

Medicaid Accountable Care Organization Programs: State Profiles

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IN BRIEF

States are implementing accountable care organizations (ACOs) to improve health care quality and better manage costs for Medicaid populations. Core components that define Medicaid ACOs are: the *payment model*; *quality measurement approach*; and the *data strategy*. This brief provides an overview of these core ACO elements and profiles how nine states – **Colorado, Illinois, Iowa, Maine, Minnesota, New Jersey, Oregon, Utah, and Vermont** – have structured their Medicaid ACOs. For each state, it outlines key ACO characteristics; details unique payment, quality, and data approaches; and spotlights one of the state's Medicaid ACOs. This set of profiles can help inform Medicaid ACO development in other states.

States are increasingly turning to Medicaid accountable care organizations (ACOs) to improve patient outcomes and control costs by shifting accountability for risk and quality to providers. To date, nine states have launched ACO programs for all or part of their Medicaid population, and 10 more are actively pursuing them. These Medicaid ACOs, which currently serve over two million Medicaid beneficiaries, are designed to achieve the “Triple Aim:” (1) enhancing the patient experience of care; (2) improving the health of the population; and (3) reducing the per capita cost of health care.

ACOs are an innovative health care delivery model designed to hold providers financially accountable for the health of the patients and populations they serve, rather than basing compensation solely on the amount of services they provide. In designing Medicaid ACOs, core components for state consideration include: *payment model*; *quality measurement approach*; and *data strategy*. Value-based payment models, typically tied to quality metrics, are established to ensure that providers are accountable for high-quality patient care. Effective monitoring of ACO activity requires timely data exchange at both a patient and system level. As such, ACOs must have the data analytic capacity to identify opportunities to improve performance.

Below is a brief description of these three key ACO components followed by profiles of nine state Medicaid ACO programs, including payment models, quality measurement approaches, and data analysis strategies for each.¹ The information draws primarily from the many states that have participated in the national [Medicaid ACO Learning Collaborative](#), directed by the Center for Health Care Strategies and supported by The Commonwealth Fund.

Payment Model

In a fee-for-service system, health care providers have financial incentives to deliver more care than may be necessary. States have several options to shift those financial incentives to reward value rather than volume. Some ACO programs have initially begun with pay-for-performance systems wherein providers receive bonus payments based on quality. Other states have established shared savings and risk models, whereby participating ACO providers can share in savings if their attributed population uses a less costly set of health care resources than an agreed-upon baseline (the “upside”). In some cases, providers also share the risk associated with more costly services (the “downside”), whereby they would have to pay the state back if costs exceed the baseline. Some states have also chosen to implement a global budget or capitated model, similar to managed care organizations, where ACOs receive a per member per month (PMPM) payment upfront to provide services and accept full financial risk for attributed patients. In some cases, the global budget payment gives the ACO the flexibility to cover non-medical services that could result in the avoidance of costly clinical interventions.

To account for the costs the patients incur, ACOs with shared savings, shared savings/risk, capitated, or global payment models are charged with managing the total cost of care (TCOC) of each attributed patient, and their patient panels as a whole. While all ACO programs include physical health services in their TCOC calculations, some Medicaid ACO programs are going beyond medical services to also include behavioral health services, long-term services and supports (LTSS), pharmaceuticals, dental services, and even other social services, such as housing. The decision regarding which services to include in TCOC calculations is sometimes made by the state, and sometimes by the ACO.

Quality Measurement Approach

A carefully defined set of quality metrics is essential for ACO programs, because a shared savings or capitation-based payment without quality metrics may create incentives to underserve to achieve savings. Requiring an ACO to achieve certain quality benchmarks, or tying the amount of shared savings, capitation, or performance payment to the ACO’s performance on identified metrics, ensures that the ACO is devoted to maintaining the health of the population.

States are using a variety of measures to assess ACO outcomes, processes, and patient experience. The measurements are compared to a baseline standard, which could be derived from the ACO’s prior performance, statewide averages of other health care providers’ performance, or the performance of other ACOs. States select quality metrics for their Medicaid ACO programs that reflect the unique needs of their Medicaid populations, and often align these metrics with other payer programs, such as the Medicare Shared Savings Program (MSSP) where possible.

Data Strategy

ACOs require substantial data to monitor accountability, and the management of those data is a key consideration for program designers. How clinical and claims data will be stored and exchanged is a key consideration for states building an ACO program, as privacy regulations such as the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2 must be

followed, and data must be transmitted in a timely manner to be useful. Many states are constructing health information exchanges (HIEs) to serve this purpose, but states must be mindful of the initial costs of an HIE as well as costs related to its maintenance.

Data analytics are necessary to compare an ACO's quality metrics and costs to a benchmark and to calculate resulting financial incentives. Data can also be mined to identify opportunities to improve care management efforts. One question all states must answer is what entity will organize and analyze the data. The state can choose to house the data in the governmental agency in charge of Medicaid, use a third-party contractor, or require the ACOs to handle reporting and analytics themselves.

