The Rise and Future of Medicaid ACOS

No two models nor markets are alike, and the pace and prevalence of Medicaid accountable care growth will largely depend on states’ ability to generate savings and successfully overcome common and unique challenges over the long run. This paper contains a state-by-state landscape analysis.

Themes, Trends and Takeaways
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EXECUTIVE SUMMARY

Call it what you may—ACO, ACE, CCO, CCE, or RCCO—Medicaid accountable care initiatives are on the rise. Although the accountable care concept was largely launched first within Medicare and the commercial sector, state-designed and Medicaid related care coordination, value based payment, and quality improvement efforts have increased steadily over the past several years. Oregon, Colorado, and Utah have the longest operational Medicaid accountable care programs, and several other states have recently either secured legislative support or operationalized efforts to incentivize quality care, reward positive patient outcomes, and lower costs. Local policy, demographic, and operational dynamics are shaping each state’s approach and contributing to a variety of models.

For simplicity’s sake, we will refer to the various state Medicaid accountable care models as ACOs. In this white paper, we will first provide background behind the movement and define some of the commonalities of state-sponsored Medicaid ACOs. We will also distinguish them from traditional managed Medicaid models. We will then discuss the emerging trends and pressures that are incentivizing states to move beyond traditional Medicaid managed care. We will next highlight different Medicaid accountable care initiatives occurring around the country and characterize areas where states likely have the most needs moving forward. Lastly, we will discuss the dynamics that will most likely influence the pace and prevalence of Medicaid ACO formation in upcoming years.

MEDICAID ACOS: BACKGROUND AND DEFINITIONS

Medicaid is America’s public insurance program for low-income Americans, and along with the Children’s Health Insurance Program (CHIP), covers over 70 million individuals in the United States. Many of these beneficiaries are among the most vulnerable, including low-income pregnant women, people with physical and mental disabilities, individuals with chronic diseases, and seniors. Nearly two-thirds of all Medicaid enrollees participate in some form of managed care—either through risk-based managed care organizations (MCOs) or primary care case management (PCCM) programs. Approximately half of Medicaid beneficiaries are enrolled in comprehensive risk-based plans, the equivalent of commercial Health Maintenance Organizations (HMOs).

Medicaid: At a Glance

- Covers over 71M people
- 8% of federal spending
- Recipients include seniors, people with disabilities, children, pregnant women, adults with (and sometimes without) dependent children
- 2/3 of beneficiaries participate in some form of managed care
- ACA expanded Medicaid eligibility in 2014 (optional)
- 10.7M dual-eligible recipients

In Medicare and commercial markets, Leavitt Partners defines accountable care organizations (ACOs) as any group of health care providers that assumes responsibility for the provision of care and works to achieve quality and financial benchmarks for a defined population. ACOs can be both government and commercial sponsored in nature. The Affordable Care Act of 2010 (ACA) formally recognized the Medicare
Shared Savings Program as an ACO as well as pediatric ACOs within Medicaid and/or CHIP. While the pediatric ACOs never really took off, states have begun to experiment with a number of different Medicaid accountable care models.

Medicaid ACOs are not synonymous with traditional Medicaid managed care. No one definition for Medicaid ACOs exists, and as demonstrated below, their parameters vary from state to state. However, they all share common characteristics in that they promote and incentivize patient-centered health care, care coordination, and improved outcomes. Medicaid ACOs generally differ from previous Medicaid managed care efforts in that many states are more directly engaging providers by having them assume risk and be more collectively responsible for their enrolled patient populations.

In the past, MCOs and HMOs acted as third parties that contracted with doctors and care providers to offer care to a defined patient base. The MCO or HMO assumed all risk if costs exceeded monthly benchmarks per person and earned profits if costs fell below targets. In current Medicaid models, providers are increasingly assuming financial risk and engaging in alternative payment models either through direct state contracts or through contracts with Medicaid managed care plans. As an incentive to assume responsibility, providers are often encountering opportunities to share in savings associated with quality improvements and positive care outcomes.

Most Medicaid ACO models include one or more of three payment arrangements: (1) enhanced per member per month (PMPM) payments, (2) shared savings, or (3) global payments. Enhanced PMPM payments, typically in the range of $4-$10, enable providers to invest in health IT infrastructure and engage in social services. Colorado’s Regional Care Collaborative Organizations (RCCO) receive PMPM payments each month for attributed members. Shared savings and global payment metrics can incentivize value-based care but also tie savings to quality metrics. Vermont has created an “encourage-incent-require” program to calculate the total cost of care of a three-year period. Providers can increase their shared savings from 50 percent to 60 percent over time by offering additional services including non-emergency transportation. Oregon’s Coordinated Care Organizations (CCO)—multi-participant entities that include payers, providers, and county health and human services departments—receive a global budget that covers beneficiaries’ physical, behavioral, and dental needs. Oregonwitholds an increased percentage every year that participating entities can earn back if they meet quality targets.

