CHCS Center for Health Care Strategies, Inc.

Policy Brief

Core Considerations for Implementing Medicaid Accountable Care Organizations

By Tricia McGinnis, MPP, MPH and Amanda Van Vleet, MPH

NOVEMBER 2012

With the passage of the Affordable Care Act (ACA) and its provisions for delivery system and payment reform, there has been a blossoming of new accountable care organization (ACO) approaches to care delivery – initially in Medicare – but now also in Medicaid. Medicaid agencies in Oregon and Minnesota recently received approval from the Centers for Medicare & Medicaid Services (CMS) for ACO-like programs and are rapidly moving toward implementation, joining company with Colorado and North Carolina. In addition, New Jersey passed legislation and is finalizing the regulations for its Medicaid ACO demonstration in early 2013.

While the Medicare Shared Savings Program (MSSP) requirements that CMS developed last year do not govern Medicaid ACO activities, this payment model has nonetheless served as a catalyst and guide. Furthermore, the Center for Medicare and Medicaid Innovation's (CMMI) interest in promoting state-driven multi-payer delivery system reform through its State Innovation Model (SIM) initiative is ramping up state interest in new accountable care approaches. States are eager to learn from each other to create ACO approaches that work for Medicaid-only populations, as well as multi-payer models.

Under its *Medicaid ACO Learning Collaborative*, the Center for Health Care Strategies (CHCS) is assisting seven states to develop and implement Medicaid ACOs: **Maine, Massachusetts, Minnesota, New Jersey, Oregon, Texas**, and **Vermont**. Through initial meetings with these states, 10 core considerations have emerged that must be addressed in developing new ACO programs. Some of these are unique to the Medicaid program and the challenges inherent in improving care for vulnerable, low-income populations. Other issues are common across all payers, signaling opportunities for multi-payer collaboration and alignment, which is particularly salient for states participating in the SIM initiative.

To assist states considering ACO models for their Medicaid population, this brief outlines these 10 critical considerations and how states are beginning to address them.

IN BRIEF

Leading-edge states across the country are exploring the potential of accountable care organizations (ACOs) to drive improvements in quality, delivery, and cost-effectiveness for Medicaid populations. With support from The Commonwealth Fund, and additional funding from the Massachusetts Medicaid Policy Institute, the Center for Health Care Strategies (CHCS) designed *Advancing Medicaid Accountable Care Organizations: A Learning Collaborative* to help seven state pioneers launch Medicaid ACO models. Drawing from the experiences of these states, this brief outlines 10 core considerations to help guide the development and implementation of Medicaid ACO approaches. This is the first in a series of resources to help states develop ACO strategies.

1. Obtain the Regulatory Approval to Create Medicaid ACOs

Medicaid agencies are working closely with CMS to determine the appropriate authority under which to establish ACO programs. CMS released guidance in July 2012 on the regulatory pathways for implementing integrated care models (ICMs), including ACOs.[1] States that design ACOs within the fee-for-service (FFS) system or under primary care case management (PCCM) must obtain regulatory approval under a waiver or state plan amendment (SPA). States that implement Medicaid ACOs within managed care can often use contracting mechanisms with managed care organizations (MCOs) to establish the necessary structure and requirements. CMS recently introduced an option for states to submit a SPA to implement ICMs for all providers under their state plan.[2]

In determining the appropriate form of regulatory approval, states will need to consider the purpose and scope of their

Made possible through support from The Commonwealth Fund.

States are deploying a range of innovative payment models to align provider incentives with high quality, efficient care across a spectrum of health services.