Conclusion

By connecting providers' reimbursement to the health outcomes of enrollees, rather than just the amount of health services delivered, ACO programs can create opportunities to achieve the Triple Aim. The nine states with active Medicaid ACO programs profiled in this brief reflect the broad diversity of emerging state ACO approaches. Other states, including Alabama, Connecticut, Maryland, Massachusetts, Michigan, New York, Virginia, and Washington are pursuing Medicaid ACO programs to address their own health care reform needs. While Medicaid ACO models differ, they are all designed to provide a greater level of accountability for improving health outcomes.² An examination of these states' programs shows the range of ACO models and the potential for ACOs to reduce costs and improve health of Medicaid beneficiaries.

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State Medicaid ACO Profiles

The following pages detail ACO approaches in nine states that have implemented this model for part or all of their Medicaid populations -- **Colorado, Illinois, Iowa, Maine, Minnesota, New Jersey, Oregon, Utah,** and **Vermont**. An overview matrix provides a side-by-side comparison of state Medicaid ACO program components. Following the matrix, one page profiles describe each state's ACO program, detailing the scope of services as well as the payment arrangements, quality measurement, and data analytic approach used. A single ACO is also highlighted to provide an operational-level illustration of each state's ACO program.

Medicaid ACO Models Overview Matrix

State	Governance Structure	Scope of Service	Payment Model	Quality Measurement Approach	Data Analysis Strategy
Colorado	Care Coordination Management Entity (geographic)	<ul style="list-style-type: none"> Physical health 	Care coordination payment and pay-for-performance	Three quality measures tied to payment	Statewide Data Analytics Contractor (SDAC) issues utilization and cost reports
Illinois	Provider-led	<ul style="list-style-type: none"> Physical health Behavioral health 	Care coordination payment transitioning to shared savings and then capitation over three years	29 quality measures, four tied to payment	Historical claims data from the state, health information exchange run by state with provider portal and health needs assessment file run by contractor
Iowa	Provider-led	<ul style="list-style-type: none"> Physical health 	Pay-for-performance	16 measures derived from 3M Value Index Score, all tied to payment	Contractor manages data required to operate program
Maine	Provider-led	<ul style="list-style-type: none"> Physical health Behavioral health Long-term services and supports (LTSS) (optional) Dental (optional) 	Shared savings using two tracks: upside only and upside/downside	17 quality measures, including 14 core measures and three elective measures; all tied to payment	State provides monthly member-level claims and utilization metrics, as well as quarterly reports on costs, utilization, and quality; contractor provides analytics and reports
Minnesota	Provider-led	<ul style="list-style-type: none"> Physical health Behavioral health Pharmacy 	Shared savings using two tracks: upside only and upside/downside	32 quality measures scored as 9 aggregate measures; all measures are reported in year one, then increasingly tied to payment	State provides claims-based analytics and reports; ACOs required to collect and report quality data
New Jersey	Community-led (geographic)	<ul style="list-style-type: none"> Physical health 	Shared savings – upside only (recommended model) ¹	27 quality measures, 21 mandatory measures and six voluntary measures, all tied to payment	ACOs required to report on measures; data analyzed by contractor
Oregon	Payer-led (geographic)	<ul style="list-style-type: none"> Physical health Behavioral health Dental 	Global budget capped at two percent growth rate	33 quality measures, 17 tied to payment	CCOs provide state with encounter data; state collects and reports data
Utah	Payer-led	<ul style="list-style-type: none"> Physical health 	Capitated payment	25 quality measures, not tied to payment	ACOs required to collect and report data
Vermont	Provider-led	<ul style="list-style-type: none"> Physical health Behavioral health (optional) LTSS (optional) Pharmacy (optional) 	Shared savings using two tracks: upside only and upside/downside	Core set of 28 measures, eight tied to payment	State produces care summaries and utilization reports using all payer claims database and/or payer claims data

¹ New Jersey ACOs form their own gainsharing arrangements with managed care organizations, but a recommended model was developed by Rutgers University to guide these negotiations.

ACO PROFILE: Colorado

Colorado's Accountable Care Collaborative (ACC) is made up of: (1) Regional Care Collaborative Organizations (RCCOs), ACO-like entities that coordinate health care across providers that serve Medicaid enrollees; (2) primary care medical providers (PCMPs) that contract with a RCCO to serve as medical home practices; and (3) the Statewide Data Analytics Contractor (SDAC), an organization that manages the ACC's data needs.³ Because Colorado has dramatically different environments across the state, there are currently seven RCCOs assigned geographically. For each region, the RCCO is responsible for: medical management and care coordination; provider network development; provider support; and accountability and reporting.

Payment Model

Currently, RCCOs receive care coordination payments of between \$8.93 and \$9.50 PMPM for all of their responsibilities. They also receive incentive payments based on Key Performance Indicators (KPIs). The RCCOs agreed to reduce their PMPM payments to create an incentive payment for PCMPs that meet five of nine standards for "enhanced patient-centered medical home" status.⁵

Quality Measurement Approach

Colorado's RCCOs used three KPIs in its first year: emergency department (ED) visits; 30-day all-cause hospital readmissions; and high-cost imaging. Currently, the KPIs are: ED visits; well-child visits (ages 3-9); and postpartum care.