Like traditional MCOs and HMOs, ACOs also disincentivize volume-based medicine. ACOs accomplish this by making care quality a focal piece of reporting and care delivery. Common areas states measure in terms of care quality include: (1) chronic disease, (2) emergency department use, (3) inpatient admission and readmission, (4) well-child visits, (5) patient experience, and (6) behavioral health. Medicaid ACO reporting requirements often reflect requirements used in Meaningful Use, the Children’s Health Insurance Program Reauthorization Act (CHIPRA), Adult Care, and Medicare ACO measures as well as measures promoted by national performance agencies including the National Committee for Quality Assurance (NCQA), National Quality Forum, and the Agency for Healthcare Research and Quality (AHRQ). At a minimum, quality measure requirements can involve basic collection and reporting. More advanced models can include achievement thresholds, benchmark comparisons, and/or improvement rates over performance years.
The broader approach state ACOs are taking to patient care by emphasizing care coordination and shared accountability naturally caters to greater inclusiveness and integration of behavioral health and other social services. While behavioral health integration is aspirational for some states, others have begun to integrate it with physical health. For example, mental health, chemical dependency, and dental services are all integrated in Oregon’s CCO program. A number of other states are also taking significant steps to better coordinate physical and behavioral health. These efforts include: (1) shared savings to support physical and behavioral health collaboration, (2) global payments to facilitate case management and rehabilitation services for patients struggling with mental illness, (3) mandates to place behavioral health providers and consumers in ACO governance positions, and (4) data reports to identify high-risk patients.

As part of a movement toward shared accountability, ACOs increasingly involve strategic partnerships between care providers—including primary care doctors, specialists, and, at times, hospitals—who agree on a pre-arranged budget for care delivered across a range of services for a given patient population. States like Illinois have engaged in deliberate efforts to organize care coordination among care team participants in a way that facilitates the appropriate delivery of health care services. These integrated care teams include collaboration and teamwork from a variety of participants, including medical care coordinators, behavioral health care coordinators, social workers, medical directors, connections representatives, program coordinators, and pharmacists.

**THE IMPETUS BEHIND MEDICAID ACO FORMATION**

What pressures are encouraging states to move beyond traditional managed care and create Medicaid ACOs? Several states have expressed concern that the traditional managed care model can no longer achieve fiscal savings or improve client outcomes in ways that meaningfully improve population health. Therefore, states are likely adopting ACOs for two critical reasons:

1. The need to address mounting economic pressures and 2. The need to coordinate care across populations to improve care quality and overall population health.

As for the economic reasons, Medicaid costs consume 23-24 percent of state budgets, and in some states costs exceed 30 percent. A combination of budgetary pressures and a need to identify near-term cost savings are driving ACO cost-containment efforts. Consequently, states are structuring Medicaid ACO payment arrangements to reduce unnecessary and costly acute care visits and incentivize primary care and wellness. Oregon explicitly launched its CCO model with the hope of reducing overall spending and preserving needed resources.

Rather than lower costs by denying care or reducing provider reimbursements, current ACO efforts are empowering and engaging providers and plans. In lieu of cherry-picking the healthiest patients, a growing number of providers and plans are incentivized to target the high-need populations where more opportunities exist to lower population costs.

Many states have also recognized that caring for the most vulnerable citizens, particularly coordinating their health care services, is a vital component to preserving these individuals’ physical and behavioral welfare and necessary to address the health care needs of local residents. Medicaid populations are particularly vulnerable, and several states are implementing ACOs as a mechanism to monitor health care utilization and ensure necessary care for all populations.
improve outcomes. In theory, if ACOs shift incentives from volume to value, medical providers will be incentivized to implement a collaborative culture, share data, and engage in more team-based care. As discussed elsewhere, several states are facilitating this process by requiring and/or incentivizing providers to engage in data sharing and explore alternative financial arrangements.

DEVELOPMENTS IN THE MEDICAID ACO LANDSCAPE

The following figure demonstrates the broad and growing state support for Medicaid ACOs.

Despite the historical and anticipated growth of Medicaid ACOs, most states’ efforts are still relatively nascent as they must undergo lengthy planning processes, accommodate differing stakeholder concerns, and navigate complex federal and state legislative and regulatory requirements in order to implement a Medicaid ACO. And while the Medicaid ACO movement is broadly supported, no two states’ initiatives are alike. States’ ACO experiments depend on their historical relationship with managed care and their own unique challenges associated with their low-income and chronically ill populations. State ACOs differ in their organizational structures, governance, provider eligibility requirements, covered populations, scope of services, required functions, payment models, and quality measures.

As an example, the state of Illinois required that 50 percent of Medicaid clients be enrolled in care coordination programs by 2015. A variety of managed care entities including Accountable Care Entities (ACEs), Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs), and Managed Care Organizations (MCOs) enabled this transformation. Illinois mandated that ACE participants include primary care, specialty care, hospital access, and behavioral health services. They also had a governance structure that includes representation from each provider type. As originally envisioned, the ACEs were to participate on a three-year path to move away from the current fee-for-service (FFS) structure as follows: (1) shared savings during the first 18 months, (2) partial risk after 18 months, and (3) full risk after three years. The ACEs were also expected to construct a supporting infrastructure that includes health information technology, risk assessment tools, data analytics, and communication support with Medicaid members.