Medicaid ACOs. States will also need to consider how ACOs align with existing state programs, such as PCCM, medical homes, and health homes to avoid duplication of payments or services. For example, Minnesota is implementing provider-led ACO models within FFS and managed care. The state received authority through a SPA to conduct an ACO demonstration project for the FFS population using shared savings/risk arrangements with nine organizations.[3] Oregon is using an 1115 waiver to develop geographically-based Coordinated Care Organizations (CCOs) that are largely based on their managed care infrastructure.[4]

As states move forward, they should work closely with CMS to ensure that their models sufficiently address important issues such as: (1) beneficiary eligibility and protections; (2) patient attribution/assignment; (3) provider qualifications; (4) payment methodology (including risk adjustment, trend, and mechanism/settlement); (5) quality measurement and improvement strategies; and (6) accountability and oversight. To engage CMS in these discussions, states are encouraged to begin by providing a concept paper outlining the proposed model and how it addresses these key issues.

2. Design a Payment Model Appropriate for Medicaid Populations and Providers

States are deploying a range of innovative payment models to align provider incentives with high quality, efficient care across a spectrum of health services. States are primarily considering models that include shared savings, shared risk for advanced ACOs, global payments, partial capitation payments, and care management payments. Many states are adapting the MSSP model to address Medicaid population and programmatic realities. Using this established model not only offers a workable, CMS-approved starting point, but also aligns with Medicare ACOs, potentially encouraging greater provider interest and participation.

States are altering the MSSP model through a variety of approaches, such as: (1) applying risk adjustment methods better suited to Medicaid populations; (2) redefining cost outliers to promote targeting of super-utilizers; (3) refining attribution methods to align with existing primary care programs such as managed care, PCCM, medical homes, or health homes; (4) applying Medicaid-relevant trend rates; and (5) adjusting patient number thresholds and minimum savings rates. For example, Minnesota's Health Care Delivery Systems (HCDS) model altered the MSSP model by:

- Applying a trend rate based upon the annual expected changes to program-wide cost and utilization for the state's public health care programs;
- Using an Adjusted Clinical Groups risk adjustment methodology, with customized population weighting;
- Using an attribution logic that first examines whether the beneficiary is enrolled in a medical home and looks at plurality of visit counts versus cost; and
- Tiering catastrophic claims benchmarks, based on the number of Medicaid patients an ACO serves to reduce variability of model performance.

These adjustments require substantial data and financial analysis, which most states have engaged their actuaries to conduct. States are also incorporating quality reporting and measurement standards in the payment model, either as a "gate" to a payment or as an "elevator" to different payment levels. For example, Colorado puts a portion of its per member per month (PMPM) payment at risk based on improvements in three key metrics: (1) emergency room utilization; (2) inpatient utilization; and (3) unnecessary imaging to treat lower back pain. Directly linking payment to quality is of particular interest to CMS.

In addition to the above technical tasks, two significant issues include: (1) tailoring the payment model for a range of provider capabilities; and (2) aligning with other Medicaid payments. Most Medicaid ACOs seek widespread provider participation, yet safety net providers vary greatly in their capacity to manage financial risk and invest in the resources necessary to function as an ACO. Some states are transitioning ACOs to shared savings with risk over a defined time period. States also recognize the need to provide upfront funding to low-capacity providers for investments in infrastructure and personnel, but are struggling to identify budget neutral funding sources. Many plan to rely on existing medical home or health home PMPM payments to support such investments, which could align well with other payers, particularly in states participating in the CMS Multi-Payer Advanced Primary Care Practice demonstration (MAPCP) or the CMMI Comprehensive Primary Care initiative (CPCi). In designing these models, states must also attend to the issue of "double-dipping," both to ensure that they are not paying for activities that Medicaid is already paying for under a different program and that savings are not counted more than once.

3. Build ACOs Atop Other Delivery System and Payment Reform Efforts

Most states that are moving forward with these new models view ACOs not as a stand-alone program, but as the next phase in broader delivery system and payment reform. Conceptually, ACOs are seen as a vehicle for encouraging providers to build connectivity and collaboration across the full spectrum of health services that rests on a strong primary care foundation.