Data Strategy

The SDAC provides data to identify high-need, high-cost utilizers of health services and other clients who may need care coordination. In addition, the SDAC provides data on population statistics and provider performance to identify trends and opportunities, and tracks the KPIs that Colorado uses to evaluate the performance of the RCCOs.

Results to Date

Colorado reported statewide net savings of \$29 to \$33 million during FY 2014, its third year of operation.⁶ The program also had net savings of \$6 million in its second year for a total net savings of \$35-39 million over the program's three years.⁷

Colorado: ACO At-a-Glance

Program name: Accountable Care Collaborative
Accountable entity name: Regional Care Collaborative Organizations
Year Launched: 2011
Governance Model: Care Coordination Management Entity
Number of ACOs: 7
Beneficiaries Served: 609,051
Payment Methodology: Care coordination fee and pay-for-performance
Number of Quality Measures: 3
Scope of Services: Physical health
Results: Saved \$35-39M in net savings over three years

ACO Spotlight: Rocky Mountain Health Plan

Rocky Mountain Health Plan (RMHP) is a RCCO that covers the westernmost region of Colorado and one county east of the Rockies. The population served by RMHP is heterogeneous, so there is no one-size-fits-all solution to the health care needs of its attributed population. RMHP has encouraged collaboration between providers and public health offices in Western Colorado. The state also selected RMHP to serve as a pilot for a full-risk, capitation payment model, RMHP Prime. The model is available to most adults and some children with disabilities in six western counties.⁴

ACO PROFILE: Illinois



In 2011, Illinois enacted an ambitious Medicaid reform law requiring 50 percent of public medical assistance clients to be enrolled in “risk-based care coordination programs” by 2015. Illinois established Accountable Care Entities (ACEs), the state’s Medicaid ACO program, as one part of this effort.⁸ Illinois’ ACEs will transition quickly from pay-for-performance (P4P) to shared savings to capitated payments over 36 months

The governance requirements for ACEs are generally flexible. For-profit or nonprofit ACEs may be provider groups, individual providers, or non-physical health providers, but they may not be managed care organizations (MCOs). Even if an ACE is not made up of primary care providers, all ACEs are required to designate a primary care physician network equipped to serve its enrollees.

Payment Model

Over a three-year phased approach, ACEs will progress from P4P payments to shared savings to full accountability. During the first 18 months, an ACE receives a \$9 PMPM payment for care coordination of FamilyCare enrollees and \$20 PMPM for adult enrollees eligible for Medicaid. In months seven through 18, ACEs may also share in up to 50 percent of the savings that the ACE realizes. From months 19-36 of the ACE’s operations, the state will pay the ACE on a risk-adjusted capitation basis for all covered services, with the state sharing the downside risk. In months 37 and beyond, the ACE will be at full capitated risk.

Quality Measurement Approach

Illinois requires its ACEs to report on 29 measures; 23 are based on HEDIS quality metrics, including several that have been adapted by the state to better fit program needs. The metrics focus on five areas: (1) access to and utilization of care; (2) prevention and screening services; (3) appropriate care; (4) behavioral health; and (5) maternal care. Four of the 29 ACE metrics are tied to payment.

Data Strategy

Illinois’ data strategy involves: the Department of Healthcare and Family Services; Illinois Health Connect, a contractor that manages the state’s PCCM program; the Illinois Health Information Exchange, the statewide HIE; and Maximus, a contractor that manages enrollment services. Illinois Health Connect provides its ACEs with a provider portal that shares a list of enrollees on a daily basis, updated through a dedicated transmittal system, while Maximus provides a monthly health needs assessment file, including information from member enrollment surveys. The state provides two years of historical claims data and seven years of immunization data on all new enrollees on a monthly basis through its Care Coordination Claims Data set,¹⁰ which ACEs can use for risk stratification purposes.

Results to Date

The program launched in 2014 and has not yet reported results.

Illinois ACO: At-a-Glance

Program name: Accountable Care Entities Program

Accountable entity name: Accountable Care Entities

Year Launched: 2014

Governance Model: Provider-led

Number of ACOs: 9

Beneficiaries Served: Not available

Payment Methodology: Pay-for-performance transitioning to shared savings/risk transitioning to capitation

Number of Quality Measures: 29

Scope of Services: Physical health; behavioral health

Results: Pending

ACO Spotlight: MyCare Chicago

One of Illinois’s ACEs is MyCare Chicago, a multi-provider organization that operates hospitals, federally qualified health centers (FQHCs), and other safety-net providers in and around Chicago.⁹ It is owned by its members: four hospitals, six FQHCs, and two behavioral health providers. MyCare maintains a strong connection to the community by inviting residents to be part of its consumer advisory board and share recommendations for improving ACE operations.