North Carolina’s General Assembly proposed to construct a budget model for each state ACO where providers can share in savings if they improve health outcomes.

Key Takeaway

“State ACOs differ in their organizational structures, governance, provider eligibility requirements, covered populations, scope of services, required functions, payment models, and quality measures.”

1 Although Illinois began to implement the supporting infrastructure as outlined above, recent proposed budget cuts for FY 2016 will likely discontinue CCEs and will expedite the transition of ACEs to managed care organizations. However, as of early August 2015, it appears these cuts have yet to be implemented. Illinois Academy of Family Physicians Webinar, May 1, 2015.
Providers would also share in losses if costs exceeded the benchmark. The General Assembly's model builds off of North Carolina’s existing medical home program, which already embraces several ACO-like features, including quality metrics reporting and provider networks that enhance care coordination. It is estimated that North Carolina’s proposed ACO legislation, if implemented, could reduce the state’s $13 billion Medicaid spending by 3 percent or several hundred million dollars.16

The state of Oregon, perhaps the most advanced and operational of all state Medicaid ACOs, has formed a total of 16 CCOs, which cover over 750K lives. Before implementing the CCO model, Oregon had separate delivery systems for physical, behavioral and other types of health care. By moving to CCOs, Oregon developed a patient-centered and team-focused care delivery system that encourages better coordination and emphasizes prevention, chronic disease management, and patient-centered medicine.

As a result, CCO emergency department visits have dropped 13 percent since 2011. The CCOs also lowered hospital admissions for congestive heart failure by 32 percent, chronic obstructive pulmonary disease by 36 percent and adult asthma by 18 percent. Spending for primary care is also up 18 percent.8

Table 1 below compares Oregon’s CCOs with similar initiatives in Colorado and Utah, the two other states with the most established Medicaid accountable care programs. As demonstrated in this table, Oregon uses a global payment mechanism, Colorado uses FFS reimbursement, and Utah uses full capitation. Oregon’s model incorporates traditional services, but also covers behavioral, dental, and pharmacy. Utah covers traditional services and most pharmacy and Colorado only covers traditional services. Oregon and Utah exert penalties for going over budget but Colorado does not.

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>OREGON</th>
<th>COLORADO</th>
<th>UTAH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Approved Organizations</td>
<td>16 (CCOs)</td>
<td>7 (RCCOs)</td>
<td>4 (ACOs)</td>
</tr>
<tr>
<td>Expected Lives</td>
<td>1,100,000</td>
<td>609,051</td>
<td>234,757 and growing with rural expansion</td>
</tr>
<tr>
<td>Services Included</td>
<td>Traditional + behavioral + most pharmacy; dental added July 2014</td>
<td>Traditional</td>
<td>Traditional + most pharmacy</td>
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<tr>
<td>Payment Mechanism</td>
<td>Global payments</td>
<td>FFS</td>
<td>Full capitation</td>
</tr>
<tr>
<td>Federal Waiver</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Penalties</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Populations</td>
<td>Medicaid and CHIP</td>
<td>Traditional pop.</td>
<td>Traditional pop.</td>
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<tr>
<td>Quality Metrics</td>
<td>Yes (17 measures)</td>
<td>Yes (readmissions, imaging, etc.)</td>
<td>Yes (mostly HEDIS-based)</td>
</tr>
<tr>
<td>Provider Incentives</td>
<td>Yes</td>
<td>Yes</td>
<td>TBD by ACO</td>
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<tr>
<td>Projected Savings</td>
<td>Not available</td>
<td>$20 million (est.) for FY2011-2012</td>
<td>$17 million at close of SFY 201420</td>
</tr>
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The tables in Appendix I highlight key Medicaid ACO initiatives and programs among select states. In the tables, we highlight the general program approach, key facts, the number of approved organizations, covered lives, payment model, inception date, and any reported results to date.

**WORK TO BE DONE**

There appears to be at least four core areas where states need the most assistance in rolling out ACOs: (1) understanding how to deploy population health analytics to improve care, (2) integrating behavioral health, (3) integrating long-term services and supports, and (4) addressing dual eligibles.21

At its core, engaging in patient-centered care management and targeting high-risk patients requires data infrastructure and analytics. Population health analytics, however, has traditionally been absent in Medicaid patient care. Consequently, a growing recognition has emerged that ACO providers need timely access to data, capacity to analyze the data, and know-how to translate data into actionable care protocols.22

**Deploying Population Health Analytics**

Studies have found that Medicaid accountable care providers are increasingly using health care analytics to manage population health.21 Many Medicaid accountable care models are encouraging providers to take responsibility not only for the patients they currently serve but also for regional populations surrounding their practices. For example, Colorado has employed a statewide data analytics contractor (SDAC) to collect, aggregate, and share relevant data with providers via a web-based portal. By pooling Medicaid eligibility and claims data across settings, Colorado providers can develop more robust patient profiles as a way to enhance the patient care experience. These profiles can include actionable data that allows practices to segment patients, comprehend patient utilization and spending trends, measure performance, and identify areas to improve care. By forming common metrics to track and share data, providers and other interested stakeholders can more readily track performance, create accountability, and more appropriately distribute performance-based payments.21

