CHCS Center for Health Care Strategies, Inc.

FACT SHEET | FEBRUARY 2018

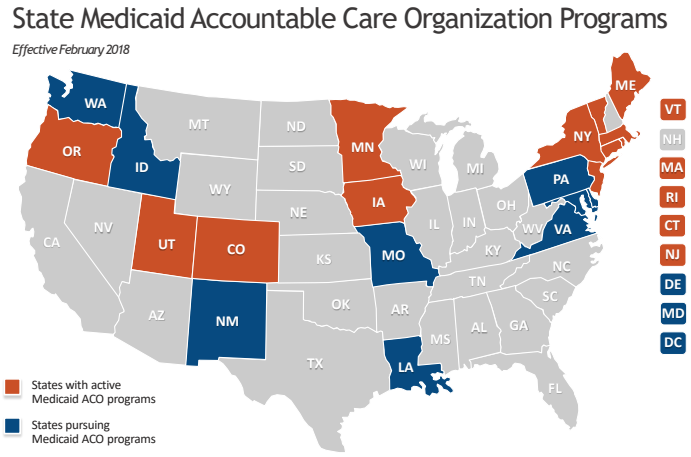
Medicaid Accountable Care Organizations: State Update

Many states have begun to implement Medicaid accountable care organizations (ACOs) that align provider and payer incentives to focus on value instead of volume, with the goal of keeping patients healthy and costs manageable. Currently, 12 states have active Medicaid ACO programs, and at least 10 more are pursuing them.

What is an ACO?

ACOs are designed to improve care coordination and delivery by holding providers financially accountable for the health of the patient population they serve. This accountability is achieved through three key activities:

- Implementing a value-based payment structure;
- Measuring quality improvement; and
- Collecting and analyzing data.



Value-Based Payment Structure

To establish a financial incentive for providers to deliver value instead of volume within Medicaid ACO programs, states typically use one of the following models:

- ***Shared Savings Arrangement*** - Providers participating in an ACO have an opportunity to share in savings if their attributed population uses a less costly set of health care resources than a predetermined baseline (the "upside"). In some cases, providers transition over time to share the risk of providing more costly services (the "downside"), whereby they would have to pay the state back a percentage of costs if they exceed baseline numbers.
- ***Global Budget Model*** - ACOs receive a capitated per-patient payment to provide services and accept full financial risk for the health of their patient population.

To determine how patient costs are measured under either model, states define the type of services offered under ACOs (in addition to physical health services, some Medicaid ACO models include behavioral health, long-term services and supports, pharmaceuticals, and even social services) and calculate the predicted total cost of care of these services, either on a per-patient or population-wide basis.

Quality Measurement and Improvement

Quality metrics are used to track whether Medicaid ACOs improve patient outcomes and to ensure that providers are not withholding health services to retain savings. States typically require ACOs to measure health outcomes, report process metrics that focus on service delivery, and record patient experience metrics to determine an ACO's quality performance. These measurements are compared to quality benchmarks, which could be based on either the ACO's prior performance, the performance of other ACOs, or statewide averages of other health care providers' performance.

Quality metrics are tied to payment, and providers typically will not receive a portion of shared savings if they do not meet or exceed their quality benchmarks.

Data Analysis and Health Information Technology

Timely and accurate data collection and analysis are essential to a Medicaid ACO's operation, since data allows ACOs to track patient utilization and costs, and target patients for care management interventions and programs. States implementing ACOs must establish and maintain their own data infrastructure to adequately support ACOs and determine which organizational entity will "own" — i.e., store and analyze — ACO data. States may consider helping providers with financial resources to facilitate the implementation of health information technology that supports ACO data management needs.

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The Promise of Medicaid ACOs

Medicaid ACOs have shown success for several years now, and some programs have been refined into "2.0" versions to build upon those early successes. Here are some results from Medicaid ACO programs:

- **Colorado's** Regional Care Collaborative Organizations (RCCOs) have reported $77 million in net savings for Colorado Medicaid.[1] RCCOs have demonstrated lower rates of emergency department (ED) visits, high-cost imaging, and hospital readmissions for adult patients who have been enrolled in the program for more than six months.[2]
- **Maine's** Accountable Communities realized a savings of 3.15 percent in Medicaid costs, netting $4.56 million for MaineCare, the state's Medicaid agency.[3]
- **Minnesota's** Integrated Health Partnerships (IHPs) have served 460,000 residents and saved nearly $213 million in the four years they have been operating.[4] They have also reduced hospital admissions by 14 percent and emergency department visits by seven percent over that same time frame.[5]
- **Oregon** reported that in FY 2015, all Coordinated Care Organizations (CCOs) showed improvement in quality measure performance, and 15 of the 16 earned 100 percent of their potential quality pool bonuses. In 2016, 62 percent of children were screened for risks of developmental, behavioral, and social delays, which is up from 41 percent improvement from 2011. In the past two years, Oregon also experienced a 19 percent increase in the number of women ages 18-50 who are using an effective contraception. These improvements have allowed the state to stay well within its two percent annual growth target.[6]
- **Vermont** reported $15.7 million in savings due to its Vermont Medicaid Shared Savings Program (VMSSP) in the program's first two years. Both of the state's Medicaid ACOs improved their quality scores in the first two years.[7]

These early efforts demonstrate the value of connecting providers' reimbursement to patient health outcomes and cost savings rather than the volume of services, as in the traditional fee-for-service model. Although the model is still evolving, Medicaid ACOs offer significant potential for positive change at the provider level to support a healthier population at lower cost.

