical care management activities to the point of care and aligning incentives more effectively at the provider level. For Medicaid beneficiaries, ACOs must knit together medical and social service financing and delivery at the community level and deploy those resources more effectively to improve outcomes. To meet these goals, Medicaid ACOs must have: (1) a clear mission; (2) a set of core capabilities; (3) collaborative relationships across their

## IN BRIEF

Accountable care organizations (ACOs) are emerging in multiple states with strong interest and support from Medicaid. This brief summarizes state ACO activities across the country based on a national scan undertaken by the Center for Health Care Strategies (CHCS). It outlines key issues for federal and state agencies, health plans, providers, and communities to consider in designing ACO programs to serve low-income beneficiaries, with a focus on:

1. Core capabilities;
2. Financial models;
3. Design issues; and
4. Fit with the current system, including providers, purchasers, health plans, and the state and federal governments.

communities, providers, and payers; and (4) strong executive and provider leadership. States and health plans must be willing to invest in infrastructure development and must tie payment explicitly and directly to achieving the desired results.

A variety of ACO models will emerge, each shaped by local markets. State programs offer the unique opportunity to test a range of ACO models in different delivery system contexts. At the same time, policy and operational challenges need to be addressed to help states design programs that can move beyond traditional primary care case management or managed care. This brief outlines essential requirements for ACO programs serving low-income populations as well as considerations to assist federal and state agencies, health plans, providers, and communities in designing ACO programs. It also presents a summary of Medicaid-focused ACO activities underway in states across the country.

## Essential Elements for ACOs Serving Low-Income Patients

The following are crucial functions for Medicaid-focused ACOs:

### 1. Build Core Capabilities

To improve population health and lower costs, ACOs must establish a solid foundation centered on team-based primary care to manage patients across a continuum of medical, behavioral, and social services. CHCS' interviews uncovered the following core capabilities for ACOs serving Medicaid and other low-income populations:

- a. *Patient-Centered Care Management and Coordination:* ACOs should provide medical home and broader health home services. In ACOs, care management resides at the point of care and is directed by the primary care team (as opposed to the managed care organization (MCO)). Care is coordinated, with the primary care team and hospitals jointly planning transitions from inpatient and emergency rooms to more appropriate care settings. ACOs should monitor the overall quality of care across their patient population, identify health trends and issues, and use predictive modeling to identify high-risk subsets.
- b. *Targeted and Intensive Complex Care Management:* ACOs are structured to serve a large patient population, ranging in acuity levels. But in order to substantially reduce costs, ACOs must identify, outreach to, and manage a smaller subset of high-need, high-cost patients, with high-intensity care approaches tailored to each patient. For low-income patients, this requires the development of cross-functional care teams that span the continuum of physical health, behavioral health, and social services, including long-term supports and services.
- c. *Data Infrastructure and Analytics:* The first two capabilities outlined above require robust data infrastructure and analysis skills, which are frequently lacking at the point of care. At a minimum, ACOs need timely access to claims-based data (particularly for emergency room visits), the skills to effectively analyze the data, and the ability to translate that information into care management activities. Ideally, providers will have electronic health records (EHR) that feed electronic disease registries, clinical decision support, predictive modeling, and other analytic software. A health information exchange across delivery system partners is essential for efficient care coordination.
- d. *Motivated and Mission-Driven Leadership and Providers:* Success will depend on commitment across all levels of the organizations involved in an ACO, including the clinical leadership that creates the vision, the administrative team that

## Innovative ACO Data Supports

As a part of Colorado's Accountable Care Collaborative (ACC) model, the state contracts with an external statewide data and analytic contractor for help with data aggregation and analytics. The contractor is charged with: (1) developing a repository of Medicaid claims data; (2) cleaning and aggregating data; and (3) making data available to providers, the Regional Care Collaborative Organizations, and the state in a useful format. These data play a critical role in identifying best practices and opportunities for quality improvement. The contractor also has responsibility for a cost evaluation and for calculating incentive payments for providers.

allocates financial resources, as well the ground-level provider team that changes the way patient care is delivered.

## 2. Empower Providers to Transform Care Delivery

The ACO model hinges on the hypothesis that supporting core capabilities and decision-making power at the point of care can meaningfully improve health care delivery and reduce costs. Physician leadership will be critical. On-the-ground primary care teams – not just the physician organization – must be empowered, energized, and funded to assume this new role and collaborate with new partners, including: (1) mental health, substance abuse, and long-term supports and services providers; (2) community organizations and social service providers; and (3) patients and their families. Building high-performing, cross-functional teams – in which all partners have well-defined roles and responsibilities and work closely with the primary care team – is essential.

States and Medicaid health plans pursuing ACOs are using several approaches to foster provider engagement, collaboration, and leadership, including:

- Engaging providers in the program design process, which can build physician buy-in for the ACO model;
- Placing practicing PCPs in ACO leadership roles, creating a sense of ownership and empowerment;

- Creating care teams that collaborate across practices and meet regularly to review cases, conduct root cause analyses, and develop patient-specific care plans;
- Giving practices decision-making power to invest savings as they see fit; and
- Easing administrative burdens and utilization oversight to empower physicians, free up practice resources, and build more collaborative relationships between practices and payers.

Yet delegating greater decision-making to practices is not sufficient to achieve clinical innovation. Practices will need support via technical assistance grants, learning collaboratives, project management, and other formal mechanisms. One ACO, for example, is using quality improvement advisors to help practice teams reconfigure care delivery to serve patients more efficiently, while another is providing grants for practice-led projects.

