

# The History, Evolution, and Future of Medicaid Accountable Care Organizations

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Alongside its broad changes to the health insurance market, the Affordable Care Act of 2010 (ACA) authorized the implementation of a wide variety of health care delivery system reforms. Perhaps the most notable of these reforms was the federal recognition of the accountable care organization (ACO), an entity that is responsible for achieving the “Triple Aim” of better health, improving patient experience, and lowering costs.<sup>1</sup> There is no single, precise definition of an ACO, but generally a mature ACO is financially responsible for the total cost of care (TCOC) and quality of care delivered to an attributed population. There are currently more than 900 ACOs in the United States, across commercial, Medicare, and Medicaid markets, covering over 32 million lives (see Exhibit 1).<sup>2</sup> However, Medicaid lags behind Medicare and commercial payers when it comes to the number of estimated covered lives in ACO contracts. As of early 2017, there were an estimated 1,336 active ACO contracts across public and private payers, with just 88 (12 percent) of those contracts accounted for by Medicaid, covering approximately 3.9 million Medicaid beneficiaries.<sup>3</sup>

## Exhibit 1: Current ACO Landscape by Payer

Payer	States with Active ACOs	Beneficiaries Covered
Medicare	50 states plus Washington, D.C. and Puerto Rico	10.5 million <sup>4, 5</sup>
Commercial	50 states plus Washington, D.C. and Puerto Rico	19.1 million <sup>6</sup>
Medicaid	12 (statewide programs)	3.9 million <sup>7</sup>

Since 2011, 12 state Medicaid agencies have developed ACO or ACO-like programs using a range of program designs. With the support of The Commonwealth Fund, the Center for Health Care Strategies (CHCS) has convened a learning collaborative for states at various stages of designing and implementing Medicaid ACO programs.<sup>8</sup> For the past five years, CHCS has worked with nearly

## IN BRIEF

Accountable care organizations (ACOs) have become increasingly prevalent in the United States. These organizations shift more accountability for health outcomes to providers and many have shown positive results for improving care and reducing costs for Medicare, Medicaid, and commercial populations.

This brief, made possible by The Commonwealth Fund, highlights the results of Medicaid ACO programs across the country to date, as well as key themes and lessons from these early adopters. It examines how Medicaid ACO programs have evolved over time, and informs state and federal policymakers, researchers, and foundations about considerations to further the development of effective ACO approaches moving forward. Key findings are that most early adopter states reported positive results with their Medicaid ACO programs, but designing and operationalizing statewide programs can be a significant undertaking.

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every state that has established a statewide Medicaid ACO program. For this brief, CHCS conducted interviews with representatives from seven states that were early adopters of Medicaid ACOs and identified common themes and lessons from their experiences. This brief provides a history of Medicaid ACO programs and details the opportunities realized and challenges overcome by those early adopter states to inform future efforts in the area.

## History of Medicaid ACOs

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In the late 1990s and early 2000s, health services researchers focused on the problem of unnecessary health care utilization arising from the misalignment of incentives provided to health care payers and providers, which operate in uncoordinated silos. The ACO model was envisioned to align those interests through innovative payment arrangements, such as shared savings, that compensate providers not for the volume of health care services provided, but for the quality of the care delivered (see Exhibit 2).

While ACOs were first developed in the commercial market, they quickly expanded into publicly funded health care under the ACA with the introduction of the Medicare Shared Savings Program (MSSP) by the Centers for Medicare & Medicaid Services (CMS).

MSSP offers financial incentives to organizations that reduce health care spending for a defined population by offering them a percentage of any net savings realized as a result of their efforts.<sup>9</sup>

### Exhibit 2: How Shared Savings Works

Shared savings arrangements are often used to structure payment in Medicaid ACOs.

Following are basic steps involved in developing and implementing a shared savings approach:

1. **Execute a shared savings contract** between the payer and the ACO, defining the exact terms of the arrangement, including how the parties will calculate the “baseline” cost of care benchmark (typically developed by calculating an ACO’s average historical expenditures for a wide-range of health services) against which the incurred costs will be compared.
2. **Attribute patients to ACOs** based on an agreed-upon methodology, generally provider preference and/or utilization patterns.
3. **Provide traditional fee-for-service payment** for health care services for a year of operation.
4. **Calculate the total cost of care** for the attributed patients, and risk-adjust payment after the first 12 months.
5. **Distribute shared savings**, by comparing the total cost of care for the ACO’s attributed patients to the baseline cost of care, and paying out shared savings if costs come in under the cost benchmark, with a share of losses recouped by the payer if costs come in above the cost benchmark.

*Source: CHCS summary of ACO shared savings contracts.*



## Early Adopters: Initial Medicaid ACO Approaches

Most, if not all, Medicaid ACO programs have been born out of state fiscal crises that necessitated significant changes to how care is paid for and delivered, as well as a desire to improve the quality of care and health outcomes for Medicaid beneficiaries. Colorado, for example, was facing unsustainable cost growth in its Medicaid program (a challenge shared by many early adopters) and policymakers realized that major change was necessary. State officials decided to build upon an existing, successful medical home program for children and, after gathering extensive stakeholder input, established the first Medicaid ACO-like program in the nation in 2010. Colorado's Regional Care Collaborative Organizations (RCCOs) supported primary care practices through assisting with care management and connecting them to local social services. Initially, Colorado identified three priorities for quality improvement and cost reductions — emergency department (ED) visits, 30-day all-cause readmissions, and high-cost imaging.

Similarly, Minnesota initiated development of its Medicaid ACO program when policymakers recognized that health care cost growth was unsustainable. The state legislature required the development of the Health Care Delivery System reform program (later renamed Integrated Health Partnerships) to address cost growth and move the state toward more value-based purchasing. As in Colorado, Minnesota built upon existing programs, specifically its Health Care Homes program, and leveraged the Statewide Quality Reporting and Measurement System, which publicly reports provider quality measures.

Unlike the Medicare ACO models, Medicaid agencies have the flexibility to define the contours of their ACO programs. States are, however, constrained by the authority granted to them in the Social Security Act as well as policy guidance on integrated care models outlined by CMS.<sup>10</sup> Depending on the type of ACO program and the health care environment, states have used various statutory or regulatory authority to develop Medicaid ACO programs (see Exhibit 3).

### Exhibit 3: Federal Authorities Used to Establish Medicaid ACO Programs

- **§1115 demonstrations** are used when states propose to waive particular requirements of the Social Security Act to implement their programs. Oregon's Coordinated Care Organizations (CCOs) are part of an expansive restructuring of the Medicaid system in the state, and since in some cases the program can restrict enrollees' choice of payer, the program required an 1115 waiver.
- **State plan amendments** are used when the proposed changes to Medicaid health care delivery comply with the broad requirements of the Social Security Act. Maine used a state plan amendment to implement its Medicaid ACO program as an Integrated Care Model under federal Primary Care Case Management authority, which did not require the waiving of any requirements in the Social Security Act.
- **Managed care authority** can be used by states to permit implementation of their Medicaid ACO programs. If the ACOs contract with managed care organizations, then the arrangements between the ACOs and managed care organizations (MCOs) are considered part of the ordinary contracting process and do not typically require any further waiving of statutory requirements.<sup>11</sup> Minnesota relied on managed care authority for its Integrated Health Partnership (IHP) population enrolled in MCOs, and a state plan amendment to implement the IHP program for its fee-for-service population.<sup>12</sup>



Source: CHCS review and summary of CMS and state documents.