The following table (**see next page**) includes details from the 12 states that have active Medicaid ACO programs and provides basic information about how the programs are designed, including their payment models, approaches to quality measurement, and the scope of services included in the total cost of care.

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 fact sheet 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**.

ENDNOTES

[1] Colorado Department of Health Care Policy and Financing. Colorado Medicaid Program Continues Record Savings, Improved Outcomes. Press release. November 3, 2015. Available at: https://www.colorado.gov/pacific/hcpf/news/colorado-medicaid-programcontinues-record-savings-improved-outcomes.

[2] Colorado Department of Health Care Policy & Financing. Creating a Culture of Change: Accountable Care Collaborative 2014 Annual Report. 2014. Available at: https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%202014%20Annual%20Report.pdf.

[3] Maine Department of Health and Human Services. Accountable Communities Initiative webpage. Available at: http://www.maine.gov/dhhs/oms/vbp/accountable.html.

[4] Minnesota Department of Human Services. State launches next step in health care reform. Press release, November 16, 2017. Available at: https://mn.gov/dhs/media/news/?id=1053-318197.

[5] Minnesota Department of Human Services. Integrated Health Partnership webpage. Available at: https://mn.gov/dhs/integrated-health-partnerships/

[6] Oregon Health Authority. Oregon Health System Transformation: CCO Metrics 2016 Final Report. June 27, 2017. Available at: http://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/CCO-Metrics-2016-Final-Report.pdf.

[7] Center for Health Care Strategies. Medicaid ACO Programs: Promising Results from Leading-Edge States. January 17, 2017. Available at: https://www.chcs.org/resource/medicaid-aco-programs-promising-results-leading-edge-states/.

Overview of Active Medicaid ACO Programs

State	Program Name	Governance Structure	Scope of Service	Payment Model	Quality Measurement
CO	Accountable Care Collaborative	Care coordination entity / behavioral health organization	■ Physical health ■ Behavioral health	Care coordination payment and pay-for-performance; capitated behavioral health payment	Eight key performance indicators tied to payment
CT	Person Centered Medical Homes Plus (PCMH+)	Provider-led	■ Physical health ■ Behavioral health	Upside only shared savings	27 quality measures, including 9 scoring, 4 challenge, and 14 reporting only measures
IA	State Innovation Model Accountable Care Organization Program	Provider-led	■ Physical health	VBP options via MCO contracting (e.g., shared savings or incentive payments linked to quality)	14 measures in 6 domains; shared savings or incentive payments dependent on ACO performance
MA	Accountable Care Organizations	Provider-led organizations that may partner with managed care organizations	■ Physical health ■ Behavioral health (via community partners) ■ Long-term services/supports (LTSS) (in year three, via community partners)	Three models: (1) full risk capitation; (2) shared savings and losses with MassHealth; and (3) shared savings and/or loss contracts with MassHealth MCOs	(*Proposed*) 38 quality measures, including 32 tied to payment in second and subsequent years (first year, reporting only)
ME	Accountable Communities Initiative	Provider-led	■ Physical health ■ Behavioral health ■ LTSS (*optional)* ■ Dental *(optional)*	Shared savings using two tracks: (1) upside only; and (2) upside/downside	17 quality measures, including 14 core measures and three elective measures; all tied to payment
MN	Integrated Health Partnerships	Provider-led, with two tracks: (1) smaller providers and ccare coordination entities; (2) larger, integrated systems that manage TCoC for beneficiaries	■ Physical health ■ Behavioral health ■ Pharmacy	Two tracks: (1) risk-adjusted, population based payment tied to quality metrics; (2) shared savings with upside and downside risk	Core measures drawn from patient care, health IT, and pilot domains; focus on alignment with MACRA/MIPS
NJ	Medicaid Accountable Care Organization Pilot	Community-led (geographic)	■ Physical health	ACOs and MCOs negotiate an upside only shared savings agreement[1]	27 quality measures, 21 mandatory measures and six voluntary measures; all tied to payment
NY	Accountable Care Organizations	Provider-led	■ Physical health	Shared savings or shared savings/risk contracts are negotiated between ACOs and MCOs	ACO must propose a quality management and improvement program (which includes quality metrics) to the state for approval
OR	Coordinated Care Organizations	Payer-led (geographic)	■ Physical health ■ Behavioral health ■ Dental	Global budget capped at 2% growth rate. Quality pool bonus available via 4% withhold	17 Incentive measures tied to quality pool payments based on CCO achievement or improvement
RI	Accountable Entities (AE)	Provider-based entities contracting with MCOs under shared savings arrangement; two potential tracks: (1) all populations; (2) LTSS population	■ Physical health ■ All Medicaid services that are covered by Executive Office of Health and Human Services' (EOHHS) contracts with MCOs ■ Does not include services reimbursed by EOHHS fee-for-service programs ■ For LTSS track, long-term care services	Shared savings/loss via MCO contracting	11 required core measures; 4 additional optional measures identified by the AE and the MCO
UT	Accountable Care Organizations	Payer-led	■ Physical health	Capitated payment	25 quality measures, not tied to payment
VT	Next Generation Accountable Care Organization	Provider-led	■ Physical health	Prospective capitation plus quality withhold, with risk corridor capped at 3% savings/losses	Quality withhold (increases from 0.5% to 3% over 3 years) tied to performance on 10 out of 12measures

[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.