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**Medicaid ACO: Key Issues to Address**

**CHALLENGES:**
- Understanding how to deploy population health analytics
- Integrating behavioral health
- Integrating long-term services and supports
- Addressing dual eligibles

**IMPLICATIONS:**
- Difficulty targeting high-risk patients
- Lack of care coordination
- Siloed care
- Increased variation

**Integrating Behavioral Health**

Enhanced data collection, aggregation, and usage capabilities could further states’ efforts to make more meaningful differences for patients who struggle with behavioral health challenges. At the same time, the lack of behavioral health integration limits data sharing and the lack of data sharinglimits behavioral health integration. For example, Colorado and other ACO-sponsoring states cover behavioral health services through a capitated behavioral health carve-out on a regional basis.2 This siloed nature of behavioral health services increases the difficulty of sharing health data and hamstrings behavioral health integration. This can especially be true when provider organizations must negotiate separate agreements with behavioral health providers to obtain behavioral health data. Patient privacy concerns and unknowns related to what can and cannot be shared also complicate physical and behavioral health data integration.21 Furthermore, many behavioral health organizations do not have sophisticated electronic data compilation and sharing capabilities, which undermines their ability to share data across organizational boundary lines.
Coordinating Long-Term Services and Supports

Most value-based reform to date has focused on primary and acute care services provided in physician clinics, hospitals, and outpatient diagnostic centers. For accountable care to become more meaningful from a patient wellness and cost-saving perspective, states will need to experiment with and implement post-acute and long-term services and supports. This encompasses a much broader array of residential, community-based, and in-home services to keep individuals out of more expensive forms of care. But long-term care services have been difficult to integrate due to the inherent logistical and incentive-based challenges associated with communicating across provider settings. Capital constraints and tight operating margins, however, threaten the financial viability of many long-term care organizations unless they can successfully integrate into accountable care models. If states can more effectively incorporate long-term care into their ACOs, then they could potentially enhance chronic disease management, reduce unnecessary emergency room visits and re-hospitalizations, develop more efficient care transitions, and facilitate the pro-active diagnosis and prevention of post-discharge conditions.23

Addressing Dual Eligibles

Lastly, states have largely struggled to coordinate care for “dual eligibles”—low income beneficiaries enrolled in both Medicaid and Medicare. Addressing dual eligibles can be particularly difficult for state accountable care planning. Dual eligibles pose unique challenges as they are typically among the sickest and poorest citizens in a state and are also the highest cost beneficiaries. They often have the most complex medical needs and the highest utilization of long-term care services. Although approximately 15 percent of Medicaid beneficiaries are dual eligibles, they account for nearly 40 percent of all Medicaid costs.2 Although states can mandate participation in ACOs in exchange for certain benefits, Medicare does not authorize such mandates. Identifying how to distribute shared savings between state Medicaid agencies and Medicare is also particularly challenging. Some states, like Oregon, have pursued separate ACO plans for the dual eligible, while other states have excluded this population from enrollment. Still others have neither explicitly excluded nor included them in ACO enrollment.2 As states identify effective ways to address their dual eligible populations, they can alleviate economic pressures and improve overall population health.

THE PACE AND PREVALENCE OF GROWTH

What dynamics will influence the pace and prevalence of Medicaid ACOs? The ability of Medicaid ACOs to avoid unnecessary costs and generate savings will play into the pace and prevalence of their growth. As Medicaid ACO early adopters see some success at controlling Medicaid costs, more states will embrace the movement and follow the lead. Colorado has saved approximately $33 million over the past three years.24 Minnesota launched its Integrated Health Partnership initiatives in 2013, and reportedly saved $10.5 million across all six provider participants within its first year.24 Oregon recently announced that it had awarded $150 million in funds from a quality pool based on baseline data submitted for 11 measures. The Oregon Health Authority (OHA) noted that hospitals are doing well in the area of increased medication safety and post-hospitalization follow-up for mental illness.25 Emergency department visits for patients served by CCOs have decreased 21 percent since 2011.25

It is important to note, however, that Medicaid ACOs are still relatively young and only a few states, Colorado and Oregon, are using them to cover the entire state population. Outlined below are a few areas that may protract or delay Medicaid ACO adoption.

Assuming Risk

States will, of course, experience setbacks as providers struggle to wear multiple hats, manage Medicaid populations that pose unique demographic challenges, confront network difficulties, and innovate with limited resources. For example, juggling provider and insurer roles while simultaneously learning how to generate shared savings will naturally stretch even the most advanced accountable care minded entities. One hospital executive recently raised concerns about providers’ ability to adequately manage risk for Medicaid patients due to their higher prevalence of chronic health issues relative to the general population.3
Outreach Efforts

Medicaid patients also typically have lower health literacy. Outreach efforts can thus be time consuming and intense. States without a strong preexisting managed care infrastructure and well-established physician pay rates will also face a more challenging rollout process.