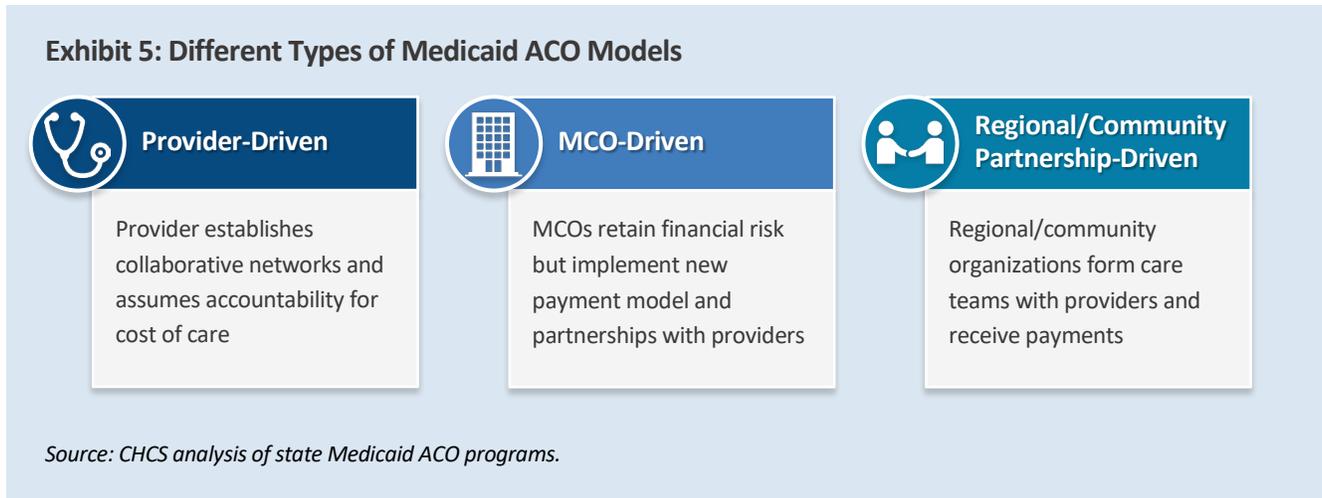
Many early adopter states also leveraged federal funding opportunities designed to advance delivery system and payment reform initiatives (see Exhibit 4). Those most commonly used include funds provided under the: (1) State Innovation Models (SIM) initiative to support state-based multi-payer health care delivery and payment systems;<sup>13</sup> and (2) Delivery System Reform Incentive Payment (DSRIP) initiatives, which are part of §1115 waiver programs and provide states with a portion of projected federal savings that can be reinvested in Medicaid care delivery improvements.<sup>14</sup> Six states were awarded federal funding that was allocated, at least in part, to designing, testing, implementing and/or expanding Medicaid ACO programs. While some states were already pursuing Medicaid ACOs prior to receiving federal funding, officials in Maine reported that federal funding allowed them to accelerate implementation of their Medicaid ACO program. Other states, such as Colorado and New Jersey, implemented their ACO programs without any federal funding.

**Exhibit 4: Select Early-Adopter Medicaid ACO States: Use of Authority and Federal Funding**

State	Program Name (Year Launched)	Authority	Federal Funding <sup>15</sup>
Colorado	Accountable Care Collaborative (2011)	State Plan Amendment	No federal funding
Oregon	Coordinated Care Organizations (2012)	Authorized by the Oregon legislature in 2011 through House Bill 3650; <sup>16</sup> §1115 Demonstration Waiver	DSRIP, \$1.9 billion; SIM Grant, \$45 million
New Jersey	Medicaid ACOs (2011)	Authorized by New Jersey legislation, P.L. 2011, Chapter 114 <sup>17</sup>	No federal funding; \$1 million per ACO appropriated from state budget in each of first two years
Maine	Accountable Communities (2013)	State Plan Amendment <sup>18</sup>	SIM Grant, \$33 million <sup>19</sup>
Massachusetts	Medicaid ACOs (2016, pilot; 2018, full launch)	§1115 Demonstration Waiver; <sup>20</sup> state legislation provided a mandate for the state’s reform strategy: Chapter 224 of the Acts of 2012 <sup>21</sup>	DSRIP, \$1.8 billion; <sup>22</sup> SIM Grant, \$44 million
Minnesota	Integrated Health Partnerships (2012)	State legislation established the initial program: 256B.0755; <sup>23</sup> State Plan Amendment and Managed Care Authority	SIM Grant, \$45 million
Rhode Island	Accountable Entities (2016, pilot; 2018, full launch)	Managed Care Authority	Designated state health program funding, \$129 million <sup>24</sup>
Vermont	Medicaid Shared Savings Program (VMSSP) (2014)	State Plan Amendment <sup>25</sup>	SIM Grant, \$45 million

Source: CHCS interviews with state Medicaid agency officials and analysis of state documents.

Medicaid ACO models vary greatly, but generally fall under one of three models: (1) provider-driven; (2) MCO-driven; and (3) regional/community partnership-driven (see Exhibit 5).



Many states designed provider-led Medicaid ACOs, where the organization that executes the ACO contract is either a hospital system, integrated health system, and/or a group of physicians. These states' programs are intentionally closely aligned with CMS' definition of a Medicare ACO, defined as "groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients."<sup>26</sup> Minnesota's IHPs and Maine's Accountable Communities (ACs) are prime examples of provider-led Medicaid ACO models. On the other hand, Oregon's CCOs are similar to managed care organizations (MCOs), but include some key differences, such as more active roles of providers and community members in the governance and leadership than traditional MCOs. A final approach is the regional or community partnership, whereby an organization is responsible for supporting care coordination in a particular region of the state, as implemented in Colorado, or accountable for the total cost of care of beneficiaries in specified zip codes, such as in New Jersey's program.

The lines between the various models are not entirely distinct — the Oregon CCOs are for the most part geographically exclusive, with only a few areas of the state covered by more than one CCO. Similarly, New Jersey's community-based Medicaid ACOs are made up of provider organizations that are responsible for the care of beneficiaries in their covered areas, so they share some characteristics with provider-led models. The decision that states have made to focus on provider- or payer-led entities is informed primarily by the existing state environment. Rhode Island, for example, wanted to retain the state's high-performing managed care program, and so designed its ACOs to be provider-driven and operate within managed care. In contrast, other states have either explored or designed ACO programs that enable provider-led entities to operate alongside (and essentially compete with) MCOs.

Many Medicaid ACO programs also require a role for beneficiaries in the participating organizations. Oregon requires each CCO to convene a community advisory council that include Medicaid beneficiaries in a majority of the seats. Other Medicaid ACO programs, such as Maine and Vermont, require Medicaid beneficiaries to serve on the governing boards, and New Jersey's Medicaid ACO program requires that two members of the governing board be individuals that represent the larger community served by the ACO.<sup>27</sup>

## Results from Early Adopter States

While not all individual ACOs have demonstrated success in delivering better health outcomes at a lower cost, at a programmatic level, most state efforts have achieved promising results. The early adopter states have produced reports detailing the impact that the Medicaid ACO programs have had on cost and quality (see Exhibit 6). Colorado reported net savings in each of the years that the program has been operational. Minnesota’s IHP program has likewise shown savings and increased quality across the participating organizations. Perhaps most dramatically, Oregon’s CCO program has helped the state to achieve an annual growth target for Medicaid expenditures that Oregon negotiated with CMS as part of its \$1115 waiver.<sup>28</sup> Evaluations from Medicaid ACO pilot programs launched in early-adopter states, such as Rhode Island and Massachusetts, were not yet available at the time of this brief.

### Exhibit 6: Cost and Quality Results for Medicaid ACO Programs in Early Adopter States

State	Results
<b>Colorado</b>	RCCOs saved \$77 million for Colorado Medicaid in the program’s first three years, and have lowered emergency department (ED) visits, high-cost imaging, and hospital readmissions. <sup>29</sup>
<b>Maine</b>	Accountable Communities saved MaineCare \$4.56 million in the first year of operation and \$8.14 million in the second year of operation. <sup>30</sup>
<b>Minnesota</b>	IHP saved more than \$212 million for Minnesota Medicaid in the program’s first four years, and IHPs have consistently exceeded quality targets. <sup>31</sup>
<b>Oregon</b>	CCOs have kept the annual growth of Medicaid expenditures to 3.4 percent, <sup>32</sup> and have improved key quality measures, including a 23 percent statewide reduction in ED visits, and a 68 percent decrease in inpatient admissions related to asthma and COPD. <sup>33</sup>
<b>Vermont</b>	Two VMSSP organizations reported approximately \$17 million in savings in the first two years of the program, and exceeded their quality benchmarks. <sup>34</sup>

Source: CHCS interviews with state Medicaid agency officials and analysis of state documents.

In addition to state-reported data on the impact of Medicaid ACO programs on cost and quality, several recent peer-reviewed articles have found promising results for Medicaid ACO programs. A 2017 study of Oregon’s CCOs found that, in comparison to the neighboring state of Washington, Oregon’s CCOs were associated with a seven percent reduction in expenditures, primarily via reductions in inpatient utilization.<sup>35</sup> The move to CCOs was also linked to reductions in avoidable ED visits and improvements in some measures of appropriateness of care, but was associated with reductions in primary care visits, which was highlighted as a potential area of concern given the state’s desire to shift utilization to primary care.<sup>36</sup> This study speculated that the reduction in primary care could have been related to a number of factors, including: (1) Medicaid expansion, which strained provider capacity by adding nearly 400,000 newly enrolled Medicaid beneficiaries within a year; and (2) shifting of services to nontraditional supports, such as community health workers, social workers, and care coordinators. Another study published in 2017 compared the performance of Medicaid ACO programs in Oregon and Colorado, and found that both programs — despite significant differences in the level of federal investments and in program design — generated comparable reductions in expenditures and declines in inpatient care days.<sup>37</sup>

The range of successful Medicaid ACO programs among the early adopter states suggests that there is not one correct way to design an ACO program nor a particular approach that precludes success. Oregon's and Colorado's programs, for example, differ greatly in terms of financial structure and the scope of services for which they are responsible, but both approaches achieved savings and improved quality.<sup>38</sup> Evaluations of Medicaid ACO programs — along with academic studies on the topic — have not generally been designed to identify what specific program features correlate to high performance, presenting a promising area for future inquiry. The diverse range of ACOs, including wide variation in attributed patient populations, care practices, governance models, and geography, make it difficult to design an evaluation that can isolate the impact of any one care intervention.<sup>39</sup> Another confounding factor is that some states built Medicaid ACOs programs off a strong foundation of existing Medicare and commercial ACOs, and studies have shown that previous experience with ACO contracts can be a factor contributing to success. Examples of delivery system initiatives implemented under Medicaid ACO programs to improve quality and curb costs include: (1) high-utilizer programs; (2) programs to reduce ED utilization; (3) support for health-related social needs; and (4) care transition programs.