ACO PROFILE: Iowa



Iowa's Medicaid Accountable Care Organization program provides value-based care for the state's newly eligible Medicaid expansion population.¹¹ The program, which currently has five ACOs providing physical health services to beneficiaries, is designed to align closely with the state's existing Medicare and commercial ACOs. Much of the state's efforts thus far have supported ACOs in developing health IT infrastructure. Iowa plans to extend value-based payment models, including its ACO program, to all Medicaid beneficiaries through the implementation of statewide managed care and its Round 2 SIM Test grant.

Payment Model

Iowa ACOs can receive bonus payments based on the 3M Value Index Score (VIS), a set of measures developed by 3M Health Information Systems and adapted from Iowa's private insurance market. In addition to the VIS bonus, Medicaid offers ACOs three potential bonuses for helping members achieve healthy behaviors:

1. \$10 PMPY if at least 50 percent of the PCPs' patients have received an annual physical exam;
2. \$4 PMPM in year 1 or \$5 PMPM in subsequent years if the ACO meets measures focused on broader delivery system transformation; and
3. \$4 PMPM if the ACO achieves a target percentage of attributed members achieving identified healthy behaviors.

Quality Measurement Approach

Iowa uses 16 VIS measures to produce a score from six domains: (1) member experience; (2) primary and secondary prevention; (3) tertiary prevention; (4) population health status; (5) continuity of care; and (6) chronic and follow-up care. In 2015, ACOs will also be evaluated on their ability to engage enrollees in Iowa's Healthy Behaviors Plan. If an enrollee receives an annual physical from his or her primary care provider and completes a health risk assessment, that enrollee is no longer required to pay the \$5 or \$10 monthly premium for Iowa Wellness Plan coverage, as outlined in the state's §1115 waiver.¹³

Data Strategy

Iowa's Medicaid ACO uses a private contractor, 3M Health Information Systems, to manage ACO program data. The system was adapted from the approach used by the predominant insurer in the state, Wellmark Blue Cross/Blue Shield, in its commercial ACO program.

Results to Date

In 2014, roughly 51 percent of ACO members achieved at least one healthy behavior, and on average 28 percent achieved both healthy behaviors. In comparison, for the regular Medicaid population, only five percent completed the wellness exam. Medicaid paid out \$430,000 in VIS bonuses in 2014, with PCPs in an ACO being five percent more likely to earn a VIS bonus than non-ACO PCPs.

Iowa ACO: At-a-Glance

Program name: Medicaid Accountable Care Organizations
Accountable entity name: Accountable Care Organizations
Year Launched: 2014
Governance Model: Provider-led
Number of ACOs: 5
Beneficiaries Served: 35,000
Payment Methodology: Pay-for-performance
Number of Quality Measures: 16
Scope of Services: Physical health
Results: Improved healthy behaviors

ACO Spotlight: Broadlawns Medical Center

Broadlawns Medical Center (BMC), a designated Medicaid ACO in Iowa, is a public community hospital in Des Moines that serves as the primary acute care hospital and the core safety net provider in central Iowa.¹² Broadlawns has strong connections to the community through the BMC Academy, an organization that provides resources to staff, patients, and the broader community, including continuing education for professionals, a community health resource guide, and support programs for patients.

ACO PROFILE: Maine



Maine's Accountable Communities (AC) initiative is part of a comprehensive value-based purchasing strategy across the state.¹⁴ An AC requires a designated lead entity that must either be a primary care provider or contract with one. There are currently four ACs, which include a total of 28 primary care practices. Each AC must have a contractual or other documented relationship to ensure coordination with: (1) at least one provider in each of three categories: chronic conditions, developmental disabilities, and behavioral health (if there are such providers in the AC's service area); (2) all hospitals in the service area; and (3) at least one public health agency. An AC must also directly involve its community in decision making by requiring that the lead entity's governing body include at least two MaineCare members served by the AC or their caregivers or guardians.

All ACs are measured on the total cost of care (TCOC) for core services, which include physical and behavioral health services. ACs can also choose to be measured on TCOC for optional services, such as long-term services and supports and dental services (the choice of optional services could generate opportunities for greater shared savings).

Payment Model

The program offers two shared savings models: one that allows for up to 50 percent of shared savings (up to 10 percent of benchmark TCOC), with no downside risk; and a second that allows an organization to share up to 60 percent of the savings, but also holds the organization accountable for 40-60 percent of downside risk (capped at five percent of benchmark TCOC in the first year, and 10 percent in the second). Performance on quality metrics proportionately affects the amount of savings or losses.

Quality Measurement

AC performance is measured through 17 quality metrics in four areas: (1) patient experience; (2) care coordination and patient safety; (3) preventive health; and (4) at-risk populations. ACs must report on all 14 core metrics and choose three of seven elective metrics. All of the 17 metrics are tied to shared savings payments.

Data Strategy

The Maine Department of Health and Human Services (DHHS) provides participating providers with quarterly data reports on cost, utilization, and quality. DHHS provides a portal through which ACs and their primary care practices can download claims and utilization metrics for all attributed members and the data are updated monthly. Maine partners with the Maine Health Management Coalition to provide data analytics support to participating ACs.