Consequently, states seek to leverage existing investments in primary care by incorporating ACOs within current delivery reform initiatives, such as patient centered medical homes (PCMH), health homes, duals integration, community health teams, and pay-for-performance. This alignment leverages current investments and may make it easier to recruit providers to participate and facilitate multi-payer participation. One potential limiting factor, however, is that the adoption of these foundational delivery reform models among the Medicaid provider network is not widespread in some states.

To build upon these programs effectively, states must identify how their various delivery reform programs will fit together, in a non-duplicative manner, and determine critical points for alignment. States should be clear about the services that existing programs already provide and the delivery gaps that ACOs will be expected to fill. Potential programmatic areas for alignment include:

- Provider participation criteria;
- Payment methods;
- Key provider functions, activities, and workflows;
- Scope of clinical services;
- Care coordination and case management services;
- Performance measurement;
- Enrollment criteria;
- Certification processes; and
- Reporting requirements.

Presenting a clear vision of how the programs build on one another and how their requirements fit together will be critical to provider buy-in and participation.

Some states are explicitly leveraging these existing delivery reform programs as foundational ACO program requirements. For example, Oregon has many existing state-wide initiatives that it is building on in a stepwise manner. In the first phase, the CCOs, a managed care/ACO hybrid, are required to contract with both Patient Centered Primary Care Homes (PCPCHs) and health homes in their catchment area(s). In the application process to become a CCO, the state holds the CCOs accountable for incorporating other delivery

States can seek to leverage existing investments in primary care by incorporating ACOs within current delivery reform initiatives, such as patient centered medical homes, health homes, duals integration, community health teams, and pay-for-performance.

Perhaps more than any set of providers, safety net providers vary widely in their capacity to perform ACO functions.

reform initiatives. In Oregon's Request for Applications, the state also asks how applicants will provide certain elements, such as HIT. Maine, Massachusetts, and Vermont are likewise looking to build on their PCMH and health home programs. Texas is looking to leverage community-focused Regional Health Partnerships, based on the Delivery System Reform Incentive Payment Program, as well as multi-payer initiatives developed by the Texas Institute of Health Care Quality and Efficiency.

4. Facilitate Provider ACO Building Capacity

Perhaps more than any set of providers, safety net providers vary widely in their capacity to perform ACO functions. While some providers, particularly integrated systems and some federally qualified health centers (FQHCs), have the infrastructure and staff to track population- and patient-level data and deploy effective care management approaches, many others lack the data, software, staff, and workflow processes to perform these critical functions. States recognize that payment reform alone is insufficient to enable providers to change the way they deliver care, and that assistance is needed. A key challenge for Medicaid agencies is to meet providers at various development stages, with appropriate resources, and give them the tools and incentives needed to promote delivery transformation. Defining the appropriate role for the state in providing this assistance and finding the necessary funding are related challenges.

Provider supports would help in three key areas: (1) ACO functional capacity development; (2) data sharing and analytics; and (3) leadership and change management. To effectively coordinate care, providers need to build highly functioning care teams and workflows that support collaboration across a wide spectrum of providers and the integration of health services and community supports. Having timely data across care settings is not only essential to identify overall population-level trends and care needs, but also to identify high-cost "super-utilizer" beneficiaries for whom care management and coordination can make a difference. Finally, ACOs must find leaders with change management skills to guide clinicians and staff through this transformation.

States are exploring a variety of provider-support models including: (1) learning collaboratives that bring stakeholders together for training and/or peer-to-peer learning; (2) coaches that work hands-on with the ACOs; (3) liaisons that help the ACOs and the state communicate and collaborate effectively; and (4) training with subject matter experts. For example, Oregon is creating a team of Innovator Agents to serve as a single point of contact between the CCO and the state. They will help CCOs, their providers, and Community Advisory Councils develop strategies to support the adoption of care innovations and to gauge the impact of health systems transformation on community health needs.