## 3. Structure ACOs for Meaningful Patient and Community Partnerships

In low-income populations, poor health outcomes are often driven by poverty and related social issues, including unstable housing and employment, problems getting transportation, and insufficient access to a nutritious diet. A recent survey found that physicians believe that unmet social needs directly lead to compromised health status, but do not feel confident in their capacity to help their patients meet those needs.<sup>1</sup>

### ACOs for Medicare-Medicaid Enrollees

Several states are evaluating the feasibility of using ACOs to deliver integrated care for Medicare-Medicaid enrollees, which would enable the ACO to provide both Medicare and Medicaid services, as well as behavioral health and long-term supports and services. States with Medicare ACOs may be particularly well-positioned to develop Medicaid-focused MCOs, but should be mindful of complexities that may result due to the overlap of enrollment, shared savings, and accountability that the ACO would likely be attributing to Medicare. These elements would need to be reevaluated if the ACO also included Medicaid-funded services.

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ACOs serving low-income populations are uniquely positioned to engage community-based organizations and patients to help bridge these gaps.

Starting with the ACO certification or application process and continuing through implementation, states and health plans can foster provider-community partnerships by:

- Requiring ACO governance structures to include meaningful community and patient representation;
- Asking ACO applicants to provide a detailed community engagement strategy;
- Requiring community and social services participation in care teams; and
- Using community-level performance metrics to assess ACO performance.

Involving behavioral health, social services, and community stakeholders, such as faith-based groups and community organizers, throughout the program design process enables states to incorporate valuable expertise and lays the groundwork for critical partnerships once the ACO is operational. Some states are building programs onto existing community health worker or Medicaid health homes programs, which help connect patients to essential behavioral health and social services. Once the ACO is launched, formal mechanisms to convene community, social services, and public health workgroups to assess community needs and develop new delivery approaches may also be effective.

#### 4. Catalyze ACO Development at the State and Federal Levels

As large purchasers, state Medicaid agencies can provide leadership for ACO development and innovation, particularly in markets where Medicare has not gained traction. ACOs offer an opportunity for Medicaid to guide the development of delivery systems capable of effectively managing care for the additional 16 to 20 million low-income people who will become

newly eligible through health reform in 2014, many of whom will have pent-up demand and complex health problems. One interviewee suggested that Medicaid must exert its influence in the ACO arena since delivery innovations for Medicaid will vary from those for Medicare and commercial populations, where underlying patient characteristics and the root causes of excess expenditures look very different.

States can use their regulatory powers, managed care contracting, and direct ACO contracting to craft programs with maximum flexibility and incentives for innovation. The market-leader role may be a big shift for some states. Given the relative nascence of the ACO model, Medicaid may want to engage a range of community stakeholders to design an approach that functions well to meet a variety of needs. Medicaid can assist in the development of robust ACO models by leading efforts to integrate financing for physical health, mental health, behavioral health, and long-term supports and services, and by fostering collaborations with state and local agencies responsible for funding critical social services. At the implementation level, Medicaid can facilitate alignment across MCOs, ease administrative burdens for ACOs, and either lead key technical support activities, such as data aggregation and data feeds, or leverage their MCO contracts for these supports.

CMS has an opportunity to foster state innovation by providing federal policy guidance in the following areas:

- *Regulatory Options.* States need clarification from CMS around how different ACO approaches fit into existing regulatory structures for both Medicaid managed care and fee-for-service (FFS) delivery systems, and what modifications to existing authorizations are necessary. CMS can assist states by outlining the regulatory options, the contexts in which they may apply, and the considerations/

requirements states should bear in mind while deciding between those options.

- *Financing Approaches.* Given federal-state matching arrangements, states need CMCS guidance on ACO financing issues – specifically, the distribution of shared savings to states, health plans, and ACOs, and how states can meet actuarial soundness requirements for managed care rates.
- *Legal Issues.* CMS can leverage its work on the Medicare Shared Savings program and the Pioneer ACO initiative to help states manage anti-trust, anti-kickback, and fraud and abuse issues with the Department of Justice and the Federal Trade Commission. In fact, anti-trust issues in Medicaid may be easier due to the state-action doctrine.
- *Start-Up Resources.* CMMI can help capitalize the start-up and testing of Medicaid ACO models, including those covering long-term supports and services and beneficiaries dually eligible for Medicare and Medicaid. It is also in a position to support program evaluation and measurement objectives.

## Critical Considerations for ACO Program Planning

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As outlined in Figure 1, CHCS closely examined ACO models being developed in five states (see appendix for program details). The experience of those states offers key decision points for all states and their partners to consider in designing and developing Medicaid-focused ACOs.

### 1. Determine ACO Organizational Structure

The interviews revealed a range of perspectives regarding which entities should or could perform the ACO functions noted above. Three models, described below, emerged for consideration: provider-led ACOs; MCO-led ACOs; and MCO/provider partnerships. Some states are choosing a single model from among the

three, while others are deliberately building in flexibility.

- a. *Provider-Led ACOs:* In this model, providers assume full responsibility for their patient panel and receive the financing necessary to build and perform the ACO core capabilities. Depending on the payment method, the ACO may or may not perform traditional MCO functions such as risk management and claims payment. Provider-led ACOs may be formed by large integrated delivery systems; by non-integrated, but affiliated provider organizations; or by networks of previously unaffiliated providers serving a specific community. Within Minnesota, for example, both integrated and non-integrated systems can apply to become an ACO. In New Jersey, a group of previously unaffiliated social workers, physicians, nurses, administrators, hospitals, and health services organizations have formed a citywide network called the Camden Coalition of Healthcare Providers to serve patients across their community.