## Key Challenges and Lessons

Designing a Medicaid ACO program is a significant undertaking. Given that Medicaid ACO programs are not governed by federal laws and regulations in the same way as Medicare ACOs, states must also tackle numerous decisions to define the characteristics of the ACO program.<sup>40</sup> This section outlines key challenges and lessons from states on a number of design decisions, as well as selected operational issues, including:

1. Building upon existing state reforms and delivery system characteristics;
2. Determining how to involve MCOs in the ACO program;
3. Structuring ACO payment models and ensuring program sustainability;
4. Engaging stakeholders and establishing adequate state staffing;
5. Addressing legislative and regulatory challenges;
6. Supporting financial and data infrastructure.

### ***1. Building Upon Existing State Reforms and Delivery System Characteristics***

States with successful ACO programs designed their programs to fit the payer and delivery system environment in which they were intended to operate, and found success with a variety of models. For example, Minnesota provided a defined payment model for the initial implementation of its IHP program, but allowed for flexibility in terms of what types of organizations could participate (e.g., one is a group of county service providers including a public hospital, another a coalition of federally qualified health centers) and which of two risk tracks the organizations could assume. Vermont developed its Medicaid ACO program in response to providers participating in CMS' MSSP, and so was able to take advantage of a market that was primed for ACO participation. Colorado built upon a successful patient-centered medical home (PCMH) program, and the state engaged stakeholders and developed its RCCO model with flexibility for the different RCCOs to provide services that are appropriate for their attributed regions (which range from urban Denver to the frontier west beyond the Rocky Mountains). Finally, Maine similar to Minnesota, allowed flexibility in terms of AC

composition (e.g., one AC is a coalition of FQHCs, while others consist of hospitals/health systems partnering with other hospitals or with FQHCs), choice of risk tracks, and optional service costs and quality metrics in addition to mandatory ones.

## 2. Determining How to Involve MCOs in the ACO Program

One key challenge facing many states is determining how to involve MCOs in the ACO program. This decision includes thoughtful consideration of the roles played by each organization: the state, the health plan, and the ACO. In particular, the shift toward ACOs has the potential to create duplication as ACOs assume responsibilities previously delegated to MCOs, such as those around care management, unitization management, and risk management.<sup>41</sup> In New Jersey’s case, MCOs’ participation in the Medicaid ACO program was voluntary, as permitted by the legislation, meaning that they chose whether or not to contract with the Medicaid ACOs certified by the state. As a result, ACOs have needed to develop strategies to engage and prove their value to MCOs.<sup>42</sup> Interviewees for an evaluation conducted by Rutgers University noted that the lack of traction with MCOs was driven by: (1) the voluntary nature of MCO participation within the demonstration; and (2) MCO doubts about the cost and quality benefits of working closely with Medicaid ACOs.<sup>43</sup>

In contrast, Minnesota’s IHPs operate in an almost fully managed care environment, and the state mandates in the Medicaid MCO contracts that MCOs make shared savings payments to in-network providers operating as IHPs. For the Medicaid population in managed care, payment flows to each IHP through the state’s contracted MCOs, but are calculated by the state. In Massachusetts, the state designed three Medicaid ACO models that provide a range of options for how health plans and providers can work together (see Exhibit 7).<sup>44</sup> Rhode Island’s designed a program where MCOs contract with provider-led ACOs responsible for the total cost of care and health care quality and outcomes of an attributed population. In its pilot program, Rhode Island allowed for ample flexibility between the MCOs and the Accountable Entities (AEs) with respect to certain aspects of the ACO program, but the state learned that such flexibility could create challenges that make it difficult to monitor the impact of the program, including variability.

## 3. Structuring ACO Payment Models and Ensuring Program Sustainability

In determining Medicaid ACO payment models, several states modeled their initial methodology on the MSSP, including Maine, Minnesota, and Vermont. Similar to MSSP, those states created multiple payment track options: one providing upside shared savings only, and another with shared upside savings and downside risk, with financial risk phased in over time so ACOs had an opportunity to familiarize themselves with managing the cost of care. However, few providers in those states opted in to payment models with downside risk without being required to do so. Further, states can face challenges in attracting providers to voluntarily participate even in “upside only” payment tracks. Although the potential for shared savings is generally used as an incentive for ACO providers, there are limitations to relying on future shared saving payouts to encourage providers and help defray start-up costs. Not only is there uncertainty around whether an ACO will generate the level of savings needed to generate payouts to the provider, but there are also concerns around the timing of such payments. In general, ACOs are not eligible for shared savings payouts until about 18 months

### Exhibit 7: Massachusetts’ ACO Models



#### Accountable Care

**Partnership Plan:** An MCO with a closely partnered ACO provider or a single, integrated entity that includes both an ACO provider and an MCO.

**Primary Care ACO:** An ACO provider organization that contracts directly with MassHealth, which remains the insurer.

**MCO-Administered ACO:** An ACO provider organization that contracts directly with MassHealth-contracted MCOs.

after the beginning of the first performance year, due to the time needed for collection of, claims submission and processing, and analysis of the results. For these reasons, shared savings programs are often viewed as an “on-ramp” or “training wheels” for moving away from fee-for-service to risk-based capitated payments.<sup>45</sup>

Not all states opted to exclusively use a shared savings payment approach. For example, Massachusetts offers different payment models for its three Medicaid ACO options, ranging from prospective, monthly capitation for the Accountable Care Partnership Plan ACOs to shared savings/risk for Primary Care ACOs and MCO-Administered ACOs.<sup>46</sup> Oregon’s CCOs are globally budgeted, with prospective, risk-adjusted, per-capita payments made to the organizations; the CCOs’ payments do not increase from year to year more than an agreed-upon target. With Oregon’s heavy focus on VBP initiatives and investments in cost-effective health-related services, the state could face challenges related to “premium slide,” where CCOs’ rates may decline over time, given that CCO capitation rates are based on prior utilization of state plan services.<sup>47</sup>

#### ***4. Establishing Adequate State Staffing and Engaging Stakeholders***

Despite the complexity inherent in designing a statewide Medicaid ACO program, states often implemented Medicaid ACO programs with relatively few state Medicaid agency staff (see Exhibit 8, page 10). States also deal with high levels of turnover and changes in leadership, both at the Medicaid agency level as well as at the executive level. For example, Oregon’s Governor John Kitzhaber, a prominent champion for the CCO program, resigned in early 2015.

Interviewees frequently mentioned the importance of stakeholder engagement in program development as a way to determine where organizations are and their capacity. The stakeholder engagement process enabled policymakers to ensure that the program requirements are not perceived to be too burdensome by the organizations that will bear the costs of implementation. Additionally, successful stakeholder engagement creates a relationship between state officials and payers and providers that can facilitate communication about program successes and challenges throughout implementation, allowing for continuous improvement. Vermont convened stakeholder workgroups for its health care reforms, including a Quality and Performance Measures workgroup that developed quality measure recommendations. The Oregon Health Authority established the Oregon Transformation Center, an office that fosters innovation and quality improvement in Oregon’s health system transformation efforts by providing learning collaboratives and technical assistance at both the CCO and practice level.

However, several states referenced challenges with finding time and resources to dedicate to stakeholder engagement, as well as the complexity inherent in communicating information about Medicaid ACO programs. This includes challenges in providing information that is easy-to-understand about the nuances of the ACO payment model or quality measurement, specifically when communicating with beneficiaries. To address these challenges, a number of states developed Medicaid ACO programs that require a role for beneficiaries, such as having Medicaid beneficiaries serve on governing boards.

