

Accountable Care Organizations: Creating a Workable Approach for Medicaid

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Across the country, health purchasers are exploring the potential of accountable care organizations (ACO) to provide higher quality and more efficient care. Progress is being made for Medicare and commercial populations: the Brookings-Dartmouth ACO Pilot¹ is developing commercial shared savings contracts with private payers; the Centers for Medicare & Medicaid Services (CMS) released a proposed rule for a Medicare Shared Savings Program;² and the Center for Medicare and Medicaid Innovation is supporting a Pioneer ACO Model for Medicare and multi-payer ACOs.³

Yet, while much of the national ACO focus has been on Medicare and commercially insured populations, these new models also offer a critical opportunity to improve care and control costs for Medicaid programs. A community-focused, integrated model of care provides significant potential for improving care coordination and reallocating health care dollars more effectively for millions in the nation's health care safety net. As Medicaid prepares to expand coverage to an additional 16 to 20 million Americans in 2014, the program must also rethink how it delivers primary and chronic care, particularly for its highest-need, highest-cost patients. Medicaid can use its tremendous purchasing power to drive delivery system redesign and payment reform through ACOs.

To create a Medicaid-focused ACO demonstration, CMS and states could start by building on the framework developed for the Medicare Shared Savings Program. Structural and population differences between the two programs, however, necessitate many of the underlying provisions of the Medicare ACO rule be reconsidered. This issue brief was developed to help Medicaid stakeholders in designing feasible safety-net ACO approaches. It outlines 10 key issues that CMS and states would need to address in developing a future Medicaid ACO Program:

1. Provide upfront demonstration funding support.

Based on a 2008 Government Accountability Office (GAO) analysis of the Medicare Physician Group Practice Demo, the

IN BRIEF

Policy experts across the country are considering accountable care organizations (ACOs) as a way to rethink the delivery of higher quality and more efficient care. Yet Medicaid, which cares for 60 million patients has been largely absent from the ACO conversation.

This brief outlines 10 key issues for states and the Centers for Medicare & Medicaid Services (CMS) to consider in exploring options for safety-net ACOs. By providing a stable structure for medical, behavioral health, and social service providers to collaborate, safety-net ACOs offer significant potential for improving care coordination and curbing spending, particularly for Medicaid's highest-risk, highest-cost patients.

average start-up and first year ACO operating costs exceed \$1.7 million.⁴ Yet under the proposed Medicare Shared Savings Program, no upfront funding is available to help provider organizations assemble the infrastructure and additional staff required to launch an ACO. ACOs must meet specific patient-centeredness requirements, which require a multi-disciplinary team consisting of primary care physicians (PCPs), care managers, community health workers, health educators, and other staff. To date, it has been financially difficult, if not prohibitive, for Medicaid PCPs to hire this staff due to relatively low levels of Medicaid reimbursement. ACOs are also required to administer a beneficiary experience-of-care survey, which is expensive to undertake. Without upfront funding for these investments, Medicaid providers that are otherwise well-positioned to become ACOs may choose not to pursue this new model of care.

There are other obstacles to Medicaid provider readiness. Because Medicaid providers typically do not have the levels of information technology (IT) infrastructure, staff, and economies of scale necessary to quickly transition to an ACO

organizational structure, a three-year program (e.g., the proposed Medicare Shared Savings and Pioneer ACO programs) may not be the right approach. Other programmatic approaches, such as a five-year demonstration to establish budget neutrality with upfront funding and/or alternative payment methods, may be more appropriate.

2. Support Medicaid ACOs operating in multiple delivery models.

The proposed rule for Medicare Shared Savings creates a shared savings model designed to work within a fee for service (FFS) payment structure. However, roughly 70% of Medicaid beneficiaries receive care through full and partially risk-based managed care systems.⁵ Administering ACO programs within managed care will present unique challenges that will need to be addressed.

Under Medicaid managed care systems, cost savings resulting from ACO care delivery will accrue directly to the managed care organization (MCO), not to the state. CMS and states will need to consider how savings can be shared among the state, the MCOs, and the Medicaid ACOs. For example, states may need to develop mechanisms to revise actuarially sound capitation payments so that they reflect the cost savings and can be shared with the ACO.