Provider-led ACOs are well positioned to create locally tailored innovations and partnerships essential for success. Rather than increase the clinician work load, the ACO can create a care team infrastructure to perform the ACO core capabilities and assume the heavy lift on behalf of providers. Such teams can support providers through data collection and sharing, analytics/informatics, project management, and the identification, outreach, and management of high-cost patients. The provider-led ACO is also optimally positioned to facilitate broader community/provider partnerships to better address overall health.

- b. *MCO-Led ACOs:* Some states are deploying a model in which the MCO serves as the ACO, building on existing prevention, disease management, and

complex case management programs to create more expansive patient care management capabilities. Utah is taking this approach, which may be successful among integrated organizations that currently perform both payment and care delivery functions, or with local plans that have strong ties to providers and the community. However, most MCOs have not developed the programmatic infrastructure necessary to manage complex patients on the ground, and do

not have the concentrated local market share needed to make this high-touch approach financially viable.

- c. *MCO/Provider-Led ACOs*: Under a hybrid model, MCOs and providers partner to jointly meet ACO core capabilities, dividing responsibilities based on their respective strengths. Health plans continue to perform compliance, state rate setting, and contracting functions and develop payment models. Plans deliver

**Figure 1: Overview of Five State ACO Programs**

State	Payment Model	Organizational Structure	Delivery System	Geographic System/Scale	Beneficiary Population	Implementation Status
<b>Colorado</b>	PMPM payment both to the ACO and to primary care practices	Hybrid MCO/provider-led ACOs	Fee-for-service	Statewide; seven regions, each served exclusively by a single Regional Care Collaborative Organization (RCCO)	Initial phase: all except dual eligibles and those who reside in a state psychiatric institution or nursing facility  Expansion phase: all Medicaid beneficiaries	Initial phase in progress through July 1, 2012
<b>Minnesota</b>	Shared savings with upside risk only or upside and downside risk	Provider-led ACOs; hybrid MCO/provider-led ACOs	Fee-for-service and managed care	Statewide; approved providers only	All beneficiaries except dual eligibles	Demonstration launch expected 1st quarter 2012
<b>New Jersey</b>	Shared savings with upside-risk only	Provider-led ACOs	Fee-for-service and managed care	Statewide; approved providers only	All beneficiaries except dual eligibles	Regulatory process is underway
<b>Oregon</b>	Global payment	Hybrid MCO/provider-led ACOs	Fee-for-service and managed care	Statewide; approved Coordinated Care Organizations (CCO) only	All beneficiaries except PACE	Rollout beginning in July 2012
<b>Utah</b>	Global payment	MCO-led ACOs	Managed care	Four most populous counties in the Salt Lake City area	All beneficiaries except those in nursing homes or other inpatient facilities	State submitted an 1115 waiver on June 30, 2011

additional support to providers through encounter and claims reporting, analytics/informatics, project management, and investment capital. For example, one MCO is planning to give providers data and to conduct patient population analysis, creating a drill-down list of patients who should be engaged proactively. Providers are responsible for targeted complex care management and partnering with local organizations to link patients with social services. Oregon is designing its ACO model to build on the state's strong managed care infrastructure.

This model can tap into the strengths of both MCOs and providers. Intensive care coordination and management are essential ACO functions and, many would argue, can only be done successfully at the local provider and community level. Yet, at the same time, some interviewees argued that providers are not ready to assume traditional MCO functions such as obtaining network discounts, underwriting risk, and paying claims. That said, some MCOs are struggling to define their role, particularly in markets with multiple MCOs. These MCOs may hesitate to delegate functions while playing a greater role overseeing and supporting providers.

## 2. Identify a Feasible Financial Model

State purchasers and health plans are looking at various payment models to align financial incentives and support ACO

capacity-building, estimated to require an upfront investment of between \$1.5 and \$2 million.<sup>2</sup> Most of the payers interviewed for this scan plan to use either global payments or shared savings models, although other models such as per-member-per-month (PMPM) and partial capitation payments are also being considered.

One fundamental question is how much “front-end” investment will be needed to build the infrastructure and staff to perform the core ACO functions. States and plans will need to understand existing capacity and the financial and technical supports that providers and care teams may need to achieve core functionality. Providers serving low-income populations, in particular, may require assistance securing upfront financing to build their ACO capacity and hire the necessary staff before they can achieve cost savings. States should consider an initial payment model that recognizes these upfront costs.

States and their partners are considering a range of financial models, including:

- a. *Global Payments:* A single global payment with full risk may drive transformational change by fully aligning incentives for provider teams to invest in care models that will reduce inappropriate and wasteful use of health care resources. Global payments also offer some measure of upfront funding to build ACO infrastructure, transition systems away from FFS, and orient providers toward a population-based budgeting approach.

## Innovations in Cooperative, Community-Wide ACOs

New Jersey's ACO model is unique in its ground-up, community-based approach. Providers, defined broadly as local general hospitals, clinics, pharmacies, health centers, qualified primary care and behavioral health care providers, social service agencies and others, have the opportunity to form a single ACO that serves the entire community. Based on legislation passed in August 2011, the ACOs must include participation by 75 percent of qualified primary care providers and all local hospitals. The state is developing regulations, which include guidelines for governance and community representation and for shared savings between health plans and ACOs. Organizations such as the Camden Coalition of Healthcare Providers and the Trenton Health Team have emerged to serve those communities.