**Exhibit 8: Resources and Staffing for Medicaid ACO Programs by State**

State	Staffing Summary
<b>Colorado</b>	At least 20 Medicaid staff on at least an 80 percent basis, including: <ul style="list-style-type: none"> <li>■ Six contract managers;</li> <li>■ Five staff in quality office;</li> <li>■ One budget analyst; and</li> <li>■ Multiple staff in the data and innovations department.</li> </ul>
<b>Maine</b>	Between 1 and 1.5 full-time equivalents (FTEs) worked on the design and now ongoing management of the Accountable Communities program, with the development of quality and total cost of care reports contracted out.
<b>Minnesota</b>	Initially, three dedicated staff. Currently, a team of seven mostly full-time staff supporting the IHP program, including: <ul style="list-style-type: none"> <li>■ Two data analysts;</li> <li>■ One informatics lead;</li> <li>■ One policy lead;</li> <li>■ One contract manager;</li> <li>■ One quality manager; and</li> <li>■ One program manager (75% FTE).</li> </ul> Minnesota had a data and analytics grant through SIM that provided technical assistance to the state and the IHPs on an ad hoc basis. The state also brought in an actuarial consultant to help develop the IHP program.
<b>New Jersey</b>	Approximately 1.5 FTEs dedicated to designing and implementing the Medicaid ACO pilot program. Rutgers University is serving as a staff extender (named in legislation to handle data collection and reporting, funded via the Nicholson Foundation).
<b>Oregon</b>	At least 20 state staff across Medicaid, the Transformation Center, and the Office of Health Analytics support the CCO program. This includes a metrics manager and metrics analyst from the Office of Health Analytics who provide regular quality performance reports.
<b>Rhode Island</b>	Approximately 3.3 FTEs support the design and implementation of the AE program, with additional analytic and consulting help. The state is recommending nine additional people for program launch and implementation, including two to three people dedicated to MCO operations and oversight.
<b>Vermont</b>	Through 2015, five to six FTEs for the VMSSP and contractor support, made possible through a SIM grant. Currently, the Next Generation program has approximately 2.5 FTEs dedicated to implementation and oversight; this could change if the program gets significantly larger or more routinized.

Source: CHCS interviews with state Medicaid agency officials.

### 5. Addressing Legislative and Regulatory Challenges

Several state policymakers indicated their Medicaid ACO programs were constrained by state legislation, but in differing ways. The legislation establishing Oregon’s CCO model became effective July 1, 2011, yet the Oregon Health Authority needed to have its CCO proposal to the Legislative Assembly for approval by February 1, 2012. This provided only seven months to define the key program details, ranging from criteria for the composition and governance of the CCOs, to identifying quality measures and benchmarks.<sup>48</sup> New Jersey’s ACO program operated under the constraints of prescriptive legislation outlining detailed aspects of the Medicaid ACO program demonstration, including governance and participation requirements (i.e., that ACOs have “support”

from general hospitals, at least four behavioral health specialists, and no less than 75 percent of the primary care providers who serve Medicaid enrollees in their region), but did not require contracting between ACOs and the state's Medicaid MCOs.

Several states pointed to challenges associated with federal legislation and regulations. For example, Medicaid expansion under the ACA resulted in large enrollment increases during the same period that several states were implementing ACO programs. In Oregon, CCO enrollment increased from about 600,000 to nearly one million beneficiaries within one year, which was the second largest increase in Medicaid enrollees in the country.<sup>49</sup> A study of Oregon's and Colorado's Medicaid ACO programs suggested that observed declines in primary care utilization under both programs may have been related to the significant increases in Medicaid enrollment, pointing to potential challenges with access to care.<sup>50</sup>

Another federal-level challenge facing ACOs involves the laws and regulations governing the confidentiality of patient records for substance use disorder treatment. Title 42 of the Code of Federal Regulations (CFR) Part 2 — often referred to as 42 CFR Part 2 — imposes restrictions on the use of patient information related to alcohol and drug use.<sup>51</sup> Despite recent revisions to 42 CFR Part 2 designed to facilitate health integration and information exchange, several state policymakers pointed to 42 CFR Part 2 as a barrier to comprehensive care integration under Medicaid ACO programs.<sup>52</sup> This poses a significant challenge given that Medicaid spending is typically much higher for beneficiaries with a behavioral health diagnosis, and in turn, lack of data and ability to fully coordinate care for those individuals makes it more difficult for ACOs to bring costs under control. While one state policymaker acknowledged that this was more about perceived than actual barriers under 42 CFR Part 2, another state official noted that the “inability to share substance use information is debilitating to the entire ACO program.”

## ***6. Supporting Financial and Data Infrastructure Needed for Medicaid ACO Programs***

A key component of a successful ACO program is access to timely, reliable, and accurate data. On the payer side, such data is needed to operationalize various components of ACO programs, including performance measurement, financial benchmarking, and patient attribution.<sup>54</sup> On the provider side, data is needed to assess the quality and cost of care; coordinate care; identify high-need, high-cost patients; and develop targeted quality improvement activities.<sup>54</sup> However, substantial financial investments can be required to get an ACO up and running. State officials interviewed stressed the importance of providing ACOs with support for data analytics, noting that supporting data capacity was one of the most valuable investments that a state Medicaid agency could make.

Securing the upfront capital to form and manage an ACO is also a significant issue for safety-net providers that do not typically have the resources that larger, integrated systems have to invest in care transformation or the cash reserves needed to take on financial risk. CMS estimated in its June 2015 final rule that upfront investments for ACO formation under the MSSP — including health information technology, process development, staffing, population management, care coordination, quality reporting, and patient education — would be approximately \$580,000. Furthermore, CMS' estimated annual costs to manage day-to-day operations under an MSSP ACO were even higher, at \$860,000 per year.

States have taken a variety of approaches to support their ACOs, and a number of states used federal dollars provided under SIM and/or DSRIP to support investments in necessary data infrastructure such as enhanced information technology at both the state and provider levels:

- **Maine** maintains a data portal with encounter claim data, and provides ACOs with various population-level data on cost and quality, as well as patient-level data.
- **Minnesota** maintains a data portal with encounter claim data, and provides IHPs with various population-level data on cost and quality, as well as patient-level data, such as medical and pharmacy utilization histories, as well as predictive risk information. It also offered data and analytics grants from SIM resources to IHPs to improve their capacity.
- **New Jersey** engaged the local state university to develop a suggested shared savings methodology for its ACOs, and encouraged ACOs to contract with them to conduct the calculations. The New Jersey legislature also appropriated \$1 million from its budget for each of the state's three Medicaid ACOs to provide the financial support needed to establish the programs.
- **Oregon** Medicaid's Office of Health Analytics provides frequent reports to their CCOs, and has close relationships with CCOs enabling the collection of quality performance information. The state also used its SIM resources to establish the Oregon Transformation Center, which provides technical assistance to CCOs.
- **Vermont** used SIM funding to support an independent analytics contractor; the state and ACO partners found that there was a benefit to having a single entity handle the analytics for the VMSSP.
- **Colorado** contracts with a Business Intelligence and Data Management system that allows RCOs to access claims and encounter data to produce reports for the state and providers. The system also manages dashboards and other data analytics for participating practices.

## Evolution of Medicaid ACO Programs

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States continue to enhance their Medicaid ACO programs in response to the challenges outlined above and to strengthen the programs' quality and cost impact. State ACO enhancements for these evolved, version "2.0" programs generally fall into four categories:

1. Increasing use of payment models with downside risk;
2. Maximizing provider participation and program sustainability;
3. Expanding services included in the Medicaid ACO model; and
4. Focusing on fewer and greater alignment of quality measures.

(For a side-by-side comparison of "1.0" and "2.0" State ACO program characteristics by state, see Exhibit 9, page 14)

### 1. Increasing Use of Payment Models with Downside Risk

Given the lack of voluntary provider participation in risk-based Medicaid ACO payment models, states are increasingly moving away from "upside-only" contracting options to payment models that require at least some level of downside risk, either by requiring upside/downside risk in shared savings contracts, or by moving to capitated payments. Beginning in 2018, Minnesota's IHP program is moving away from a payment model that includes an upside-only payment option, to requiring downside risk for IHPs responsible for managing their attributed patients' total cost of care. States are also aiming to better align their programs with the Medicare Access and CHIP Reauthorization Act's (MACRA) Quality Payment Program. For example, states such as Rhode Island are aiming to align risk levels and other program requirements to help Medicaid ACO programs qualify as "Advanced Alternative Payment Models" under MACRA.<sup>53</sup> In Vermont, the state recently transitioned from the Medicaid Shared Savings Program — where the underlying payments were still primarily based on fee-for-service — to the Medicaid Next Generation model, which uses prospective capitation with a risk corridor capped at three percent of savings/losses. This dramatically changed the way the state is paying providers, which in turn resulted in a number of required systems changes. In making the transition toward required downside risk, a Vermont policymaker stressed the importance of iterative change, noting that the early years of the Next Generation Medicaid ACO program — which currently has one participating ACO — will be helpful to illustrate the possibility of success in an arrangement with downside risk. As states shift to downside risk models, it is likely that more focused attention will be paid to developing more robust monitoring and oversight mechanisms due to incentives to withhold care in order to avoid losses.