States are also exploring different mechanisms for data collection and sharing that include: (1) all payer claims databases (APCD); (2) state data analytics contractors (SDACs); (3) electronic health record incentives for providers that do not qualify for meaningful use incentives; (4) support for more rapid adoption of functional health information exchanges (HIE); and (5) care management software tools that can incorporate necessary data from a variety of sources. Colorado is leading the way with the development of its SDAC, though many states are soon to follow, particularly those that will receive SIM funding. States are struggling to obtain guidance on the best legal/operational practices for sharing data (e.g., Stark, HIPAA, fraud and abuse).

5. Determine How to Include High-Cost Populations in ACOs

The potential for better coordinated care offered by Medicaid ACOs may be particularly promising for two high-cost Medicaid populations: (1) beneficiaries who are dually eligible for both Medicare and Medicaid; and (2) beneficiaries who will be covered through the Medicaid expansion.

Many states believe that Medicare-Medicaid beneficiaries could benefit greatly from an ACO model, as their care is often so poorly coordinated due to the separate Medicare and Medicaid financing streams. Initial results from the Medicare Physician Group Practice Demonstration, one of the first demonstration models using shared savings, found that costs were significantly reduced among dually eligible individuals.[5] For them, the increased use of more appropriate long-term services and supports (LTSS) such as home-based care, for example, could potentially reduce more expensive inpatient hospital stays. However, under current financing arrangements, Medicaid picks up the tab for increased utilization of LTSS, while Medicare benefits from lower inpatient stays, creating perverse financial incentives for Medicaid to exclude duals from their ACO programs. Additional challenges include: 1) LTSS stakeholders and consumer advocates who may be less supportive of an integrated approach; and 2) provider reluctance to share accountability with LTSS providers. Under MSSP, dual eligibles are attributed to a Medicare ACO as the default. States participating in the Financial Alignment Demonstration Model for Medicare and Medicaid Enrollees[6] are hopeful that this integrated financing model will form the basis for ultimately including individuals who are dually eligible in Medicaid ACOs, with Massachusetts potentially leading the way.

States are also hopeful that the ACO model will benefit the Medicaid expansion population. This population will include primarily low-income, childless adults, many of whom have gone without health care for extended periods of time.[7] One critical challenge with this population is the difficulty attributing and assigning new patients to an ACO, due to the lack of claims history. Relatedly, actuaries may be unable to incorporate the expected expenditures into cost of care benchmarks used in shared savings/risk models or to appropriately risk adjust. Since this population may have a very different risk profile from current Medicaid enrollees, it is unclear how to adjust shared savings methodologies appropriately, without putting either the state or the ACO at risk for unintended losses. Early examples of how states are beginning to incorporate these populations include Minnesota, which has an ACO demonstration in Hennepin County that serves 6,000 childless adults at income levels at or below 75 percent of the federal poverty level. New Jersey's demonstration will also include the general assistance population currently covered in its 1115 waiver.

Many states believe that Medicare-Medicaid beneficiaries could benefit greatly from an ACO model, as their care is often so poorly coordinated due to the separate Medicare and Medicaid financing streams.

6. Select Appropriate Quality Measures, Measurement Strategies, and Value-Based Purchasing Techniques

States are pursuing strategies to measure and encourage quality improvement in ACOs. Quality monitoring will be important not only to demonstrate meaningful improvements, but also to ensure that ACOs are not creating perverse incentives that result in underutilization of services and poor quality of care.

Medicaid agencies are aligning metrics with existing efforts (e.g., adult core measures) to ease data collection and quality reporting requirements for providers, plans, and the state. At the same time, measures should also align with the goals of the ACO, which may focus on a particular health need or complex population versus ensuring their broader Medicaid population benefits from their model. These two goals can present a conundrum for states. Metrics tailored to complex populations often do

ACOs are a vehicle for pushing the locus of responsibility for patient care and the appropriate financial incentives down to the practice level.

not exist or are outside of the scope of existing core measures. Furthermore, ACOs that use a super-utilizer strategy and target a small subset among their attributed patient population may not have sufficient patient numbers to reliably measure changes in quality.