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Global payments offer some measure of upfront funding to build ACO infrastructure, transition systems away from FFS, and orient providers toward a population-based budgeting approach.

One key issue is whether the ACO will have the financial wherewithal to accept downside risk when losses exceed a certain budget. Global payments will be more amenable to organizations already performing at a high level. Full risk may be feasible within MCO-led or hybrid models, given MCO reserves and their core capabilities in risk management and predictive risk modeling, but provider-driven ACOs may not have that capacity. States interested in full risk may consider mechanisms such as risk corridors, similar to those currently used by some health plans, to protect the ACO if it loses money due to catastrophic claims. In order to achieve meaningful change and cost savings, states pursuing global payments within the context of managed care will need to consider other programmatic approaches that will distinguish this ACO financing strategy from traditional capitation.

- b. *Gain and Risk Sharing:* A shared savings approach may be attractive to states since it can work for providers who cannot bear full risk. Under this model, ACOs may assume partial risk for a fixed percentage of savings or losses, or have the opportunity to share in cost savings without facing any downside risk. The Medicare Pioneer ACO initiative as well as many commercial health plans are pursuing shared savings methods, with upside and downside potential. Shared savings models can easily be incorporated into existing FFS systems without significant systems changes.

Shared savings models present a few challenges worth noting. The first is measuring statistically valid savings. States may have to require ACOs to serve a high number of Medicaid beneficiaries or risk paying for savings that result from random statistical variation rather than from improved quality and efficiencies. A second

challenge is that gain sharing alone may not be a sufficient incentive to achieve the behavior changes that the model seeks. Finally, shared savings may unfairly reward currently inefficient providers, who stand to reap the greatest financial benefit from improvements on high baseline expenditures.

- c. *Upfront PMPM Payments:* PMPM payments based on a patient panel, acuity levels, and patient activity may effectively support ACOs as well. Colorado, which has a FFS delivery system, is initially paying an enhanced PMPM to both ACOs and the primary care practices associated with them, in order to provide upfront financing for capacity-building. The state will consider deploying shared savings or global budgeting models in the future. One Colorado interviewee is channeling resources into provider-level grants for specific primary care capacity-building activities. In order to drive accountability, such payments must be tied to achieving specific outcomes.

There are a variety of considerations for selecting the most appropriate payment methodology. States may want to select payment methods that account for provider capabilities and gradually increase accountability as those capabilities develop. Medicare has taken a similar approach in its Pioneer ACO program: if ACOs achieve savings in the first two years, payment will shift away from shared savings toward a “population-based” payment. Medicaid may also wish to consider aligning its payment models with arrangements that ACOs currently have in place through participation in the Pioneer ACO initiative, Medicare Shared Savings, and commercial ACO programs.

### 3. Weigh Standardization vs. Flexibility in ACO Models

States will need to consider whether to create a standardized ACO program or use a “high-level” framework, under which plans and providers can take variable approaches to crafting ACOs.

A standardized ACO approach has several advantages. First and foremost, it would be simpler to implement, administer, regulate, and evaluate. Standardized programs may be easier for providers to participate in, particularly in markets where they contract with multiple MCOs. Depending on the underlying capacity of providers and health plans, standardization around ACO functional requirements can help clarify expectations and direct where investments should be made. Standardization can also help ensure equal access for patients by creating a uniform framework for enrollment, assignment, evaluation and treatment. For states looking to take a statewide approach as discussed below, some level of program standardization will be essential.

Yet excessive standardization could stifle locally-tailored innovations that might drive success. Because these are new models of care delivery, the features of successful ACOs are not yet clear. States should be flexible enough to let multiple models thrive as data are collected and formative evaluations conducted. Flexibility is also critical to successfully managing variable regional and provider capacities.

Several interviewees commented that rather than delineating specific ACO structures and processes, states should set key goals,

outcomes, and milestones, and let ACOs develop locally-tailored strategies to meet those objectives. Payment must be explicitly and directly tied to achieving those results. Key areas to define and standardize include: (1) data-sharing; (2) analytic support; (3) technical assistance; (4) performance measurement; and (5) the role of the health plans in providing these supports.

### 4. Stimulate Competition or Collaboration

Before proceeding with Medicaid ACO development, states may want to evaluate local market dynamics to determine the programmatic approach that can best address dysfunctional health care marketplaces. Some argue that ACOs should stimulate competition and act as a counterbalance to unhealthy consolidation of market power, which ultimately drives up costs. Others expressed the view that within Medicaid, fostering collaboration among providers will be more critical to success than deterring anti-competitive behavior. At issue is whether, given local dynamics, harnessing competition or collaboration would best stimulate effective coordinated care for complex patients across providers.