Exhibit 9: Comparison of Medicaid ACO 1.0 and 2.0 Program Characteristics by State

<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>COLORADO</b></p>	<p><b>1.0 - Colorado Accountable Care Collaborative (2011)</b></p> <ul style="list-style-type: none"> <li>■ <b>Number of ACOs:</b> 7</li> <li>■ <b>Covered lives:</b> Over 1 million</li> <li>■ <b>Overview:</b> Care-coordination entities known as Regional Care Collaborative Organizations (RCCOs) manage and coordinate services in seven geographic regions</li> <li>■ <b>Scope of service:</b> Physical health</li> <li>■ <b>Payment model:</b> Monthly care coordination payments, and an additional payment that varies based on level of performance</li> <li>■ <b>Quality performance:</b> Three quality measures tied to payment</li> </ul>	<p><b>2.0 - RFP released in 2017, begins July 2018</b></p> <ul style="list-style-type: none"> <li>■ <b>Overview:</b> Regional Accountable Entities (RAEs) replace the RCCOs, and will be responsible for care coordination, practice support and for providing behavioral health services</li> <li>■ <b>Scope of service:</b> Coordination of physical health and provision of behavioral health</li> <li>■ <b>Payment model:</b> Monthly care coordination and behavioral health management payments that vary based on level of performance and population (e.g., children, adults, etc.)</li> <li>■ <b>Quality performance:</b> Eight measures tied to payment</li> <li>■ Alignment with other state and federal initiatives, including MACRA, CPC+, and the Colorado Opportunity Framework</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>MINNESOTA</b></p>	<p><b>1.0 - Minnesota Integrated Health Partnerships (2013)</b></p> <ul style="list-style-type: none"> <li>■ <b>Number of ACOs:</b> 21</li> <li>■ <b>Covered lives:</b> 460,000</li> <li>■ <b>Overview:</b> Provider-led organizations with two tracks: (1) Integrated IHP: larger systems with upside/downside payment options; and (2) Virtual IHP: smaller systems with upside only payment</li> <li>■ <b>Scope of service:</b> Physical health, behavioral health, and pharmacy</li> <li>■ <b>Payment model:</b> Shared savings</li> <li>■ <b>Quality performance:</b> 22 measures; start with pay-for-reporting and increasingly linked to quality performance over three-year contract</li> </ul>	<p><b>2.0 - RFP Released in 2017, began January 2018</b></p> <ul style="list-style-type: none"> <li>■ <b>Overview:</b> New options allow wider spectrum of providers: (1) Track 1: smaller providers and care coordination entities that receive quarterly population-based payment (PBP), does not include a TCOC risk arrangement, responsible for a set of metrics including health equity, utilization, and clinical care; and (2) Track 2: larger, integrated systems that receive PBP, including a TCOC risk arrangement that requires downside risk</li> <li>■ <b>Scope of service:</b> Physical health, behavioral health, and pharmacy</li> <li>■ <b>Payment Model:</b> Shared savings for Track 2; introduction of quarterly PBP available to Tracks 1 and 2</li> <li>■ <b>Quality performance:</b> Quality measurement includes more domains across patient care. For Track 2, 50% of savings payouts contingent on care quality; health IT; and pilot measures. Focus on alignment with MACRA/MIPS</li> <li>■ Increased focus on social determinants by incentivizing community partnerships and inclusion of health equity metrics</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>OREGON</b></p>	<p><b>1.0 - Oregon Coordinated Care Organizations (2012)</b></p> <ul style="list-style-type: none"> <li>■ <b>Number of ACOs:</b> 16</li> <li>■ <b>Covered lives:</b> Nearly 1 million</li> <li>■ <b>Overview:</b> Regional provider/payer/community partnerships</li> <li>■ <b>Scope of service:</b> Physical, behavioral, and oral health</li> <li>■ <b>Payment model:</b> Global budget, capitated payment with no savings / loss caps</li> <li>■ <b>Quality measurement:</b> Quality incentive based on CCO performance on 17 measures</li> </ul>	<p><b>2.0 - New 1115 Waiver (2017)</b></p> <ul style="list-style-type: none"> <li>■ <b>Overview:</b> Retains regional provider/payer/community partnerships model</li> <li>■ <b>Scope of services:</b> Physical, behavioral, and oral health; automatic enrollment of dually eligible beneficiaries, rather than opt-in</li> <li>■ <b>Payment model:</b> Retains global budgets, revised rate-development process to improve accounting for health-related services</li> <li>■ <b>Quality measurement:</b> Quality incentive based on CCO performance on 17 measures</li> <li>■ Move toward increased value-based contracting between CCOs and providers</li> </ul>
<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>VERMONT</b></p>	<p><b>1.0 - Vermont Medicaid Shared Savings Program (2014)</b></p> <ul style="list-style-type: none"> <li>■ <b>Number of ACOs:</b> 2</li> <li>■ <b>Covered lives:</b> 79,000</li> <li>■ <b>Overview:</b> Provider-led model based largely on the Medicare Shared Savings Program with two payment tracks (1) upside only; and (2) upside/downside</li> <li>■ <b>Scope of services:</b> Include physical health, and optional behavioral health, pharmacy, and LTSS</li> <li>■ <b>Payment model:</b> Shared savings</li> <li>■ <b>Quality performance:</b> 28 measures, 8 tied to payment</li> </ul>	<p><b>2.0 - Vermont Medicaid Next Generation ACO (2017)</b></p> <ul style="list-style-type: none"> <li>■ <b>Number of ACOs:</b> 2</li> <li>■ <b>Covered lives:</b> 30,000</li> <li>■ <b>Overview:</b> Provider-led with model based largely on Medicare Next Generation ACO model</li> <li>■ <b>Scope of service:</b> Physical health</li> <li>■ <b>Payment model:</b> Prospective capitation plus a quality withhold, with a risk corridor capped at 3% savings/losses</li> <li>■ <b>Quality performance:</b> Withhold increases from 0.5% to 3% over 3 years; tied to performance on 10 out of 12 measures</li> </ul>

Source: CHCS interviews with state Medicaid agency officials and analysis of state documents.

## 2. Maximizing Provider Participation and Program Sustainability

A number of states have also revised their payment models to attract more provider participants. Rhode Island is planning several enhancements to the shared savings payment model that it used under its ACO pilot program for the full program launch in 2018. Modifications include adding historical savings from prior years into the cost of care benchmark so that AEs can retain a portion of savings generated in past years, and offering upward adjustments to the cost of care benchmark for historically efficient providers to help “sweeten the pot.”<sup>54</sup>

Massachusetts also intends to move its payment model over time to an approach in which all ACOs are, after accounting for the risk profile of the members they serve, accountable to the same market-based total cost of care standard; this is in lieu of using an ACO-specific benchmark based on each ACO’s historical spending.<sup>55</sup> As noted above, Vermont moved away from shared savings to prospective capitation in 2017, in part because of the perception that the ACOs had “maxed out” on their shared savings potential under the Medicaid Shared Savings Program. Only one of the two ACOs participating in the Medicaid Shared Savings Program opted to participate in the Medicaid Next Generation program. Under that program, Vermont requires contracted ACOs to distribute quality incentive pool funds to network providers based on performance on quality measures, ensuring that the quality withhold payments “trickle-down” to individual providers participating in the ACO, and do not remain at the executive or administrative level.

Similarly, Oregon’s waiver renewal requires the state to promote VBP arrangements designed to improve quality and manage cost growth through CCO contracts, and continue to offer health-related services to replace or reduce the need for medical services. As CCOs offer health-related services that are more cost-effective than Medicaid state plan services, the growth rate for CCOs’ capitation rates should gradually decrease over time. For example, providing an air conditioner for an individual with congestive heart failure who lives in a building without air conditioning can prevent future spending on hospitalizations, since a hot day can put unnecessary strain on the cardiovascular system. These kinds of initiatives are generally designed to help reduce utilization of unnecessary and expensive services, such as inpatient hospitalizations and ED use. To help address concerns about “premium slide,” Oregon is exploring mechanisms to account for quality and efficiency outcomes, including developing capitation rates with a profit margin that varies by CCO, as opposed to a fixed percentage of premium for each CCO. The capitation rates for high-performing CCOs (i.e., those that show quality improvement and cost reduction) could have a higher percentage of profit margin built into their capitation rates than lower performing CCOs. Oregon has not yet determined the details for how this will be calculated or what CCOs will have to report in order to receive this additional incentive.