Stakeholder Engagement

The degree to which states face stakeholder pushback and resistance will also affect the pace at which a market adopts Medicaid ACOs. Oregon included a diverse array of stakeholders in its Medicaid ACO process. The stakeholder collaboration process included eight community events attended by over 1,200 Oregonians, four workgroups with 133 government-appointed representatives, and public feedback elicited through multiple comment periods. In Colorado, one group that initially disfavored the state’s ACO ended up supporting it after productive collaborative events. Other states are seeking less collaboration, which could potentially prolong rollout efforts over the long run.

Legislative and Regulatory Requirements and Timing

Other factors that may protract or delay Medicaid ACO adoption in certain locations include state legislative requirements, the need for implementation guidance and regulatory structure, and the phasing in of different initiatives. For example, the New Jersey legislature quickly passed ACO legislation, but the state confronted delays in syncing the ACO model with its existing Medicaid program and drafting the associated regulations. Although New Jersey’s legislature had authorized grass-roots provider-led accountable care entities, the state desired to maintain the MCOs’ authority to negotiate provider contract terms. Other states have experienced similar delays as they encountered complexities combining ACO initiatives with Medicaid expansion strategies and/or federal waivers.

Data Analytics

Lastly, the ability of providers to deploy resources to make the transition from paper to electronic technology will also affect the growth of Medicaid ACOs. Data analytics are a critical component of providers’ ability to better understand their patients’ unique needs and manage their patients across the care continuum. States like Illinois are working to facilitate the transition from paper to technology by implementing a health information exchange, a private platform that enables providers to more securely share patient data.

CONCLUSION

While the jury is still out on the efficacy of various state-sponsored Medicaid ACOs, few people would question the impact the Medicaid ACO movement is beginning to have across the country. Even though MSSP and Pioneer ACOs have received the lion’s share of press attention, Medicaid ACOs will play a vital role in shaping local market dynamics for the foreseeable future. No two models or markets are alike, and the pace and prevalence of Medicaid ACO growth will largely depend on states’ ability to generate savings and successfully overcome common and unique challenges. How states balance near-term cost-containment objectives with long-term investments needed to redesign care delivery remains to be seen. State lawmakers will need to exercise patience as financial savings and patient outcome improvements will take time. As states establish clear objectives, incentivize providers to develop core capabilities, promote collaboration across the care continuum, and exercise strong leadership, they can enhance their prospects for long-term success.
# APPENDIX I:

## INFORMATION CURRENT AS OF SEPTEMBER

### Medicaid ACO Reforms: Select State Snapshots

#### ALABAMA

1. **Program Approach:** Risk-bearing Regional Care Organizations (RCOs) that will manage a continuum of health care services under a capitated rate.

2. **Key Facts:** A member’s residence determines RCO regional assignment for capitation. RCOs must contract with providers willing to comply with their reimbursement and other requirements. Medicaid will establish a floor for provider payments.

3. **Number of Approved Orgs:** Eleven organizations across the five regions have been granted probationary certification.

4. **Covered Lives:** 800,000

5. **Payment Model:** Capitated payment to RCOs, which determine how to apportion that payment amongst providers in both FFS and at-risk contracts.

6. **Incepted:** May 2013, with the passage of Act 2013-261. 1115 waiver submitted to CMS in May 2014, approval pending.

7. **Planned Implementation:** October 2016

8. **Pay for Performance/Quality Approach:** Still developing. A quality assurance committee aims to complete measures when RCOs begin October 1, 2016.

9. **Coverage Approach:** Beneficiaries are served by the RCO that covers their geographical region. Beneficiaries are assigned to each RCO by Medicaid.

#### ARKANSAS

1. **Program Approach:** Multi-payer program with commercial plans also participating. Payers designate a principal accountable provider (PAP) who bears partial risk through episodes of care (not all care is provided through episodes of care).

2. **Key Facts:** PAPs are responsible for the cost and quality of a beneficiary throughout each episode of care, covering care provided by all providers involved. The first phase of the initiative designated five episodes, and currently 13 are operational.

3. **Covered Lives:** 243,000

4. **Payment Model:** PAPs are eligible for risk- and gain-sharing only for specific episodes. FFS is utilized for all other payments.

5. **Incepted:** 2011, per proposal from Arkansas Dept. of Human Services.

6. **Implementation:** First phase September 2012; a second wave of enrollment occurred in July 2014 and a second phase is planned for 2016.
7) **Pay for Performance/Quality Approach:** PAPs are required to report quality indicators, which differ for each episode type. Providers that do not meet quality targets are not eligible for shared savings.

8) **Coverage Approach:** All state Medicaid enrollees are covered.

9) **Quality Measures:** Different for each episode; no core group for measurement or tracking.

10) **Reported Results:** A June 2014 report shows a 23.2 percent decrease in antibiotics use for upper respiratory infection; an average episode cost decrease of 2.74 percent for heart failure and 29 percent for ADHD.28,29,30,31

### COLORADO

1) **Program Approach:** Seven Regional Care Collaborative Organizations (RCCO) that contract with Primary Care Medical Providers (PCMP) who provide primary care and care coordination.