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Access to robust and complete data is critical for providers to function as an ACO. Patient-level claims data will enable ACOs to more effectively evaluate the needs of their patient population, measure and monitor provider quality of care, improve outcomes, and track expenditures. However, within Medicaid managed care programs, states may not have access to robust encounter data and will be challenged to provide complete claims-level data. Processes will need to be established for both the Medicaid agency and the MCOs to share aggregate and claims-level patient data with the ACO.

3. Provide technical assistance.

State Medicaid purchasers and their safety net health care provider partners will likely need intensive technical

assistance to establish ACO models of patient-centered, lower-cost care that are sustained by robust payment methods to drive accountability. Given the numerous policy and regulatory challenges in designing and implementing ACOs within Medicaid and within different delivery systems, states could benefit from working closely with their peers and experts through an ACO Learning Network.

Technical assistance should also focus on helping Medicaid ACOs support population-based management, including Electronic Health Record (EHR) implementation, care process redesign, and cultural shifts to sustain continuous quality improvement. An ACO Learning Network could play an important role in providing this assistance and helping ACOs establish relationships with peers. More intensive onsite support will be particularly critical to help time- and resource-strapped Medicaid practices adopt ACO tenets of care.

4. Help Medicaid providers meet IT requirements.

Under the proposed Medicare Shared Savings Program, ACO providers should be able to “electronically exchange summary of care information when patients transition to another provider or setting of care, both within and outside the ACO, consistent with meaningful use requirements under the EHR incentive program.” Specifically, at least 50 per cent of an ACO’s PCPs must be “meaningful EHR users” by the beginning of the second year. Many Medicaid providers – particularly one- and two-physician practices and small rural health centers – still use paper-based systems and have few resources to put toward upgrading IT infrastructure. Medicaid ACOs would need additional time and funding in order to meet such demands, bolstered by existing resources such as funding from the HITECH Medicaid Incentive program and technical support from the Regional Extension Centers.

5. Include Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).

The Medicare-proposed ACO rule excludes FQHCs and RHCs from serving as ACOs due to the lack of FFS claims data necessary for calculating shared savings or assigning beneficiaries to an ACO. While only a small percentage of Medicare beneficiaries receive care in these community health centers, they currently serve seven million Medicaid beneficiaries, a number that will expand with additional coverage provided under the Affordable Care Act (ACA).⁶ Determining how to extend this new opportunity to include these health care providers should be a priority for a future Medicaid safety-net ACO program.

6. Use geographic or population-based approaches for patient attribution.

Unlike Medicare ACOs, which base patient attribution on the number of primary care visits, Medicaid ACOs should take a population-based approach anchored in a specific geographic service area. Within Medicaid, some of the biggest opportunities to improve care and lower costs lie with patients who do not access primary care services regularly and who over-utilize high-cost services such as the emergency department. Basing patient assignment on geography, particularly in high poverty areas, will help connect hard-to-reach populations to a care delivery infrastructure that is well-suited to meet their health care needs. This approach will also make it easier for FQHCs to serve as ACOs and will be particularly important when the Medicaid expansion populations join in 2014 and Medicaid functions has a health insurance program for all Americans up to 133% of poverty.

7. Engage community organizations.

For Medicaid ACOs to succeed in improving the health of their patient population, they must be able to connect beneficiaries to community resources and social supports. Medicaid's highest-need, highest-cost patients in particular confront daily life challenges that make it extremely difficult to access the health care that they need, when they need it. The resources to help address these challenges reside not within a clinician's office walls, but rather in community organizations. For example, community health workers play a critical role in providing peer-based support and helping people integrate disease prevention and management regimens into their daily situation. Engaging community organizations fully as partners and including them in the ACO governance structure will enable Medicaid ACOs to most effectively leverage these resources, which are key to the success of this care delivery model. Such partnerships are particularly relevant when using geography-based patient assignment, as ACOs can leverage existing relationships that community organizations often have with hard-to-reach patients. CMS and states may consider ways to structure regulations or requirements so as to encourage Medicaid ACOs to engage community partners effectively.