## 3. Expanding Services within the Medicaid ACO Model

Many states are incorporating additional services into their ACO model, such as behavioral health, long-term services and supports (LTSS), dental, pharmacy, and social services (see Exhibit 10, page 16). Expansion of services is critical to the success of Medicaid ACOs given that many high-need, high-cost Medicaid patients typically have needs beyond basic physical health, such as substance use disorders and LTSS, which are often not well-served in the current fragmented health care system. States use multiple levers in their Medicaid ACO programs to drive coordination and incorporation of additional services, including: (1) expanded service types in the payment model; (2) incorporating quality measures related to expanded service types; (3) requiring or encouraging ACOs to partner

with providers that offer expanded services; (4) including expanded services as part of the ACO’s care management responsibilities; and (5) offering data and other technical support on expanded services to ACOs.

### Exhibit 10: The Expanding Scope of Services in Medicaid ACO 2.0 Programs

Several states are using ACO program levers to achieve higher levels of service integration as they evolve their Medicaid ACO programs. Following are brief overviews of five state models:



- **Colorado:** Beginning in 2018, Colorado’s Accountable Care Collaborative will combine the administration and management of primary care and behavioral health under a single entity to encourage provider integration.<sup>56</sup> Colorado will also include non-physical health quality measures in its required ACO measurement set, including behavioral health engagement and dental visits.<sup>57</sup>
- **Massachusetts:** MassHealth requires Medicaid ACOs to contract with Community Partners—behavioral health and LTSS entities—to help provide coordinated care to members.<sup>58</sup> MassHealth plans to measure ACOs on select quality measures not related to physical health, such as social service screenings, as well as the use of the Community Partners. The program also incorporates social factors into ACO rate setting, such as level of poverty and unemployment in the patient’s zip code.<sup>59</sup>
- **Minnesota:** Minnesota seeks IHPs that are mindful of the impact of social determinants and rewards them accordingly. IHPs that enter into meaningful partnerships to address social determinants of health may be eligible for non-reciprocal risk arrangements (i.e., greater upside than downside potential). Minnesota also plans to incorporate social factors into ACO rate setting, as required by legislation,<sup>60</sup> and is planning to share data with ACOs on social factors related to attributed patients.
- **Oregon:** Since 2012, Oregon’s CCOs have been paid a global budget covering a wide-range of services, including physical, behavioral, and oral health. Under Oregon’s recently renewed 1115 waiver, CCOs are encouraged to increase the provision of health-related services and value-based payments and address their members’ social determinants of health.<sup>61</sup>
- **Rhode Island:** Rhode Island’s AEs must have the capacity to address social determinants of health and to provide “nonmedical services that impact a member’s health and ability to access care (e.g., housing, food).”<sup>62</sup> Rhode Island is also developing an LTSS-focused ACO pilot program to encourage partnerships between LTSS providers—including nursing facilities, assisted living facilities, adult day care, and other home- and community-based providers—and support collaborative integrated care delivery systems.

*Source: CHCS interviews with state Medicaid agency officials and analysis of state documents.*

Providing more comprehensive service integration within ACOs can also introduce other challenges. For example, several states highlighted variation in provider readiness to integrate into an ACO model, as well as cultural differences across non-physical health care providers, such as social service, behavioral health, and LTSS providers. To address provider readiness, one of the explicit goals of the MassHealth Community Partners program is to help build the capacity of behavioral health and LTSS providers by helping to invest in enhanced information technology and data analytics.<sup>63</sup> Medicaid ACOs that incorporate expanded services can also conflict with another key delivery system and payment reform goal — multi-payer alignment. In Vermont, for example, the state envisions evolving its Medicaid ACO program over time by adding services, such as mental health and substance use disorder treatment. To do so, it may need to design a total cost of care benchmark methodology that differs across payers, given that Medicare and commercial payers

generally do not include behavioral health services, and rather focus on more traditional medical health services, such as inpatient hospital care, skilled nursing facility, laboratory tests, and outpatient care.

#### 4. Focusing on Fewer and More Aligned Quality Measures

States monitor and update their selected quality measures to ensure they represent current priorities and can yield the highest impact in terms of opportunities for improvement and/or potential cost savings. For example, Colorado has changed the focus of quality measures due to a changing enrollee mix and successes that the RCCOs have had in addressing the needs identified by the state. For example, Colorado dropped a key performance indicator (KPI) focused on the use of high-cost imaging after several years of improvement on this measure and added a well-child checkup KPI as more children entered the program. Oregon's quality measures are selected by a committee established by state legislation that includes three members at large, three with health outcomes expertise, and three CCO representatives.<sup>64</sup> Oregon's CCOs have generally improved the care delivered to their beneficiaries, particularly with respect to prevention and wellness for children and adolescents; ED and hospital use; and avoiding low-value care.

It has been recommended that the state now use a larger quality pool and higher performance standards to drive improvement in areas with relatively little progress — such as access to primary care and integration of physical, behavioral, and oral health care — by raising standards or introducing new measures in these areas.<sup>65</sup>

As Medicaid ACO programs have evolved, there has also been an increased focus on using a smaller number of high-impact, population-health focused quality metrics that align with other delivery system and payment reform initiatives where possible. In general, these steps will relieve provider burden associated with the time and expense of collecting and reporting clinical quality data. For example, Vermont has reduced the number of quality measures from 28 under the state's original Medicaid Shared Savings Program to 12 measures under the Medicaid Next Generation ACO model, which align with other payers in the state.<sup>66</sup> Minnesota and Colorado have also sought to align their Medicaid ACO program quality measures with those used in the Merit-based Incentive Performance System (MIPS) track of CMS' Quality Payment Program. An increasing number of states have also begun testing "pilot" measures for non-physical-health services, such as substance use and social determinants, as they have expanded the scope of services in their Medicaid ACO programs.

## Future of Medicaid ACO Programs

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Despite uncertainty in Medicaid policy and financing, states continue to pursue and evolve their Medicaid ACO programs. If designed well, ACOs can provide an effective vehicle for moving providers away from fee-for-service payments and toward more sophisticated VBP models, such as shared savings models with upside/ downside risk and population-based payments. With 12 states currently running statewide Medicaid ACO programs, and at least 10 more exploring or actively pursuing this option, Medicaid ACO programs will be part of the health care landscape for the foreseeable future. Several developments in the current U.S. health policy landscape point toward the potential for increased Medicaid ACO activity moving forward. PCMH initiatives currently operate in 30 state Medicaid programs,<sup>67</sup> yet some evaluations have found no or minimal impact of these initiatives on reduced costs and improved quality of care.<sup>68</sup> As PCMH programs, an increasing number of states may turn toward ACOs as a natural next step for transitioning PCMHs into organizations with even greater accountability for cost and quality. Further, under MACRA, provider interest in participating in more advanced VBP models that involve downside risk is likely to grow.

Another key consideration is how Medicaid ACO programs will interact with states operating in a managed care environment, given that 39 states now use risk-based managed care contracting for at least some portion of their Medicaid beneficiaries.<sup>69</sup> According to a recent survey of Medicaid directors, 13 states had VBP requirements in MCO contracts as of fiscal year 2017, and nine more were pursuing such requirements for fiscal year 2018.<sup>70</sup> Given the incentives that such contracting approaches offer, some state policymakers are weighing the tradeoffs between a standardized, state-run Medicaid ACO program over a more laissez-faire approach that allows plans and providers to contract on their own terms. It is unclear whether statewide ACO programs accelerate or hinder achievement of these VBP targets.

Finally, at the federal level, states currently pursuing Medicaid ACO programs are also trying to read the tea leaves in an administration that is generally supportive of the continued move toward VBP, but has signaled that federal funding for payment and delivery system reforms will not be as readily available as it was under the previous administration. As a result, states currently exploring or pursuing Medicaid ACOs are trying to figure out how to support such initiatives without the kinds of federal funding generally available to states implementing earlier Medicaid ACO programs. A recent study on the impact of Colorado's and Oregon's respective Medicaid ACOs programs is encouraging in that it concluded that significant federal investments might not be necessary for success. While there are a lot of unknowns moving forward, one thing is certain: ongoing concern about the high-cost and poor outcomes of health care in the U.S. continues to create an impetus for states to seek ways to do more with less. Medicaid ACOs — offering increasingly demonstrated success in bending the cost curve while maintaining or improving quality of care — are one viable option for achieving those goals.

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## 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. It 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](http://www.chcs.org).

## ADDITIONAL RESOURCES

State-based Medicaid ACOs are becoming increasingly prevalent, with more states pursuing this model as a way to improve health outcomes and control costs. CHCS' Medicaid Accountable Care Organization Resource Center, made possible through The Commonwealth Fund, houses practical resources to help states design, implement, and refine ACO programs. Visit [www.chcs.org/aco-resource-center](http://www.chcs.org/aco-resource-center).