Results to Date

The program launched in 2014 and has not yet reported results.

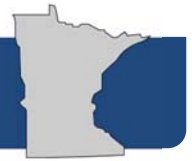
Maine ACO: At-a-Glance

Program name: Accountable Communities Initiative
Accountable entity name: Accountable Communities
Year Launched: 2014
Governance Model: Provider-led
Number of ACOs: 4
Beneficiaries Served: 30,000
Payment Methodology: Shared savings/risk
Number of Quality Measures: 17 (14 core, and AC chooses 3 of 7 elective)
Scope of Services: Physical health; behavioral health; LTSS (optional); dental (optional)
Results: Pending

ACO Spotlight: Penobscot Community Health Care

Penobscot Community Health Care (PCHC) is an FQHC that serves more than 60,000 patients in Eastern Maine.¹⁵ Also recognized as a patient-centered medical home, PCHC was the first health care facility in Maine to be named a "top performer" in the Healthcare Equality Index, a national LGBT benchmarking tool, and three of its individual practices received "Better" or "Best" designations by Get Better Maine, an organization devoted to the quality of health care in the state. PCHC participates in multiple reform efforts in Maine, illustrating the state's broad approach to health care reform.

ACO PROFILE: Minnesota



Minnesota launched its Its provider-led Integrated Health Partnerships (IHPs) program through legislation in 2010.¹⁶ Six providers started with the program in 2013, and since then, 10 more have joined.

Provider groups can participate in one of two IHP tracks: “virtual” or “integrated.” Virtual IHPs are not formally integrated with a hospital through financial arrangements and information systems and they serve between 1,000 and 1,999 attributed members. Integrated IHPs are delivery systems that provide outpatient and inpatient care and serve at least 2,000 attributed members.

Payment Model

Virtual IHPs are eligible for a portion of shared savings, but share no downside risk. Integrated IHPs phase-in risk over three-years: (1) upside risk only in the first year; (2) share in upside savings and responsible for downside risk equivalent to half of the upside risk potential in the second year; and (3) symmetrical savings and risk sharing in the third year. Integrated IHPs can also propose their own performance thresholds for shared savings. Both the state and its MCOs will pay portions of shared savings to IHPs or share in losses from IHPs that do not achieve savings. This creates an incentive for MCOs to work with providers to achieve cost savings.

Quality Measurement Approach

Minnesota requires IHPs to report on 32 quality metrics, which are scored as nine aggregate metrics. IHPs are encouraged to propose additional measures tailored to the specific communities and populations served by the IHP. IHP phases in shared savings distributions tied to quality performance over a three-year period: (1) in year one, 25 percent of shared savings are based on reporting quality metrics; (2) in year two, 25 percent of savings are based on the overall quality score; and (3) in year three, 50 percent of savings are based on overall quality performance. IHP performance is assessed for achievement and improvement.

Data Strategy

By regulation, the hospitals and physician clinics participating in the program must send the state the data necessary to calculate quality performance. By contract, MCOs also submit data to the Minnesota’s Department of Human Services, which manages its claims data in a state-run warehouse, and provides a monthly risk adjustment reports to the IHPs. The data contain both fee-for-service and MCO encounter claims data.

Results to Date

Minnesota’s IHP program saved the state \$76.3 million over its first two years (\$14.8M in the first year and \$61.5M in the second year).¹⁸ All nine IHPs achieved shared savings in year two and exceeded their quality targets.

Minnesota ACO: At-a-Glance

Program name: Integrated Health Partnerships
Accountable entity name: Integrated Health Partnerships
Year Launched: 2013
Governance Model: Provider-led
Number of ACOs: 16
Beneficiaries Served: 175,000
Payment Methodology: Shared savings/risk
Number of Quality Measures: 32 scored as 9 aggregate measures
Scope of Services: Physical health; behavioral health; pharmacy
Results: Saved \$76.3M over first two years

ACO Spotlight: Federally Qualified Health Center Urban Health Network

The Federally Qualified Health Center Urban Health Network (FUHN) is an IHP created by 10 FQHCs in the Minneapolis-St. Paul area. It serves a diverse group of more than 22,000 enrollees.¹⁷ Prior to the IHP partnership, the participating member organizations often competed for resources, including grant funding, providers, and even patients. By joining together as an IHP, the participants have strengthened their capacity to move toward value-based payment. Due to limited capacity at its member FQHCs, FUHN contracts with Optum, a health information technology company, to handle the data analytics required for its ACO. Notably, FUHN was the first FQHC-only Medicaid ACO recognized by any state.

ACO PROFILE: New Jersey



The Camden Coalition of Healthcare Providers (CCHP), established more than a decade ago, gained nationwide recognition in the past few years for its community-based “hotspotting” efforts that identify high-cost utilizers of the city’s health care system and provide patient-centered, intensive interventions. CCHP’s efforts led the New Jersey legislature to introduce a Medicaid ACO Demonstration.¹⁹ New Jersey’s three active ACOs are accountable for the care of patients in a defined geographic area. Per legislation, each organization is required to contract with all hospitals in the designated region, 75 percent of the primary care providers, and at least four behavioral health providers, ensuring both local stakeholder buy-in and the resources available for effective care coordination.