Interviewees cited examples where collaboration may be insufficient to combat anti-competitive, cost-inflationary forces. In rural markets, a single hospital often serves the community, and efforts to reduce emergency department visits and inpatient admissions may be thwarted, especially given impending reductions in disproportionate share hospital funding. In larger markets, powerful hospital systems are consolidating purchasing power by acquiring

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### Innovations in Payment Flexibility

To support ACO adoption among providers with a range of capabilities, Minnesota’s Health Care Delivery Systems Demonstration (HCDS) includes two options within managed care and FFS. For integrated provider delivery systems, the Integrated HCDS option includes symmetrical two-way risk sharing, in both gains and losses. Providers who are not part of an integrated delivery system are eligible for the Virtual HCDS option, which allows organizations to participate in one-way gain sharing with the state. Both models include the use of a Minimum Performance Threshold – a two percent minimum that must be met in either direction prior to any gain or loss sharing.

practices to lock in alignment and referral patterns in preparation for forming ACOs. In certain markets, ACOs, including those serving low-income patients, can only change the dynamics driving higher costs by promoting competition.

Other interviewees questioned whether anti-competitive behavior is of primary concern within Medicaid, given purchasing dynamics and cost drivers for low-income populations. Given low levels of Medicaid reimbursement, for-profit, high-cost hospitals and health systems may be less likely to serve Medicaid beneficiaries in the first place. Patterns of high, inappropriate hospital and emergency department utilization are likely the biggest driver of avoidable Medicaid costs, rather than high per-unit costs. Collaboration among providers may be more effective in solving what is fundamentally a utilization issue related to unmet health and social needs, not a cost issue.

It is possible to structure ACOs to harness both collaboration and competition. For example, ACOs led by primary care practices and supported by MCOs, rather than hospitals and specialty groups, may stimulate competition among hospitals while building collaboration among coordinating providers. States can use payment models and ACO regulations to foster such complementary arrangements.

## 5. Choose Between Statewide Roll-Out and Regional or Local Pilots

States are grappling with the issue of scalability, deciding whether to develop ACOs within select communities or to create a statewide program. States must

weigh the capacity of regional and statewide providers, MCOs, and other organizations to serve as ACOs. A state's approach may depend on whether program elements such as medical or health homes, community health workers and teams, or data-sharing are in place.

A regional approach may be preferable if the foundation for the ACO is stronger in a handful of locales. Further, regional Medicaid analyses often reveal local pockets of high costs, suggesting that a targeted approach may yield a higher return on investment for states.<sup>3</sup> Additionally, competitive dynamics will differ across markets, making ACOs more viable in certain markets than in others. Finally, taking an iterative approach and scaling up from local or regional to statewide is one way to create a continuous learning process.

A statewide program, however, may be more appealing in states with little managed care penetration or less geographic variability. States seeking to build ACO programs to complement a strong managed care system may view this as an opportunity to push managed care to the next level, believing that an across-the-board approach will drive the greatest level of competition and innovation. From a patient perspective, a statewide approach may be more equitable, offering all beneficiaries access to improved care.

## 6. Sustain ACOs Over Time

There is understandable skepticism that the as-of-yet unproven ACO model will achieve the long-term cost savings necessary to put the overall health care system on firmer financial footing. Interviews revealed layers

## Innovations in Program Scale

Oregon will replace a strong but fragmented managed care delivery system with a statewide network of regionally-based Coordinated Care Organizations (CCOs). Oregon's approach is expansive, both in terms of coverage and in the scope of services that the CCOs are expected to provide. All Medicaid beneficiaries, including persons dually eligible for Medicaid and Medicare services, will be included in this new system. CCOs are required to cover and provide all services for beneficiaries, including physical, behavioral, and oral health; comprehensive transitional care; and linkages to community and social support services. Only long-term care services are currently excluded.

of uncertainty around scalability. Several people expressed concern that this may be a very expensive model – particularly where competition gives way to monopolistic conditions, or for healthier populations who do not need high levels of clinical management. Also, scalability will be an issue if not all practices – particularly small or rural practices – are ready to embrace the ACO model. As one interviewee put it, policymakers must “unpack the black box that prevents these models from spreading.”

Another interviewee observed that relationships between providers and MCOs will need to evolve to a “business-to-business” model. For example, health plans may need to provide capital to practices and create a provider relations model focused less on contracting and utilization management and more on engaging and supporting practices to develop effective complex care management approaches.

Sustaining the magnitude of savings expected of ACOs over the long term will also pose a challenge for Medicaid and local communities. ACOs must continuously seek new ways to restructure investments to meet population health needs while simultaneously lowering overall systems costs. Providers must do a better job of linking patients to long-term supports and services. Disparate health and social service delivery approaches will need to be unified under a single community strategy. Blending medical and social service funding streams

within shared savings or global payment models, for example, may enable communities to use both health and social resources more effectively and achieve greater reductions in the cost of care. Whether or not ACOs will have the leadership and the clout to drive change of this magnitude is unclear. Interviewees expressed skepticism, saying that even if ACOs can transform segmented delivery systems to an integrated system, the path towards an accountable community model is much less certain.

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## Conclusion

Given its growing role as a universal insurance program for all Americans up to 133 percent of the federal poverty level, Medicaid can leverage its purchasing power to stimulate new, innovative models of care. ACOs offer promising new integrated care models for Medicaid beneficiaries. However, all stakeholders involved need to provide more of a policy structure, more capital, and more support for provider capacity-building for ACOs to truly flourish. While Medicaid stakeholders wrestle with design and implementation issues, they should also keep an eye on and seek alignment with ACO developments in the rest of the U.S. health care system.

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Blending medical and social service funding streams within shared savings or global payment models may enable communities to use both health and social resources more effectively and achieve greater reductions in the cost of care.

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## ENDNOTES

<sup>1</sup> “Health Care’s Blind Side: The Overlooked Connection between Social Needs and Good Health.” The Robert Wood Johnson Foundation, December 2011.