## ENDNOTES

- <sup>1</sup> R. Houston and T. McGinnis. Accountable Care Organizations: Looking Back and Moving Forward. Center for Health Care Strategies. January 2016. Available at: <https://www.chcs.org/media/ACOs-Looking-Back-and-Moving-Forward.pdf>.
- <sup>2</sup> D. Muhlenstein, R. Saunders, and M. McClellan. "Growth of ACOs and Alternative Payment Models in 2017," Health Affairs Blog, June 28, 2017, available at: <http://www.healthaffairs.org/doi/10.1377/hblog20170628.060719/full/>.
- <sup>3</sup> Ibid.
- <sup>4</sup> Fast Facts: All Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs). Centers for Medicare & Medicaid Services. January 2017. Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>.
- <sup>5</sup> Next Generation Accountable Care Organization Model (Next Generation ACO Model) Fact Sheet. Centers for Medicare and Medicaid Innovation. Available at: <https://innovation.cms.gov/Files/fact-sheet/nextgenaco-fs.pdf>.
- <sup>6</sup> Muhlenstein, et al., op.cit.
- <sup>7</sup> Ibid.
- <sup>8</sup> For more information about the Medicaid Accountable Care Learning Collaborative, visit <https://www.chcs.org/project/medicaid-accountable-care-organization-learning-collaborative-phase-iv/>.
- <sup>9</sup> M. Bailit and C. Hughes. Key Design Elements of Shared-Savings Payment Arrangements. The Commonwealth Fund. August 2011. Available at: [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Aug/1539\\_Bailit\\_key\\_design\\_elements\\_sharedsavings\\_ib\\_v2.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Aug/1539_Bailit_key_design_elements_sharedsavings_ib_v2.pdf)
- <sup>10</sup> State Medicaid Director Letter re: Integrated Care Models (SMDL#12-001). Centers for Medicare & Medicaid Services. July 10, 2012. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-12-001.pdf>; State Medicaid Director Letter re: Policy Considerations for Integrated Care Models (SMDL#12-002). Centers for Medicare & Medicaid Services. July 10, 2012. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-12-002.pdf>; and State Medicaid Director Letter re: Shared Savings Methodologies (SMDL#13-005). Centers for Medicare & Medicaid Services. August 30, 2013. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-005.pdf>.
- <sup>11</sup> The federal Medicaid managed care regulations published in May 2016 also expressly permit states to require managed care organizations to use specific value-based payment models, such as ACOs, although this approach requires written approval from CMS prior to implementation.
- <sup>12</sup> 81 C.F.R. 88 (Part II, 2016). Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>.
- <sup>13</sup> A. Van Vleet, and J. Paradise. The State Innovation Models (SIM) Program: An Overview. Kaiser Family Foundation. December 2014. Available at: <https://www.kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-an-overview/>.
- <sup>14</sup> A. Gates and R. Rudowitz. An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers. Kaiser Family Foundation. September 2017. Available at: <https://www.kff.org/report-section/an-overview-of-delivery-system-reform-incentive-payment-waivers-issue-brief/>.
- <sup>15</sup> While some states used federal funding specifically to design, implement, and/or expand Medicaid ACO programs, others allocated funding for multiple purposes, including activities not directly related to ACO programs, such as collection of public health data or workforce development. Maine was the only state to report the estimated amount of federal funding specifically designated for the design of its ACO program.
- <sup>16</sup> Oregon House Bill 2650. (2011). 76<sup>th</sup> Oregon Legislative Assembly, Regular Session. Available at: <http://ssl.csg.org/dockets/2013cycle/33Bbills/2133b05aorcoordinatedcarehb3650.en.pdf>.
- <sup>17</sup> New Jersey Public Law, 2011, No. 114. Available at: [http://www.njleg.state.nj.us/2010/Bills/PL11/114\\_.pdf](http://www.njleg.state.nj.us/2010/Bills/PL11/114_.pdf).
- <sup>18</sup> Maine State Plan Amendment, 2014. Attachment 3.1-A, page 12. Available at: [http://www.maine.gov/dhhs/oms/pdfs\\_doc/vbp/AC/Coverage\\_Section3\\_1A\\_AC\\_SPA5914.pdf](http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/Coverage_Section3_1A_AC_SPA5914.pdf).
- <sup>19</sup> Maine officials estimated that less than \$2 million of the \$33 million SIM grant was used to help design the state's ACO program.
- <sup>20</sup> MassHealth 1115 Waiver Approval – Factsheet. November 4, 2016. Available at: <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/ma-1115-waiver-factsheet.pdf>.
- <sup>21</sup> An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation. 2012 Mass. Acts 224. Available at: <https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>.
- <sup>22</sup> MassHealth 1115 Waiver Approval – Factsheet. November 4, 2016. Available at: <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/ma-1115-waiver-factsheet.pdf>.
- <sup>23</sup> Ibid.
- <sup>24</sup> V. Wachino. Center for Medicare & Medicaid Services approval letter. October 20, 2016. Available at: <https://lintwvpri.files.wordpress.com/2016/11/ri-medicaid-approval-letter-10-20-2016.pdf>.
- <sup>25</sup> Department of Vermont Health Access. Vermont Medicaid State Plan Amendment public notice. July 6, 2015. Available at: <http://dvha.vermont.gov/administration/1aco-ssp-public-notice-year-2-2015-6july15.pdf>.
- <sup>26</sup> For more information about Medicare ACOs, see: Accountable Care Organizations (ACO). Centers for Medicare & Medicaid Services. Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html>.

- <sup>27</sup> Beyond the state Medicaid ACO officials with whom we spoke, the organization Community Catalyst produced a checklist for consumer advocates to inform their efforts to ensure ACO programs reflect community needs: Community Catalyst (2017). Medicaid ACO Checklist for Advocates. Available at: <https://www.communitycatalyst.org/resources/publications/document/medicaid-aco-checklist-for-advocates-final.pdf>.
- <sup>28</sup> J. Kushner, et al. Evaluation of Oregon's 2012-2017 Medicaid Waiver: Final Report. Oregon Health & Science University, Center for Health Systems Effectiveness. December 2017. Available at: <http://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf>.
- <sup>29</sup> 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-program-continues-record-savings-improved-outcomes.pdf>; Colorado Department of Health Care Policy & Financing. Creating a Culture of Change: Accountable Care Collaborative 2014 Annual Report. 2014. Available at: <https://www.pcpcc.org/resource/creating-culture-change-accountable-care-collaborative-2014-annual-report>.
- <sup>30</sup> MaineCare Services. "Accountable Communities (AC) Initiative." Available at: <http://www.maine.gov/dhhs/oms/vbp/accountable.html>.
- <sup>31</sup> Outcomes-Based Purchasing Redesign and Next Generation IHP. November 15, 2017. Available at: [https://mn.gov/dhs/assets/request-for-comment-outcomes-based-purchasing-redesign\\_tcm1053-318160.pdf](https://mn.gov/dhs/assets/request-for-comment-outcomes-based-purchasing-redesign_tcm1053-318160.pdf).
- <sup>32</sup> Under terms of its agreement with CMS, Oregon's annual per member per month Medicaid expenditures cannot exceed 4.4 percent in Year 2 of the demonstration, and cannot exceed 3.4 percent in Year 3 and beyond. Cost growth without transformation was estimated at 5.4 percent per member per month annually. See <http://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/HST%20Annual%20Report%20-%202016.pdf>.
- <sup>33</sup> 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>.
- <sup>34</sup> 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>.
- <sup>35</sup> K.J. McConnell, S. Renfro, R.C. Lindrooth, D. Cohen, N. Wallace and M. Chernew. Oregon's Medicaid Reform And Transition To Global Budgets Were Associated With Reductions In Expenditures. *Health Affairs* 36, no.3 (2017):451-459.
- <sup>36</sup> Ibid.
- <sup>37</sup> K.J. McConnell, S. Renfro, B.K.S Chan, T.H.A. Meath, A. Mendelson, D. Cohen, J. Waxmonsky, D. McCarty, N. Wallace, and R.C. Lindrooth. "Early Performance in Medicaid Accountable Care Organizations: A Comparison of Oregon and Colorado." *JAMA Internal Medicine* 177, no. 4 (2017): 538-545.
- <sup>38</sup> Ibid.
- <sup>39</sup> B. Bodaken, et al. Sustainable Success in Accountable Care. National Academy of Medicine. April 2016. Available at: <https://nam.edu/wp-content/uploads/2016/04/Sustainable-Success-in-Accountable-Care.pdf>.
- <sup>40</sup> R. Houston and T. McGinnis. Program Design Considerations for Medicaid Accountable Care Organizations. Center for Health Care Strategies. February 2016. Available at: <https://www.chcs.org/media/Program-Design-Considerations-for-Medicaid-Accountable-Care-Organizations.pdf>.
- <sup>41</sup> T. McGinnis, R. Houston, and D. Brown. The Balancing Act: Integrating Medicaid Accountable Care Organizations into a Managed Care Environment. November 2013. Available at: [https://www.chcs.org/media/ACO111313\\_Final.pdf](https://www.chcs.org/media/ACO111313_Final.pdf).
- <sup>42</sup> D. DeLia, M.J. Yedidia, and O. Lontok. Year 1 of the New Jersey Medicaid Accountable Care Organization Demonstration Project: Assessment of Operations and Care Management Strategies. Rutgers University Center for State Health Policy. February 2017. Available at: <http://www.cshp.rutgers.edu/Downloads/11150.pdf>.
- <sup>43</sup> Ibid.
- <sup>44</sup> Beginning March 2018, Massachusetts will implement three Medicaid ACO models: (1) Accountable Care Partnership Plan — a managed care organization (MCO) with a closely partnered ACO provider or a single, integrated entity that includes both an ACO provider and an MCO; (2) Primary Care ACO — an ACO provider organization that contracts directly with MassHealth, which remains the insurer; and (3) MCO-Administered ACO — an ACO provider organization that contracts directly with MassHealth-contracted MCOs. MassHealth's ACOs are anticipated to be evaluated on 39 quality measures across seven domains.
- <sup>45</sup> R. Berenson, D. Upadhyay, S. Delbanco, and R. Murray. Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care. Urban Institute and Catalyst for Payment Reform. April 2016 (updated June 2016). Available at: <https://www.urban.org/sites/default/files/publication/80301/2000776-Payment-Methods-How-They-Work.pdf>.
- <sup>46</sup> Beginning March 2018, Massachusetts will implement three Medicaid ACO models: (1) Accountable Care Partnership Plan — a managed care organization (MCO) with a closely partnered ACO provider or a single, integrated entity that includes both an ACO provider and an MCO; (2) Primary Care ACO — an ACO provider organization that contracts directly with MassHealth, which remains the insurer; and (3) MCO-Administered ACO — an ACO provider organization that contracts directly with MassHealth-contracted MCOs. MassHealth's ACOs are anticipated to be evaluated on 39 quality measures across seven domains.
- <sup>47</sup> For more information on Oregon's policies to address premium slide in its CCO program, see the following document, Appendix D: Concept Paper on Increasing Use of Health-Related Services and Value-Based Payments. Available at: <http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/Documents/Waiver-Renewal-Appendices.pdf>.
- <sup>48</sup> House Bill 3650. Health System Transformation. <https://olis.leg.state.or.us/liz/2011R1/Downloads/MeasureDocument/HB3650>.
- <sup>49</sup> McConnell, et al., op cit.