Payment Model

The Rutgers Center for State Health Policy (CSHP) developed a recommended shared savings model for the New Jersey Medicaid ACOs that generally follows the MSSP model, but departs from it in some key areas, such as not requiring ACOs to meet a minimum savings rate, and not truncating costs for high cost patients. ACOs can choose to use the CSHP model, modify it to suit their purposes, or develop their own models. A unique feature of the program is that the state’s Medicaid MCOs are not required to participate in the program, which means the ACOs must negotiate their own arrangements with the MCOs.

Quality Measurement Approach

The state and CSHP will evaluate the ACOs’ performance annually in a number of broad categories, including screening rates, outcomes, and hospitalization rates for patients with chronic conditions, and the hospitalization and readmission rates for areas served by the ACOs. The measures include behavioral health metrics, so even though ACOs are not required to include these services in their TCOC, they are ultimately responsible for their patients’ behavioral health outcomes. All 27 metrics must be tied to payment in some way via the ACO’s gainsharing arrangement. The ACOs must report 21 mandatory metrics and select six more from a list of options.

Data Strategy

New Jersey’s ACO program is using CSHP’s data analytic capacity to perform the evaluation and cost savings calculations. New Jersey is currently the only state to use a university research center to evaluate health care reform efforts.

Results to Date

The program launched in 2015 and has not yet reported results.

New Jersey ACO: At-a-Glance

Program name: Medicaid Accountable Care Organization Demonstration Project

Accountable entity name: Accountable Care Organizations

Year Launched: 2015

Governance Model: Community-led

Number of ACOs: 3

Beneficiaries Served: 122,782

Payment Methodology: Shared savings (upside only)

Number of Quality Measures: 27

Scope of Services: Physical health

Results: Pending

ACO Spotlight: Trenton Health Team

Taking the lead from CCHP, the Trenton Health Team (THT) was founded in 2010 to provide care coordination to city residents in need. The organization is made up of the city health department, the Henry J. Austin Health Center (Trenton’s only FQHC), and the city’s two hospitals.²⁰ THT developed a detailed community health needs assessment to determine where the organization’s resources can be best directed. It has just begun to implement a Community Health Improvement Plan. THT’s care management team focuses on high utilizers of the city’s emergency rooms, and offers physical health care, behavioral health services, and connections to community-based organizations and social service programs.

ACO PROFILE: Oregon



Oregon's Coordinated Care Organizations (CCOs) were established by the Oregon Health Authority (OHA) as part of an ambitious §1115 waiver to help the state reduce health care cost increases by two percent per member, per year from 2013-2015.²¹ Each of the 16 regionally based CCOs is the sole payer responsible for Medicaid patients. To support the CCOs, Oregon established a Transformation Center that runs learning collaboratives for CCOs, manages a Council of Clinical Innovators fellowship program to develop health system transformation leaders across the state, and provides targeted technical assistance to help CCOs meet their outcome goals.

Payment Model

Oregon's CCOs have a global budget for all services provided for enrollees that grows at a fixed rate. Additionally, three percent of monthly payments to CCOs are held back by OHA and put into a quality pool. These funds are distributed as an incentive payment to the CCOs based on their performance on specified quality metrics at the end of each year. To earn their full incentive payment, CCOs have to meet benchmarks or improvement targets on at least 12 of the 17 incentive measures and have at least 60 percent of their members enrolled in a patient-centered primary care home.

Quality Measurement Approach

OHA requires CCOs to report on 33 quality metrics, 17 of which are used to determine the incentive payments that CCOs may earn from the quality pool. OHA must also report state performance measures to the federal government as part of the §1115 waiver that authorized the use of global budgeting.

Data Strategy

The CCOs provide OHA with regularly submitted encounter data.

OHA publishes a mid-year and an annual comprehensive report on the progress that CCOs have made toward identified quality metrics. The OHA also includes information on CCOs' quality performance and finances on its public website.

Results to Date

Since 2011, ED visits decreased by 22 percent and hospital admissions for short-term complications from diabetes and chronic obstructive pulmonary disease by 26.9 percent and 60 percent, respectively. Financial data indicate that CCOs are continuing to hold costs under the two percent capped growth rate mandated by the state's §1115 waiver.²⁴

Oregon ACO: At-a-Glance

Program name: Coordinated Care Organizations
Accountable entity name: Coordinated Care Organizations
Year Launched: 2012
Governance Model: Payer-led
Number of ACOs: 16 CCOs
Beneficiaries Served: 853,897
Payment Methodology: Global payment
Number of Quality Measures: 33
Scope of Services: Physical health; behavioral health; dental
Results: Decreased ED and inpatient utilization and costs