<sup>2</sup> “Medicare Program - Medicare Shared Savings Program: Accountable Care Organizations.” *Federal Register*, Vol. 76, No. 67, Thursday, April 7, 2011.

<sup>3</sup> T.P. Gilmer and R.G. Kronick. “Differences in The Volume of Services and In Prices Drive Big Variations In Medicaid Spending among US States and Regions.” *Health Affairs* (2011), Vol. 30, no 7: 1316-1324.

## APPENDIX: PROGRAM CHARACTERISTICS OF EMERGING STATE ACO MODELS

### COLORADO – ACCOUNTABLE CARE COLLABORATIVE (ACC)

<b>MODEL</b>	Initial phase launched in April 2010. ACC is designed to shift the health care system from a fee-for-service (FFS) model to a regional, outcomes-focused, coordinated system of care for Medicaid clients. The goal is to improve the health of Medicaid beneficiaries and control costs by transforming the health care delivery system, engaging communities, and holding providers accountable for the care they deliver.
<b>STRUCTURE</b>	Through seven regional care collaborative organizations (RCCO), regional and community resources will work together with primary care medical providers (PCMP). The RCCOs will be responsible for network development, including a formal network of contracted PCMPs as well as an informal network of community resources, specialists, and hospitals. The state contracts with an external Statewide Data and Analytic Contractor (SDAC), Treo Solutions, for data aggregation and analytics essential to effective population management. Treo Solutions is charged with: (1) developing a repository of Medicaid claims data; (2) cleaning and aggregating data; and (3) making analyzed data available to providers, the RCCOs, and the state in a useful format. The contractor also provides cost evaluation analysis and calculates incentive payments for providers.
<b>FINANCING</b>	RCCOs receive up to \$13 PMPM. In addition, PCMPs that contract with a RCCO and Medicaid receive a \$4 PMPM payment for the medical home services they provide, in addition to FFS payments for services provided. After the first year, \$1 PMPM is withheld from both the RCCO and the PCMP payments, which both can earn back through jointly meeting utilization and outcome goals. In the first year, performance measures consist of monthly utilization and quarterly cost measures, with more robust measures in subsequent years. The state will consider deploying shared savings or global budgeting models in the future.
<b>SERVICES</b>	<p>RCCOs are responsible for:</p> <ol style="list-style-type: none"> <li>1) Achieving improved health outcomes;</li> <li>2) Developing a network of PCMPs;</li> <li>3) Supporting PCMPs in delivering a medical home level of care;</li> <li>4) Ensuring that every member receives care coordination; and</li> <li>5) Remaining accountable to the state for the patients in their region.</li> </ol> <p>The RCCO is not responsible for providing or reimbursing providers for services rendered. Support for the PCMPs may include administrative support (i.e., Medicaid billing), clinical tools, client materials, practice support, or redesign. Services also include enhanced care coordination and primary care case management, regarded as central to the success of the RCCOs. To facilitate enhanced coordination beyond its network of PCMPs, RCCOs are responsible for outreach and ACC education to non-PCMP Medicaid providers. RCCOs are required to provide extended-access options for their beneficiaries. For example, at the RCCO level, beneficiaries must have access to evening and weekend care, and must be offered alternatives to visiting the emergency room for after-hours urgent care.</p>
<b>POPULATION</b>	<p>Based on their residence address, with the option to select a PCMP in another region, FFS beneficiaries are enrolled in the RCCO through a passive enrollment process: they are notified 30 days prior to enrollment and have the opportunity to opt out or tell the Department that they do not want to be enrolled. Clients then have an additional 90-day opt-out period once they officially start in the program.</p> <p>Beneficiaries dually enrolled in Medicare and Medicaid, as well as those who reside in a state psychiatric institution or nursing facility, are excluded from enrollment during ACC’s initial phase. During the program’s expansion phase, RCCOs will have the option to expand membership to all Medicaid beneficiaries.</p>