2) **Key Facts:** Large investment in Medicaid-contracted Statewide Data and Analytics Contractor (SDAC) to analyze performance for the program. Quality measures focus on emergency department (ED) utilization, hospital readmissions, and high-cost imaging.

3) **Number of Approved Orgs:** Seven RCCOs

4) **Covered Lives:** 352,236

5) **Payment Model:** Medicaid program pays $18 PMPM: $12 to the RCCO, $3 to the PCMP and $3 to the SDAC. The agency began withholding $1 PMPM, which RCCOs and PCMPs can earn back for meeting performance standards.

6) **Incepted:** Colorado's Department of Health Care Policy released an RFP for RCCOs in 2010.

7) **Implemented:** Enrollment began in May 2011.

8) **Pay for Performance/Quality Approach:** The agency withholds $1 PMPM to create an incentive pool, which RCCOs and PCMPs can earn back quarterly for meeting performance benchmarks.

9) **Coverage Approach:** Enrollment is voluntary and passive for most patients, though mandatory for adults without children. Rapid month-over-month enrollment growth, from 150,000 in July 2012 to 609,051 in June 2014.

10) **Quality Measures:** Initially focusing on four statewide metrics: ED utilization, hospital readmissions within 30 days, use of high-cost imaging, and average per member per month cost of care.

11) **Reported Results:** According to a 2014 annual report: 33 percent reduction in hospital readmissions for all patients without disabilities; 12-16 percent reduction in high-cost imaging for all patients without disabilities; 8 percent reduction in emergency room visits for adults without disabilities; 50 percent of all children under 18 had at least one well-child visit.32,33

### ILLINOIS

1) **Program Approach:** Originally implemented three new care models: Accountable Care Entities (ACE), a provider-led ACO on a three-year path to full-risk capitated payments; Care Coordination Entities (CCE), a collaboration between providers and community organizations providing care coordination on risk-based
and P4Q fees (but other services paid FFS); Managed Care Community Networks (MCCN), provider-organized entities accepting full-risk capitated payments.

2) Number of Approved Orgs: Nine


4) Payment Model: CCEs can choose from PMPM, shared savings payment (SSP), or a proposed payment model; MCCNs are capitated; and ACEs begin with care coordination payments, then transition to pre-paid capitation, then to risk-based capitation.

5) Incepted: 2011, per a state reform law that requires 50 percent of state medical beneficiaries be enrolled in risk-based coordinated care.


7) Pay for Performance/Quality Approach: An ACE receives 10 percent of savings earned automatically, but must meet quality targets to receive the remaining 40 percent of savings. Each of the following measures are worth 10 percent of that sum: follow-up after ED, child immunization, diabetes care, and follow-up after hospitalization for mental illness.

8) Coverage Approach: Voluntary enrollment will begin for children, families, and newly eligible adults in July 2014. MCCN began operation in April 2013, and expanded to Chicago.

9) Quality Measures: ACEs were required to report performance on a set of 29 quality measures, focused on access, prevention/screening services, appropriate care, behavioral health, and maternity.

10) Reported Results: None reported.7,34,35

IOWA

1) Program Approach: Regionally defined ACOs are responsible for coordinating beneficiaries’ care through PCP-led medical homes. ACOs and PCPs are eligible for three bonuses: meeting performance metrics, patients who receive physical exams, and outreach programs.

2) Key Facts: The Iowa Wellness Plan is part of Iowa’s Medicaid expansion plan.

3) Number of Approved Orgs: Three

4) Covered Lives: 107,000

5) Payment Model: In the year one of operation, PCPs are paid FFS with care coordination payments. In subsequent years, ACOs are subject to a risk-adjusted global budget with SSP based on quality performance. Two-way risk sharing begins after five years.

6) Incepted: May 2013, Iowa Legislature passed Iowa Health and Wellness Plan.

7) Implemented: January 1, 2014, coverage began.

8) Pay for Performance/Quality Approach: ACOs work towards three bonus payments: medical home bonus of up to $4 PMPM for meeting performance measures, $10/year per member if at least 85 percent of members have received a physical exam; and an additional $4 PMPM for having a comprehensive outreach program.
9) **Coverage Approach:** Individuals who are between ages 19–64 who do not have access to Medicare, and who are not eligible for employer-sponsored coverage. Most newly eligible individuals with income over 133 percent of poverty are also not covered.

10) **Quality Measures:** Value index score, based on outcomes over baseline. Domains include primary and secondary prevention, tertiary prevention, disease progression, chronic and follow-up, continuity of care, and efficiency.

11) **Reported Results:** None reported.\(^{36,37,38,39}\)

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**MAINE**

1) **Program Approach:** Through Accountable Communities (AC), Medicaid providers enter into direct contracts with Maine HHS for upside shared savings linked to quality benchmarks.

2) **Key Facts:** Communities are not limited by geographic region. Benchmarks focus on care coordination, preventive health, and at-risk populations. ACs must select three of the seven elective measures on which to be measured together with the core measure set.