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<sup>50</sup> Ibid.

<sup>51</sup> Public Health, 42 C.F.R. § 2.1 - 2.67 (October 1, 2016). Available at: <https://www.gpo.gov/fdsys/pkg/CFR-2016-title42-vol1/xml/CFR-2016-title42-vol1-part2.xml>. This regulation was designed to minimize stigma associated with receiving treatment for a substance use disorder by reducing concerns about disclosure of records, which may lead to negative consequences such as loss of employment, housing, or child custody; discrimination by medical professionals and insurers; and/or arrest, prosecution, and incarceration.

<sup>52</sup> New Rule Improves the Exchange of Medical Information in Ways that Protect the Privacy of People Receiving Substance Abuse and Mental Health Services Administration. January 13, 2017. Available at: <https://www.samhsa.gov/newsroom/press-announcements/201701131200>.

<sup>53</sup> Rhode Island Medicaid Accountable Entity Program Attachment L 1: Accountable Entity Total Cost of Care Requirements. Rhode Island Executive Office of Health and Human Services. September 2017. Available at: [http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Attachment\\_L1\\_Total\\_Cost\\_of\\_Care\\_Requirements\\_Final\\_092917.pdf](http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Attachment_L1_Total_Cost_of_Care_Requirements_Final_092917.pdf)

<sup>54</sup> Ibid.

<sup>55</sup> For more information, see “ACO Rate and Benchmark Setting Methodology” at the [MassHealth ACO procurement link](https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-0000009207&external=true&parentUrl=bid) available at: <https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-0000009207&external=true&parentUrl=bid> and the Summary of Pricing Methodology for ACOs and MCOs available at <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/170208-summary-pricing-methodology-aco-and-mco.pdf>.

<sup>56</sup> The Route to the RAEs: Analyzing the Next Phase of Medicaid’s Accountable Care Collaborative in Colorado. Colorado Health Institute. July 2017. [https://www.coloradohealthinstitute.org/sites/default/files/file\\_attachments/ACC%20Phase%20Two\\_0.pdf](https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/ACC%20Phase%20Two_0.pdf).

<sup>57</sup> Regional Accountable Entity for the Accountable Care Collaborative: Request for Proposals. Colorado Department of Health Care Policy & Financing. Released May 11, 2017. Available at: <https://www.colorado.gov/pacific/sites/default/files/Regional%20Accountable%20Entity%20for%20the%20Accountable%20Care%20Collaborative%20RFP%20Body.pdf> (see p.133).

<sup>58</sup> MassHealth Payment and Care Delivery Innovation: Community Partners Open Meeting. Executive Office of Health & Human Services. February 2017. Available at: <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/170210-community-partners-meeting.pdf>.

<sup>59</sup> Quality Measurement Approaches of State Medicaid Accountable Care Organization Programs. Center for Health Care Strategies. May 2017. Available at: <https://www.chcs.org/resource/quality-measurement-approaches-medicare-accountable-care-organizations/>.

<sup>60</sup> Accounting for Social Risk Factors in Minnesota Health Care Program Payments: Phase I Initial Findings. Health Care Administration. April 2016. Available at: <https://www.leg.state.mn.us/docs/2016/mandated/160992.pdf>.

<sup>61</sup> Oregon Health Plan. Medicaid and State Children’s Health Insurance Program Section 1115 (a) Medicaid demonstration extension. January 12, 2017. Available at: <http://www.oregon.gov/oha/HPA/HP-Medicaid-1115-Waiver/Documents/Waiver%202017.pdf>.

<sup>62</sup> Transitioning to Alternative Payment Methodologies: Requirements for Medicaid Managed Care Organizations. Rhode Island Executive Office of Health and Human Services. June 2016. Available at: <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/2016Library/RIEOHSTransitioningAPMRequirementsforMedicaidMCOs.pdf>.

<sup>63</sup> “MassHealth Selects 26 Community Partners to Help Improve Health Care for 60,000 Members.” Massachusetts Department of Health and Human Services Press Release. April 28, 2017. Available at: <http://www.mass.gov/eohhs/gov/newsroom/press-releases/eohhs/masshealth-selects-26-community-partners.html>.

<sup>64</sup> Oregon Metrics and Scoring Committee Charter. Available at: <http://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/Metrics%20Scoring%20Committee%20Charter.pdf>.

<sup>65</sup> Kushner, et al., op.cit.

<sup>66</sup> Quality Measurement Approaches of State Medicaid Accountable Care Organization Programs. Center for Health Care Strategies. May 2017. Available at: <https://www.chcs.org/resource/quality-measurement-approaches-medicare-accountable-care-organizations/>.

<sup>67</sup> Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018. The Henry J. Kaiser Family Foundation and National Association of Medicaid Directors. October 2017. Available at: <http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018>.

<sup>68</sup> J. Wiener, M. Romaine, and M. Musmeci. Can States Substantially Reduce Medicaid Spending Through Delivery System and Financing Reform? Health Affairs Blog. September 7, 2017. Available at: <http://www.healthaffairs.org/doi/10.1377/hblog20170907.061828/full/>.

<sup>69</sup> S. Rosenbaum, S. Schmucker, S. Rothenberg, R. Gunsalus, and J. Beckerman. Medicaid Payment and Delivery System Reform: Early Insights from 10 Medicaid Expansion States. The Commonwealth Fund. October 2017. Available at: [http://www.commonwealthfund.org/~media/files/publications/issue-brief/2017/oct/rosenbaum\\_insights\\_10\\_medicare\\_expansion\\_states\\_ib.pdf](http://www.commonwealthfund.org/~media/files/publications/issue-brief/2017/oct/rosenbaum_insights_10_medicare_expansion_states_ib.pdf).

<sup>70</sup> Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018. The Henry J. Kaiser Family Foundation and National Association of Medicaid Directors. October 2017. Available at: <http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018>.