8. Consider state protection from anti-trust liability.

Medicaid stakeholders will need to address myriad anti-trust issues when developing and managing a Medicaid ACO program. For example, there are concerns about anti-competitive behavior related to both price fixing and geographic market allocation. CMS, the Federal Trade Commission and the U.S. Justice Department have been

working collaboratively to provide guidance under the Medicare program, including the use of a safety-zone for certain ACOs. CMS and states will need to explore protection of anti-trust liability under the state action doctrine and the potential for states to help address these issues.

9. Mitigate potential financial risks to safety net hospitals.

Medicaid beneficiaries typically receive care from hospitals that are highly reliant upon both Medicare and Medicaid disproportionate share hospital (DSH) expenditures. The greatest cost-cutting potential for Medicaid ACOs lies in reducing inappropriate inpatient and emergency department visits. Such utilization changes are likely to occur gradually, enabling safety net hospitals to adjust over time to lower revenue streams from these services. However, the potential exists for extreme drops in utilization over a short period of time, which could threaten the financial viability of safety net hospitals. Given ACA reductions in DSH funding and potential reductions in revenue associated with ACOs, states and CMS should determine how to mitigate such factors in a rational and transparent way.

Medicaid ACOs should be required to collect and report quality measures that are relevant to Medicaid beneficiaries. Measurement will help assess the impact of the ACO delivery model, help providers track and improve their care delivery, and address concerns that quality may fall as a result of improved efficiency.

The Medicare Shared Savings Program proposed rule does not address this potential impact of the ACO program on Medicare DSH expenditures. In a Medicaid ACO program, CMS and states could consider creating a mechanism, such as a risk corridor funded out of the shared savings pool, to mitigate the impact of extreme drops in DSH reimbursement for safety net hospitals over a limited time period.

10. Measure meaningful quality outcomes.

Similar to the approach taken in the Medicare Shared Savings program, CMS and states should require Medicaid ACOs to collect and report quality measures that are relevant to Medicaid beneficiaries. Measurement will help assess the impact of the ACO delivery model, help providers track and improve their care delivery, and address concerns that quality may fall as a result of improved efficiency. CMS

and states should use measures developed specifically for the Medicaid population, such as the forthcoming adult core measures that were required under the ACA, and the CHIPRA core measure set for women and children. Measures that capture the quality of care delivered to patients with mental health issues or substance abuse will be important as well. Over-utilization measures that are pertinent to Medicaid beneficiaries, such as inappropriate emergency room visits, should also be included.

Most of the Medicare Shared Savings quality measures cannot be captured using claims data. CMS and states should consider the ease with which Medicaid ACOs can

collect and report the measures when developing a core set of ACO measures.

Conclusion

While ACOs have received ample attention in Medicare, equal focus should be given to support the development of safety-net ACOs. CMS and states can establish a solid foundation for the development of Medicaid-focused ACOs by addressing these core issues. This new delivery model offers significant promise for more community-focused, cost-effective care for millions of Americans served by Medicaid.

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 quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racial and ethnically diverse populations experiencing disparities in care. 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 For more information, visit <http://www.acolearningnetwork.org/what-we-do/aco-pilot-sites> .

² For more information, visit <https://www.cms.gov/sharesavingsprogram/> .

³ For more information, visit <http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco/> .

⁴ Government Accountability Office, “Medicare Physician Payment: Care Coordination Programs used in Demonstration Show Promise, but Wider use of Payment Approach May Be Limited,” February 2008.

⁵ *Medicaid and Managed Care: Key Data, Trends, and Issues*. Kaiser Commission on Medicaid and the Uninsured. February 2010. Note: Includes beneficiaries receiving comprehensive and limited benefits, e.g., in fully capitated managed care plans, primary care case management programs, Program for All Inclusive Care, etc.

⁶ National Association of Community Health Centers, *At A Glance*, 2009.