States are exploring ways to resolve this tension in their measurement strategies, while avoiding burdening providers. States are hopeful that increasing adoption of electronic health records and health information exchange will enable the development of more sophisticated metrics that are more accurate than claims-based metrics and easier to collect from providers. Investing in ACO data collection capacity, as mentioned above, can help states meet their quality measurement requirements as well. States are also looking at population health measures and/or community health needs assessments to monitor and track community health.

To promote quality of care rather than quantity of care, Medicaid agencies are keen to incorporate value-based purchasing principles and tie payment to quality outcomes within ACO programs. In these arrangements, provider payment is often determined by meeting specific quality standards in addition to containing costs.

Minnesota is taking a phased-in approach. In the first year, the state will monitor the performance of ACOs and report outcomes to CMS to: (1) ensure that proper care is being delivered; (2) identify potential problems early; (3) monitor care delivery transformation among practices; and (4) develop baseline total costs of care. In the following years, the state will implement payment models based both on shared savings and meeting specified quality and patient experience standards. In order to facilitate the transition of providers into this payment model, ACOs will only be expected to adequately report data in the first year. In the following years, performance on quality and patient experience measures will directly impact the level of shared savings.

7. Define New Roles for Managed Care Organizations

ACOs are a vehicle for pushing the locus of responsibility for patient care and the appropriate financial incentives down to the practice level. For this model to be effective, the relationship between ACO providers and MCOs must evolve. The latter's roles and responsibilities will need to be reconfigured in ways that better support provider-level innovation and accountability.

Health plans have traditionally supported providers by overseeing utilization review, delivering disease and care management programs, and managing quality measurement and system-wide performance improvement efforts. With ACOs increasingly assuming the responsibility of care management, MCOs must decide how best to support providers in these efforts and Medicaid agencies must decide whether to continue to pay the MCOs for these services. MCOs have the opportunity to play a stronger role in data sharing and analytics. Particularly in areas where there is not a robust HIE or APCD, MCOs are often the best source of system-wide, patient-level data. MCOs will need to implement advanced payment methods and techniques to support provider collaboration and integration between physical health and behavioral health. Working with multiple payers, financial sustainability, and creating economies of scale will all likely be important challenges for MCOs in this new environment.

States are exploring methods to align accountability among MCOs and foster collaboration between plans, providers, and the state. For example, some states are exploring stricter contracting mechanisms or payment incentives (e.g., dividing shared savings to reward both ACOs and MCOs) to ensure that MCOs undertake necessary

activities and align accountability among health plans. While Minnesota's ACO demonstration requires plans to participate with the state in shared savings/risk arrangements with ACOs, participation is voluntary under New Jersey's legislation.

8. Define the Scope of Services Offered through ACOs

Medicaid agencies must determine the range of services for which these organizations should be held accountable. Ideally, the ACO will be responsible for coordinating care across the complete range of health services used by a particular patient, and potentially services that extend beyond health care. Maine is exploring a model that would require: (1) the direct delivery or coordination with specialty services, including behavioral health; (2) coordination with all hospitals in the proposed service area; and (3) the development of formal and informal partnerships with community organizations, social service agencies, or local government. Oregon's CCOs will be accountable for physical health and behavioral health in the first year, and will incorporate dental health in year two.

States are particularly interested in using ACOs to integrate physical and behavioral health care and LTSS, which presents significant challenges given current delivery system configurations, financing streams, and data integration limitations. Some states, such as Maine, Minnesota, and Oregon are using ACOs to build off the new health homes models under ACA, which emphasize coordination among physical, behavioral,
and community health service providers to deliver care management for patients with multiple chronic conditions, mental illness, and substance abuse.