**APPENDIX: PROGRAM CHARACTERISTICS OF EMERGING STATE ACO MODELS** *(continued)*

**MINNESOTA – ACO DEMONSTRATIONS**

**I. Health Care Delivery Systems Demonstration**

<b>MODEL</b>	Demonstration launch expected first quarter 2012, as part of a project to test alternative and innovative health care delivery systems. The Health Care Delivery Systems Demonstration (HCDS) encourages the creation of ACO-like entities to serve non-dually eligible adults and children in Medical Assistance and MinnesotaCare enrolled under both FFS and managed care programs.
<b>STRUCTURE</b>	The HCDS allows provider organizations and systems to apply to form ACO-like entities. Provider-driven ACOs must: (1) develop innovative forms of care delivery; (2) engage in quality improvement activities; and (3) and meaningfully engage patients and their families with an aim towards reducing the total cost of care.
<b>FINANCING</b>	<p>The HCDS includes two payment models to be implemented across both managed care and FFS:</p> <ul style="list-style-type: none"> <li>▪ Integrated option - for integrated provider delivery systems with both inpatient and ambulatory care. Begins with gain sharing and evolves toward symmetrical two-way risk sharing of both gains and losses.</li> <li>▪ Virtual option – for primary care providers who are not part of an integrated delivery system. Allows organizations to participate in one-way, upside gain sharing with the state.</li> </ul> <p>Shared gain and risk are based on a risk-adjusted Total Cost of Care (TCOC) calculation, with TCOC defined as a subset of Medicaid services that health care organizations can reasonably be expected to impact in their current state. Generally includes inpatient, ambulatory, mental health, and chemical health services; generally excludes long-term and continuing care. This calculation includes the use of an expected trend value to adjust retrospective claims and encounter data. Savings/losses are derived from the difference between the actual spend for the attributed patients and the projected Total Cost of Care. Both models include a two percent Minimum Performance Threshold that must be met in either direction prior to any gain or loss sharing. The costs for which HCDS’ are accountable are truncated at the individual enrollee level to provide catastrophic risk protection. Based on the population of enrollees attributed to an HCDS, the state and the MCOs under contract with the HCDS will each pay its pro-rated share of the savings/losses payment.</p>
<b>SERVICES</b>	HCDS providers must deliver the full scope of primary care services, defined as “overall and ongoing medical responsibility for a patient’s comprehensive care for preventive care and a full range of acute and chronic conditions.” Providers must also coordinate with specialty providers and hospitals. All providers must demonstrate how they will partner with community organizations and social service agencies and integrate them into care delivery.
<b>POPULATION</b>	<p>For beneficiary attribution, Minnesota utilizes available retrospective claims and MCO encounter data and prioritizes assignment based on past utilization patterns, such as whether a beneficiary is enrolled in a health care home and where (s)he last received primary care services.</p> <p>All Medicaid beneficiaries not dually eligible for Medicaid and Medicare are included in the HCDS.</p>

**APPENDIX: PROGRAM CHARACTERISTICS OF EMERGING STATE ACO MODELS** *(continued)*

**MINNESOTA – ACO DEMONSTRATIONS**

**II. Hennepin County Integrated Health System Pilot - “Hennepin Health”**

<b>MODEL</b>	Hennepin Health is a unique MCO/provider hybrid ACO model in the state’s most populous county. The pilot is designed to serve the unique needs of the county’s childless adult safety-net population by integrating medical, behavioral health, and human services in a patient-centered model of care.
<b>STRUCTURE</b>	Hennepin County operates the state’s largest safety-net hospital as well as several clinics, an HMO, a large federally qualified health center (FQHC), and other affiliated physicians’ offices and clinics. The ACO: (1) must meet all federal requirements of an MCO; (2) will receive a prospective capitation payment; and (3) will have prospective enrollment similar to an MCO. Unlike a traditional MCO, the care delivery model is specific to typically high users of county services and integrated with medical, behavioral health and social services provided by the county in a tighter network.
<b>FINANCING</b>	Payment methods include shared risk and incentives based on performance and outcomes. The pilot will measure direct Medicaid costs and health care costs beyond the medical assistance benefit, including uncompensated care, human services, and public health. The project will quantify law enforcement, correctional, and court costs and savings, as well as the impact on community agency costs.
<b>SERVICES</b>	The ACO will be responsible for providing comprehensive care, including dental care, mental health and substance abuse services, and public health and human services. The ACO will also provide Medical Home services, including: (1) a comprehensive electronic health record (EHR) accessible by the patient and all members of the health care team; (2) a comprehensive patient assessment tool, with an objective tiering system to identify patients with the greatest needs; and (3) personalized care plans. Based on their needs, each beneficiary will have a health care team including medical, behavioral health, and human services professionals. The ACO must help patients leverage housing and social service resources and community partners. The ACO also has an integrated data warehouse and analytics infrastructure to provide actionable data to providers and administrators.
<b>POPULATION</b>	The pilot focuses on Minnesota’s early expansion population -- up to 10,000 childless adults with incomes at or below 75 percent of the federal poverty level. This population was previously covered under a sliding-scale premium program with a limited benefit set for childless adults, and a hospital-based block grant program. Pilot excludes parents, children, and pregnant women.

**APPENDIX: PROGRAM CHARACTERISTICS OF EMERGING STATE ACO MODELS** *(continued)*

<b>NEW JERSEY – ACO DEMONSTRATION PROGRAM</b>	
<b>MODEL</b>	Initiated in 2011. A three-year Medicaid ACO demonstration program is intended to: (1) increase access to primary care, behavioral health care, and dental care; (2) improve health outcomes; and (3) reduce costs associated with unnecessary care.
<b>STRUCTURE</b>	ACO model utilizes a ground-up, community-based approach. Innovative providers have the opportunity to develop a single ACO within a given community or geographic region. New Jersey provides regulatory guidelines on governance and community representation and requires participation by 75 percent of qualified primary care providers and all local hospitals in a given community. ACOs may also form among local general hospitals, clinics, pharmacies, health centers, qualified primary care and behavioral health care providers, and social service agencies.
<b>FINANCING</b>	<p>Medicaid can approve upside-risk-only gain-sharing agreements between community-based ACOs and Medicaid MCOs for managed care beneficiaries or the state for fee-for-service (FFS) beneficiaries. The agreement will describe how savings will be shared among physicians, Medicaid, and hospitals, and will assess the revenue impact to participating hospitals. Gain-sharing agreements must promote: (1) improved health outcomes; (2) quality of care and patient experience; (3) expansion of access to primary and behavioral health care; and (4) reduction of unnecessary costs.</p> <p>New Jersey Medicaid, with assistance from the state university, must develop the methodology that ACOs will use to establish their baseline per-recipient expenditures, against which cost savings will be measured. Medicaid ACOs will continue to receive Medicaid reimbursement through managed care and FFS arrangements.</p>
<b>SERVICES</b>	ACOs must ensure that beneficiaries receive appropriate primary care and behavioral health services, as well as have a plan for fostering collaboration between the two areas. ACOs must provide non-clinical services to beneficiaries including: (1) care coordination; (2) medication management; (3) the use of health information technology; (4) patient and family education and health promotion; and (5) open-access scheduling. ACOs must also facilitate improved access to dental services.
<b>POPULATION</b>	ACOs are expected to cover all Medicaid beneficiaries residing in their designated area, except dual eligible beneficiaries, for a period of at least three years following certification.

