

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, 10 states have active Medicaid ACO programs, and at least 13 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.

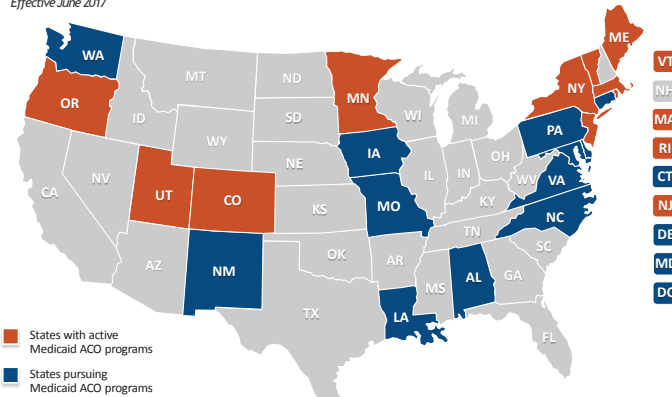
Quality metrics are tied to payment, and providers typically will not receive a portion of shared savings if they do not meet or exceed their quality benchmarks.

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.

State-Based Medicaid Accountable Care Organizations

Effective June 2017



The Promise of Medicaid ACOs

While Medicaid ACOs are still a relatively new phenomenon, some state programs have shown promising results:

- **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
- **Minnesota** attributed \$76.3 million in savings to its Integrated Health Partnerships program within its first two years. All nine IHPs achieved shared savings, exceeded their quality targets, and collectively reduced inpatient and ED utilization among patients served during the program's second year.³
- **Oregon** reported that ED visits for patients served by its Coordinated Care Organizations decreased 23 percent, admissions for short-term complications from diabetes dropped 32 percent, and admissions related to asthma and chronic obstructive pulmonary disease decreased 68 percent. In FY 2015, all CCOs showed improvement in quality measure performance, and 15 of the 16 earned 100 percent of their potential quality pool bonuses. These improvements have allowed the state to stay well within its two percent annual growth target.⁴
- **Vermont** reported \$14.6 million in savings due to its Vermont Medicaid Shared Savings Program (VMSSP) in the program's first year. Both of the state's Medicaid ACOs achieved significant savings and exceeded their quality benchmarks to receive shared savings distributions.⁵

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 (next page) includes 11 programs from the 10 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 Minnesota Department of Human Services. Minnesota's Medicaid reform initiative saves \$61.5 million in 2nd year. Press release, June 19, 2015. Available at: <http://mn.gov/dhs/media/news/news-detail.jsp?id=252-166076>.

⁴ Oregon Health Authority. Oregon's Health System Transformation: 2015 Mid-Year Report. January 20, 2016. Available at: <https://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf>.

⁵ Vermont Governor's Office. Medicaid Shared Savings Programs Helped Avoid 14.6 Million in Costs in 2014. Press release, September 8, 2015. Available at: <http://governor.vermont.gov/node/2474>.

Overview of Active Medicaid ACO Programs

State	Program Name	Governance Structure	Scope of Service	Payment Model	Quality Measurement
CO	Accountable Care Collaborative	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
MA	Accountable Care Organizations	Provider-led organizations that may partner with managed care organizations	<ul style="list-style-type: none"> 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	<i>(Proposed)</i> 38 quality measures, including 32 tied to payment in second and subsequent years (first year, reporting only)
ME	Accountable Communities Initiative	Provider-led	<ul style="list-style-type: none"> Physical health Behavioral health LTSS (<i>optional</i>) Dental (<i>optional</i>) 	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) Integrated - larger systems that provide inpatient/outpatient care; (2) Virtual - smaller systems not formally integrated with a hospital	<ul style="list-style-type: none"> Physical health Behavioral health Pharmacy 	Shared savings using two tracks: (1) virtual - upside only; and (2) integrated - upside/downside	32 quality measures scored as nine aggregate measures; all measures are reported in year-one, then increasingly tied to payment
NJ	Medicaid Accountable Care Organization Pilot	Community-led (geographic)	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Physical health Behavioral health Dental 	Global budget capped at 2% growth rate. Quality pool bonus available via 4% withhold	33 quality measures, 17 tied to quality pool payment
RI	Accountable Entities (AE) Pilot	Provider-based entities contracting with MCOs under shared savings arrangements specified by the state Two AE tracks: (1) All populations; and (2) SPMI/SMI only	<ul style="list-style-type: none"> 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 	Negotiated by the two parties in the arrangement (AE and MCO), reviewed and approved by the state. Must be: (1) total cost of care based; (2) include attributed lives in accordance with state guidance; and (3) be shared savings only	Negotiated by the parties in accordance with state guidelines; reviewed and approved by the state
UT	Accountable Care Organizations	Payer-led	<ul style="list-style-type: none"> Physical health 	Capitated payment	25 quality measures, not tied to payment
VT	Vermont Medicaid Shared Savings Program	Provider-led	<ul style="list-style-type: none"> Physical health LTSS (<i>optional</i>) Behavioral health (<i>optional</i>) Pharmacy (<i>optional</i>) 	Shared savings using two tracks: (1) upside only; and (2) upside/downside	Core set of 28 measures, eight tied to payment
VT	Next Generation Accountable Care Organization	Provider-led	<ul style="list-style-type: none"> Physical health Behavioral health 	Prospective capitation plus quality withhold, with full risk (no savings/losses cap)	Quality withhold (3%-5% over time) tied to performance on six measures

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.