ACO Spotlight: Health Share of Oregon

Health Share of Oregon is a CCO covering the Portland metropolitan area, the most populous part of the state.²² The organization includes health plans, hospitals, individual providers, health clinics, and social service agencies. Health Share also works with county health departments to address non-clinical causes of health problems including a Healthy Homes program to reduce asthma-related hospitalizations and a supportive housing initiative to help enrollees with chronic disease. These efforts appear to be working to manage enrollees' health care costs, as Health Share has reported savings of \$32.5M over three years.²³

ACO PROFILE: Utah



In 2011, the Utah legislature passed SB0180, calling on its Department of Health to replace the Medicaid fee-for-service delivery model with one or more risk-based delivery models. The statute established a framework that allows the state's MCO-led ACOs to exercise flexibility and develop solutions independently.²⁵

Medicaid enrollees in Utah have the option to select an ACO as their health plan upon enrollment, and the majority have done so. If an enrollee has not chosen an ACO or a health plan, the state Medicaid agency assigns them to an ACO based on their medical history.

Payment Model

Utah's ACOs receive a capitated PMPM payment that is re-adjusted for risk and population every six months. Though payment amounts to ACOs may vary from year to year, the amounts are not to exceed the growth of the state's general budget. Some ACOs have negotiated shared savings agreements with larger clinics or FQHCs, whereby the provider groups can receive additional payments if savings accrue.

Quality Measurement Approach

Utah's ACOs use 25 quality measures derived from three sources: (1) the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey; (2) the National Committee for Quality Assurance HEDIS measures; and (3) the National Quality Forum. The measures focus on preventive, chronic, and acute care for adults and children as well as maternity care. These measures are not tied directly to capitated rates.

Data Strategy

Utah already requires all health plans to record CAHPS and HEDIS measures, and the state uses these data for ACO quality measurement. Most large ACOs in the state have commercial lines of business as well, and collect this information themselves or through a contractor. Smaller programs in Utah can opt to use a state-contracted vendor.

Results to Date

The program has not yet published results.

Utah ACO: At-a-Glance

Program name: Medicaid Accountable Care Organizations
Accountable entity name: Accountable Care Organizations
Year Launched: 2013
Governance Model: Payer-led
Number of ACOs: 4
Beneficiaries Served: 238,255
Payment Methodology: Capitation
Number of Quality Measures: 25
Scope of Services: Physical health
Results: Pending

ACO Spotlight: Health Choice Utah

Health Choice Utah is a provider-owned managed care organization that serves 13 counties in the state.²⁶ The organization, a subsidiary of the IASIS Healthcare system, was founded in 2012 to participate in Utah's Medicaid ACO program. As part of its outreach efforts, Health Choice Utah has commissioned a Health and Wellness Education Van that travels to locations in its service area to conduct health education exercises with children and families.

ACO PROFILE: Vermont



Vermont developed the Vermont Medicaid Shared Savings Program (VMSSP) demonstration using the MSSP platform, which a number of ACOs in the state were already successfully using.²⁷ Two of the three Medicare ACOs in Vermont also participate in the state’s commercial ACO program and Medicaid SSP program.

Vermont is phasing services into its ACO program using an “encourage/incent/require” approach over the program’s first three years. In year one, ACOs are responsible for core physical health services. In year two, the ACOs had the option to include non-core services such as behavioral health, long-term services and supports, and pharmacy benefits in their TCOC, but neither ACO opted to include non-core services in year two. In year three, the ACOs will be required to include specific non-core services defined by the state.

Payment Model

Vermont’s Medicaid ACOs use a dual-track payment structure: Track 1, in which the ACO is not exposed to downside risk, but has an opportunity for shared savings; or Track 2, in which the ACO is exposed to downside risk with an opportunity for a greater percentage of shared savings than in Track 1. ACOs are able to select the track in which they will participate and may participate in this track for the entire three-year demonstration.

Quality Measurement Approach

Vermont uses two sets of measures for its ACOs: (1) a core set of 28 measures, from which ACOs must collect eight for shared savings calculations; and (2) a monitoring and evaluation set collected at the state or health plan level that will not affect shared savings. Vermont uses a “Gate and Ladder” methodology for evaluating the performance of its ACOs. An ACO’s performance must reach a certain point for it to be considered for shared savings – the “Gate” – and then to retain a greater portion of the potential savings, the ACO must reach a series of higher performance levels – the “Ladder.”

Data Strategy

Vermont has contracted with The Lewin Group to provide the analytics for both commercial and Medicaid ACOs in the state. Additionally, Vermont has developed an all-payer claims database, VHCURES, which contains medical and pharmacy claims for all Medicaid and Medicare enrollees. The state’s HIE can produce care summaries and documents on continuity of care, allowing the ACOs to better manage the care of their patients.