**APPENDIX: PROGRAM CHARACTERISTICS OF EMERGING STATE ACO MODELS** *(continued)*

**OREGON – COORDINATED CARE ORGANIZATION (CCO) PROGRAM**

<b>MODEL</b>	Rollout begins July 2012. Medicaid’s statewide managed care delivery system will be replaced by regionally-based Coordinated Care Organizations (CCO) serving as single points of accountability for the cost, access and quality of coordinated physical, behavioral and oral health. To become a CCO, organizations must demonstrate robust and detailed plans for improving health care delivery, increasing provider capacity, and ensuring effective coordination and care planning through patient centered primary care homes.
<b>STRUCTURE</b>	<p>The CCOs evolve out of the state’s existing managed care infrastructure, replacing both managed care and FFS delivery systems by 2015. CCOs can be corporate entities or contractually-linked provider networks formed through the collaboration of MCOs, community-based organizations, and other entities. The first organizations to become CCOs will most likely be existing MCOs or merged MCOs, existing or merged Mental Health Organizations (MHOs), and county government agencies.</p> <p>CCOs must have a strong community focus, with community health care stakeholders and community organizations represented within the CCO governance structure. The CCO must form a Community Advisory Council, including community and government representatives, which meets regularly to ensure that local health care needs are being met.</p>
<b>FINANCING</b>	<p>The CCOs will be full-risk-bearing entities reimbursed via a global payment methodology developed by the Oregon Health Authority (OHA). Payments will be risk-adjusted and will include reimbursement for services currently covered by MCOs and MHOs, as well as non-emergency transportation costs.</p> <p>CCOs will be responsible for reimbursing contracted providers, preferably through innovative payment methods. The CCO must develop payment structures that: (1) encourage care coordination, preventive care, and person-centered care; (2) reward improvements in efficiency; and (3) limit growth in medical expenditures. CCOs cannot reimburse facilities for “never” events.</p>
<b>SERVICES</b>	<p>CCOs must directly cover and provide all physical health, behavioral health, and oral health services, with the exception of long-term care services. Additionally, Oregon is developing a menu of Title XIX and XXI programs and funding streams for which CCOs could assume responsibility if capacity, community relationships, and accountability structures are in place.</p> <p>The CCO delivery system will be built upon Oregon’s medical and health home infrastructure. CCOs are required to provide all beneficiaries with a patient centered primary care medical home, care coordination, comprehensive transitional care, and linkages to community and social support services. CCOs must use health information technology (HIT) to link services and care across settings. The OHA is in the process of further defining CCO criteria for these critical functions.</p>
<b>POPULATION</b>	The program will include all Medicaid beneficiaries in the CCO delivery system, including those dually eligible for Medicare and Medicaid. The only exception will be beneficiaries of the Program of All-inclusive Care for the Elderly (PACE).

**APPENDIX: PROGRAM CHARACTERISTICS OF EMERGING STATE ACO MODELS** *(continued)*

<b>UTAH – ACO PROGRAM</b>	
<b>MODEL</b>	Utah Medicaid will replace its managed care contracts, in place in the four most populous counties encompassing Salt Lake City and surrounding cities, with ACO contracts by July 2012.
<b>STRUCTURE</b>	An ACO acts as an enhanced MCO, responsible for: (1) accepting global capitated payments; (2) reimbursing providers for inpatient and outpatient hospital, physician and ancillary services and pharmacy benefits; and (3) meeting Medicaid MCO requirements.
<b>FINANCING</b>	<p>ACOs will use global capitation with built-in upside and downside risk. The state will initially develop an actuarially sound baseline PMPM rate for each ACO, accounting for beneficiary severity of illness and eligibility type. Utah intends to hold PMPM rates steady, but will review rates every six months to ensure that the ACOs are not unfairly penalized for managing a complex mix of patients. The ACO will be responsible for any costs that come in above the PMPM, but they receive 100 percent of savings if actual expenditures are less than expected. This approach will lower Medicaid expenditure trends over time while creating ongoing incentives, through a fixed pool of potential savings, for ACOs to improve efficiency.</p> <p>The ACOs will be encouraged to pay providers in the manner they deem most appropriate, including incentive payments and non- FFS payment methods. Utah seeks to introduce beneficiary co-payments and allow ACOs to create financial incentives for healthy behaviors. The state will also limit out-of network payments.</p>
<b>SERVICES</b>	The ACO will be financially responsible for all services except: mental health services, substance abuse treatment services, nursing facilities, and emergency and non-emergency transportation.
<b>POPULATION</b>	Beneficiaries must enroll with an ACO, with a choice of at least two ACOs in their county. All beneficiaries are eligible for the ACO, including those dually eligible for Medicare and Medicaid, with the exception of beneficiaries in a nursing facility or other inpatient facility.

### **About the Center for Health Care Strategies**

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit [www.chcs.org](http://www.chcs.org).