Incorporating behavioral health may be particularly challenging in states with behavioral health carve-outs. Under its Comprehensive Primary Care Payment program, Massachusetts will use primary care as a foundational element of its model, but facilitate the integration of behavioral health with physical health through PCMH concepts. The state has created a Behavioral Health Integration Work Group to define the requirements of primary and behavioral health care integration. These requirements will support three models of integration: (1) non co-located, but coordinated; (2) co-located, and (3) fully integrated. Although Massachusetts' behavioral health is carved out, this approach is supported through advanced contracting mechanisms. This type of alternative arrangement has been tested successfully in a Pennsylvania regional pilot, under which the behavioral health organization receives financial incentives to improve health outcomes via increased integration among physical and behavioral health providers.[8]

9. Bring a Wide Set of Stakeholders to the Table

In order for ACOs to effectively coordinate a comprehensive array of health and social services among vulnerable populations, a broad set of stakeholders must be engaged. Multiple types of providers that typically see high-need, high-cost beneficiaries, including hospitals, FQHCs, and rural providers; health plans; community groups; government stakeholders; academic advisers; and the public must be involved to develop approaches that respond to diverse patient health and community needs. On the provider side, hospitals may be hesitant to form ACOs due to the potential financial downside associated with lower admissions and emergency department visits. FQHCs and rural providers may lack the necessary start-up costs or health information technology systems to form ACOs.

States are using a variety of strategies to engage stakeholders both in planning and operations. More than 300 Oregonians representing health plans, providers, beneficiaries, consumer advocacy groups,

States are particularly interested in using ACOs to integrate physical and behavioral health care and LTSS, which presents significant challenges given current delivery system configurations, financing streams, and data integration limitations.

Given the range of health reform buzzwords in the media, and variation in ACO models among payers, states need ways to help the public understand what ACOs are and what the potential benefits are for enrollees.

and other key stakeholder groups participated in the strategic planning and development of Oregon's CCO model. States have established governance and organizational requirements to ensure that a range of stakeholders are meaningfully participating within the ACO. For example, New Jersey legislation requires the participation of all general hospitals, 75 percent of primary care physicians, and at least four behavioral health providers in a designated area. Oregon, Maine, and Minnesota require Medicaid ACOs to partner with community and social service organizations.

States are also engaging a broad range of stakeholders in the governance of ACOs. For example, New Jersey requires an ACO's governing board to involve: patients; providers (including hospitals, clinics, private practices, physicians, behavioral health care providers, and dentists); and other social service agencies or organizations in the identified service area. The board must also have voting representation from at least two consumer organizations that can advocate on behalf of patients within the ACO's service area and either live within the area or have leadership that lives within the area.[9] In addition, Medicaid agencies are considering whether to incorporate FQHCs via partnerships with other types of providers or by forming networks of FQHCs.

Medicaid's highest-need, highest-cost patients often face significant levels of economic and social instability that make it difficult to access necessary and timely health care.[10] These patients are likely to benefit not only from better coordinated clinical care, but also from services offered within social services and community organizations. For example, social workers, legal aid programs, homeless programs, and community health workers provide services that may directly impact patients' health (such as assistance with poor housing conditions, environmental exposures, taking medications, peer-based support, or disease prevention/management regimens). Medicaid ACOs must be able to connect beneficiaries to these community resources and social supports. Engaging community organizations fully as partners and including them in the ACO governance structure should enable Medicaid ACOs to more effectively leverage these resources. ACOs based in specific communities, such as those in New Jersey, may be particularly well-positioned to form effective partnerships with these local organizations.

Medicaid agencies are also striving to clearly define ACOs and explain them to the public. Given the range of health reform buzzwords in the media, and variation in ACO models among payers, states need ways to help the public understand what ACOs are and what the potential benefits are for enrollees.