3) **Number of Approved Orgs:** Five

4) **Covered Lives:** 356, 900

5) **Payment Model:** FFS and global care coordination fees will continue under existing MCO programs. ACs can pick from two models: upside risk up to 50 percent of savings or upside risk up to 60 percent of savings, no downside risk year one, 5 percent in year two, and 10 percent in third year. SSP is dependent on quality benchmarks.

6) **Incepted:** November 2011, per RFI from Maine HHS.

7) **Implementation:** May 1, 2014. Approved by CMS on June 2, 2014.

8) **Pay for Performance/Quality Approach:** ACs earn points for meeting the minimum level on at least one measure in each of the domains. Each domain is assigned a weight, which in total determines the percent of earned savings received.

9) **Coverage Approach:** MaineCare members are assigned to AC based on an algorithm.

10) **Quality Measures:** Includes fifteen core measures and six elective measures across four domains: care coordination/patient safety (five measures), patient experience (one), preventive health (four), and at-risk populations (11 over five defined populations). ACOs must select three of the seven elective measures.

11) **Reported Results:** None reported.\(^{40,41}\)

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**MASSACHUSETTS**

1) **Program Approach:** Built off a PCMH model, the program contracts directly with primary care providers for risk-adjusted PMPM primary care payments, multi-track SSPs, and incentive payments for P4R and P4Q. Precursor to developing ACO legislation.

2) **Number PCPs Approved:** 30 physicians approved for program.
3) **Covered Lives:** Planned 600,000

4) **Payment Model:** Risk-adjusted PMPM primary care payments, multi-track SSPs for non-primary care spending, and incentive payments for P4R and P4Q. Option to add one of two bundles for behavioral health services. There is also an annual savings payment for non-primary care spending, including hospital and specialist services.

5) **Incepted:** 2012

6) **Implemented:** March 1, 2014

7) **Pay for Performance/Quality Approach:** Annual incentive for pay-for-reporting year one, and P4Q incentive for performance on defined primary care quality metrics in years two and three. No weighting details released.

8) **Coverage Approach:** Massachusetts’ Chapter 224 cost-containment legislation mandates that 80 percent of the Medicaid population be enrolled in risk-based contracts by 2015. Plan calls for 25 percent of MassHealth members participating by July 2013, 50 percent of members participating by July 2014, and 80 percent by July 2015.

9) **Quality Measures:** Twenty-nine measures are tracked under the aims of adult prevention and screening; pediatric health; behavioral health; chronic conditions; access; and care coordination.

10) **Reported Results:** None reported.  

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**MINNESOTA**

1) **Program Approach:** Integrated Health Partnerships (IHP) includes two payment and delivery models: integrated and virtual. Integrated delivery systems include ACOs and virtual networks include Federally Qualified Health Centers of PCPs (known as FUHN).

2) **Key Facts:** FUHN is one of the nation’s first safety net ACO pilots. The state is planning an Accountable communities PCMH expansion for late 2014.

3) **Number of Approved Orgs:** 16

4) **Covered Lives:** 200,000

5) **Payment Model:** Participating providers continue to receive FFS or managed care-contracted payments. Integrated delivery system ACOs use a total cost of care (TCOC) SSP model building from upside-only in year one towards two-way risk in year three. The virtual model uses an upside-only TCOC SSP.

6) **Incepted:** The state launched IHPs in 2011.

7) **Implementation:** January 2013, with more systems that began in 2014.

8) **Pay for Performance Approach:** Planned, but no program-wide approaches yet. FUHN stipulates that part of its providers’ shared savings are contingent on—year one, 25 percent on reporting; year two, 25 percent on relative quality, performance, and experience improvements; year three, 50 percent on relative improvement.

9) **Coverage Approach:** The 16 participating organizations cover all adults and children eligible for Medicaid (who are not dual eligible) under both a FFS and managed care program.
10) Quality Measures: Twenty-one measures, weighted score system: 45 percent on clinic quality, 30 percent on patient experience, 15 percent hospital quality, 10 percent on patient experience.

11) Reported Results: $10.5 million in savings across all six provider participants within the first year.\textsuperscript{13,44,45}

NEW JERSEY

1) Program Approach: A community-focused program in which nonprofit ACOs contract with all hospitals, 75 percent of PCPs, and at least four mental health providers in a targeted community under a gain-sharing plan.

2) Key Facts: Data analysis will be performed by the Rutgers Center for State Health Policy. Five MCOs currently manage all Medicaid recipients, and only one has proactively agreed to contract with ACOs.

3) Number of Approved Orgs: Six organizations have applied.

4) Covered Lives: Not yet calculated; determined by ACO approval.

5) Payment Model: Gain-sharing plan in which the ACO receives a portion of shared savings and distributes it to providers.

6) Incepted: August 2011

7) Implementation: Regulations released May 2014, but implementation at least a year away.

8) Pay for Performance Approach: Gain-sharing based on quality performance; program for payment not defined yet.

9) Coverage Approach: ACOs contract with all hospitals, 75 percent of PCPs and at least four mental health providers in a targeted community. ACOs cover Medicaid beneficiaries in the defined counties or area codes.