Results to Date

The program launched in 2014 and reported savings of \$14.6 million in its first year.³⁰

Vermont ACO: At-a-Glance

Program name: Vermont Medicaid Shared Savings Program
Accountable entity name: Accountable Care Organizations
Year Launched: 2014
Governance Model: Provider-led
Number of ACOs: 2
Beneficiaries Served: 64,515
Payment Methodology: Shared savings/risk
Number of Quality Measures: 28
Scope of Services: Physical health; behavioral health (optional); LTSS (optional); pharmacy (optional)
Results: Saved \$14.6M over first year

ACO Spotlight: OneCare Vermont

OneCare Vermont is a statewide ACO that operates in Medicare, Medicaid, and commercial markets.²⁸ It contracts with an array of providers in the state, including all 14 of Vermont’s hospitals, three FQHCs, and the Dartmouth-Hitchcock medical center in neighboring New Hampshire. OneCare is a public/private partnership that serves nearly 100,000 attributed beneficiaries through its multi-payer ACO activities. The ACO illustrates how a single entity can provide health care to Medicare, Medicaid, and commercial enrollees through a single multi-payer ACO. OneCare Vermont saved \$6,754,568 in Medicaid spending during the program’s first year of operation.²⁹

ENDNOTES

- ¹ For more information about the Medicaid Accountable Care Organization Learning Collaborative, made possible by The Commonwealth Fund, see <http://www.chcs.org/project/medicaid-accountable-care-organization-learning-collaborative-phase-iii/>.
- ² D. Hervey, L. Summers, and M. Inama. "The Rise and Future of Medicaid ACOs." Leavitt Partners white paper, September 2015. Available at <http://leavittpartners.com/2015/09/the-rise-and-future-of-medicaid-acos-2/>.
- ³ For more information about Colorado's ACC program, please see the state website: <https://www.colorado.gov/pacific/hcpf/regional-care-collaborative-organizations>.
- ⁴ Rocky Mountain Health Plan, 2014 Issue Brief. Available at: <https://www.rmhpcommunity.org/sites/default/files/resource/FinalRMHP-September2014-WEB.v3.pdf>.
- ⁵ Colorado Accountable Care Collaborative, 2014 Annual Report. Available at: <https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%202014%20Annual%20Report.pdf>.
- ⁶ Ibid.
- ⁷ Colorado Accountable Care Collaborative, 2013 Annual Report. Available at: <https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%20Annual%20Report%202013.pdf>.
- ⁸ For more information about Illinois' ACE program, please see the state website: <http://www2.illinois.gov/hfs/publicinvolvement/cc/ace/Pages/default.aspx>.
- ⁹ MyCare Chicago website. Available at: <http://www.mycarechicago.org/#ac7>.
- ¹⁰ Illinois Care Coordination Claims Data website. Available at: <http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/ClaimsData.aspx>.
- ¹¹ For more information about Iowa's ACO program, please see the state website: <http://dhs.iowa.gov/ime/about/iowa-health-and-wellness-plan/ACO-VIS>.
- ¹² Broadlawns Medical Center website. Available at: <http://www.broadlawns.org/>.
- ¹³ Iowa Health and Wellness Plan Waiver Approval: Frequently Asked Questions. Available at: http://dhs.iowa.gov/sites/default/files/IHAWP_WaiverApproval_FAQ_01022014.pdf.
- ¹⁴ For more information about Maine's Accountable Communities Initiative, please see the state website: <http://www.maine.gov/dhhs/oms/vbp/accountable.html>.
- ¹⁵ Penobscot Community Health Care website. Available at: <https://pchc.com/>.
- ¹⁶ For more information about Minnesota's IHP Program, please see the state website: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16161441.
- ¹⁷ FUHN website. Available at: <http://www.nhcn.org/>.
- ¹⁸ "Minnesota's Medicaid reform initiative saves \$61.5 million in 2nd year." Minnesota Department of Human Services. June 19, 2015. Available at: <http://mn.gov/dhs/images/IHP%2520second%2520year%2520results%2520NR.pdf>.
- ¹⁹ For more information about New Jersey's ACO program, please see the state website: <http://www.nj.gov/humanservices/dmahs/info/aco.html>.
- ²⁰ <http://www.trentonhealthteam.org/tht/index.php>.
- ²¹ For more information about Oregon's CCO program, please see the state website: <https://cco.health.oregon.gov/Pages/Home.aspx>.
- ²² Health Share of Oregon website. Available at: <http://www.healthshareoregon.org/>.
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- ²⁶ Health Choice Utah website. Available at: <http://www.healthchoiceutah.com/>.
- ²⁷ For more information about Vermont's Shared Savings Program, please see the state's overview document: http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/SSP_and_ACO_FAQ_and_Chart_7.8.14.pdf.
- ²⁸ One Care Vermont website. Available at: <https://www.onecarevt.org/>.
- ²⁹ "Medicaid Shared Savings Programs Helped Avoid 14.6 Million in Costs in 2014." Vermont Governor's Office. September 8, 2015. Available at: <http://governor.vermont.gov/node/2474>.
- ³⁰ Ibid.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. This brief was developed through CHCS' *Medicaid Accountable Care Organization (ACO) Learning Collaborative*, a national initiative made possible by The Commonwealth Fund. The Collaborative is helping states advance new ACO models designed to improve patient outcomes and control costs by shifting accountability for risk and quality to providers. For more information, visit www.chcs.org.