10. Stimulate Multi-Payer Alignment and Participation

States are well aware of the potential benefits associated with multi-payer alignment, particularly with respect to multi-faceted care models such as ACOs. As mentioned earlier, Medicaid programs are planning to use common payment methodologies and existing multi-payer efforts such as PCMH as building blocks for their efforts. Recognizing the level of investment needed, states are interested in payer partnerships that create a shared infrastructure necessary to support ACOs. Such alignment can help engage providers more effectively and also reduce the fragmentation among providers and expand the types of patients they are willing to serve. States such as Maine, Massachusetts, Minnesota, and Oregon, which have multi-payer collaboratives in place via the Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative,[11] are particularly well-positioned to begin building multi-payer ACOs. The recent multi-payer SIM grant opportunity has further stimulated states' thinking around this issue.

However, there are several challenges associated with multi-payer approaches. Foremost, states are concerned that multi-payer ACOs will not have the appropriate incentives to serve the needs of vulnerable populations effectively. The cost drivers of Medicaid patients vary greatly from those of commercial and Medicare populations, stemming to a greater extent from mental health, substance abuse, and socio-economic instability. Effective ACOs will need to coordinate more effectively with behavioral health, social services, and community organizations, whereas commercial or Medicare patients might benefit from better coordination among primary care and specialists, many of whom do not see Medicaid patients. There are also associated challenges to aligning key ACO components, such as quality metrics, which may not be relevant for all patient populations.

Finally, certain ACO organizational configurations, such as New Jersey's community-based ACO, may not be tenable in a multi-payer environment due to anti-trust prohibitions.

Conclusion

The array of Medicaid ACO efforts in states across the country is expanding rapidly. Stimulated by the ACA, flourishing ACO activity in Medicare and the commercial sector, and more recently, by the SIM opportunity, Medicaid stakeholders are engaging more earnestly in conversations about payment and delivery system reform using ACO-type approaches. Addressing the core considerations detailed in this brief can help states advance models that provide new levels of accountability to Medicaid health care delivery.

About Advancing Medicaid Accountable Care Organizations: A Learning Collaborative

With support from The Commonwealth Fund, and additional funding from the Massachusetts Medicaid Policy Institute, a program of the Blue Cross Blue Shield of Massachusetts Foundation, the Center for Health Care Strategies (CHCS) developed *Advancing Medicaid Accountable Care Organizations: A Learning Collaborative* to help states collaborate with multiple delivery system stakeholders and advance ACO models to drive improvements in quality, delivery, and payment reform. CHCS is working with Medicaid agencies from Maine, Massachusetts, Minnesota, New Jersey, Oregon, Texas, and Vermont to accelerate ACO program design and implementation.

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.

Endnotes

[1] SMDL# 12-002, ICM# 2: Policy Considerations for Integrated Care Models. Centers for Medicare & Medicaid Services. July 10, 2012. http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf.
[2] Section 1905(t)(1) 42 CFR 440.168.
[3] Minnesota State Plan Amendment: Integrated Care Models (FFS Primary Care Case Management). Approved August 6, 2012.
[4] Oregon Health Plan (OHP) Section 1115 Demonstration Waiver. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-plan2-ca.pdf.
[5] C. Colla et al., "Spending Differences Associated with the Medicare Physician Group Practice Demonstration," *Journal of the American Medical Association.* vol. 308 (10): 1015-1023, September 2012.
[6] For more information, including a list of states, see http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html.
[7] Kaiser Commission on Medicaid and the Uninsured, "Who Benefits from the ACA Medicaid Expansion?," Kaiser Family Foundation, June 2012.
[8] J. Kim, T. Collins Higgins, D. Esposito, A. Gerolamo, M. Flick. *SMI Innovations Project in Pennsylvania: Final Evaluation Report.* Mathematica Policy Research, October 2012. Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261431.
[9] New Jersey P.L. 2011 Chapter 114.
[10] M. Cristofalo, T. Krupski, L. Jenkins, A. Yee, D. Atkins, I. West, P. Roy-Byrne. *Chronic Care Management Intervention: A Qualitative Analysis of Key Informant Accounts*. Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations. June 29, 2010.
[11] For information on Aligning Forces for Quality, visit http://forces4quality.org/.