10) Quality Measures: Twenty-one mandatory measures focused on prevention, acute care, chronic conditions, resource utilization, and CAHPS/satisfaction. Thirty-nine voluntary measures.

11) Reported Results: Measurement hasn’t yet begun.\textsuperscript{13,46,47,48}

OREGON

1) Program Approach: A statewide network of regional Coordinated Care Organizations (CCOs) – some for profit, some not-for-profit – that provide care for Oregon Health Plan enrollees. They operate under a fixed global budget with quality incentives to be phased in over time.

2) Key Facts: Oregon is the first state to transfer its entire Medicaid population into CCO coverage. The CCO program is modeled on “hot-spotting,” using ED and hospital admission records to identify high utilization patients.

3) Number of Approved Orgs: 16 CCOs

4) Covered Lives: 1,100,000
5) **Payment Model:** CCOs receive a global payment to cover medical, dental, and mental services. The budget grows at a fixed rate and there are incentives for reporting and P4Q. CCOs are required to achieve a 2 percent reduction in the rate of per capita Medicaid spending growth by the second year.

6) **Incepted:** June 2011, Oregon enacted a bill that prompted a new system and held over 75 public meetings for input.

7) **Implementation:** August 1, 2012, CCOs were launched.

8) **Pay for Performance Approach:** A “quality pool” was established to reward CCOs for outcomes. CCOs were eligible for an incentive payment for reporting in year one. In 2014, CCOs were eligible for a payment of up to 3 percent of its aggregate costs, based on performance on quality metrics.

9) **Coverage Approach:** All Medicaid enrollees are covered. Each CCO covers a region of the state and there can be more than one CCO per region.

10) **Quality Measures:** CCOs report on 16 incentive measures, including follow-up and screening measures, alcohol or other substance misuse, ED utilization, CAHPS, high blood pressure, diabetes, plus others.

11) **Reported Results:** An annual report released June 2014 outlined a 17 percent decrease in ED visits and a 19 percent decrease in ED costs; an increase of 58 percent in developmental screening for under two-year-olds; and an 11 percent increase in PCP visits, with spending on primary care and preventative services up 20 percent

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**UTAH**

1) **Program Approach:** Utah modified its MCO contracts to become ACO contracts. The contracts provide a monthly risk-adjusted, capitated payment to cover all services for enrolled beneficiaries, but explicitly considers ACO features related to quality and distribution of payments.

2) **Key Facts:** Second state after Colorado to implement a Medicaid ACOs program.

3) **Number of Approved Orgs:** Four

4) **Covered Lives:** 234,757 and growing with rural expansion

5) **Payment Model:** Capitated payments

6) **Incepted:** 2011, Senate Bill 180 enacted

7) **Implemented:** January 1, 2013

8) **Pay for Performance/Quality Approach:** None yet, but the state intends to create quality requirements and incentives to which the ACO plans will be held accountable in the future.

9) **Coverage Approach:** All beneficiaries in four most populated Utah counties will have a choice of ACO; members in other counties will have the option of joining an ACO depending on where they live. Utah hopes to build on this effort by integrating mental health and long-term support services into their ACOs and further expanding ACOs to rural areas.

10) **Quality Measures:** Nineteen measures covering services such as maternity care, newborn/infant care, pediatric care, and adult care. Payment is not yet tied to performance on quality measures.

11) **Reported Results:** None reported.
VERMONT

1) **Program Approach:** The program, closely mirroring an MSSP-like framework, is a performance-based SSP with two risk tracks and provider-led ACOs.

2) **Key Facts:** Vermont’s SSP is one of three different health care delivery and payment models that began in the state on January 2014. The state is creating a statewide claims dataset (VHCURES) that maps key measures of utilization, and a statewide health information exchange for continuity of care and other reports.

3) **Number of Approved Orgs:** Three

4) **Covered Lives:** 183,618

5) **Payment Model:** Two-track SSP program: track one, no downside risk in the year one with a 50 percent savings rate; and track two, two-sided risk with up to 60 percent shared savings and increased risk each year. Points assigned based on quality performance for earned-savings eligibility. There is an option to expand services in year two for higher savings rate.

6) **Incepted:** September 2013 RFP

7) **Implementation:** January 1, 2014

8) **Pay for Performance Approach:** Must meet at least 55 percent of quality measures to receive earned savings, with the opportunity to earn a higher percentage of earned savings with higher quality scores.

9) **Coverage Approach:** In year one, TCOC will include core services, and in year two ACOs can expand the TCOC calculation to include non-core services like personal care, pharmacy, dental, and other services administered by state departments and programs, such as Mental health, Drug Abuse, Disabilities, Education.

10) **Quality Measures:** Thirty-two measures have been defined for year one payment and reporting, including claim-based measures, readmission, and mental and physical screening measures. There are 23 additional measures for reporting covering more claims measures, clinical data measures, and patient experience measures.

11) **Reported Results:** None reported.55,56,57
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36. Gov. Branstad announced in January of this year his intent to move away from this model and to a Medicaid MCO model.


54. Utah Department of Health staff, UMACOA meeting (June 2015).