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THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

Emerging Medicaid Accountable Care Organizations: The Role of Managed Care

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Executive Summary

An Accountable Care Organization (ACO) is a provider-run organization in which the participating providers are collectively responsible for the care of an enrolled population, and also may share in any savings associated with improvements in the quality and efficiency of the care they provide. Although the concept of ACOs originated in the Medicare and commercial sectors, several states are actively developing ACO initiatives in an effort to improve the care provided to people through the Medicaid program. Our review of a number of state initiatives indicates that most Medicaid ACOs are currently at an early stage of development, as states engage in relatively lengthy planning and implementation processes, both to accommodate diverse stakeholder concerns and to address state and federal legislative and regulatory requirements. The structure of Medicaid ACO initiatives is influenced by individual states' history and experience with managed care, other existing care delivery arrangements within Medicaid, and the challenges inherent in serving low-income and chronically ill populations. While Medicaid ACOs are a strategy to more directly engage providers and provider communities in improving care, cost-containment is also a significant motivating factor for many states. It remains to be seen how states will balance short-term cost-containment pressures against the investments in partnerships and delivery system redesign necessary for the success of Medicaid ACOs over the longer term.

Introduction

Medicaid is the nation's public health insurance program for low-income Americans, covering close to 60 million children, families, seniors, and people with disabilities.[1] Approximately two out of three Medicaid beneficiaries are currently enrolled in a comprehensive form of managed care – either risk-based managed care organizations (MCOs) or primary care case management (PCCM) programs.[2] In recent years, states have increasingly turned to managed care in response to a growing interest in improving care for beneficiaries with complex needs and to address ongoing budget pressures. At the same time, states are exploring other strategies and reforms that incentivize high quality and effective care, reward improved outcomes, and/or lower costs. In this environment of change and innovation, states are also looking ahead to 2014, when key provisions of the Affordable Care Act (ACA) will take effect and Medicaid enrollment will expand.

Recently, a number of states have begun to explore the possibility of implementing Accountable Care Organizations (ACOs) in Medicaid. The ACO concept, which originated in the context of the Medicare

Program and subsequently migrated to the private health insurance market as well, refers to a provider-run organization in which the participating providers are collectively responsible for the care of an enrolled population, and also may share in any savings associated with improvements in the quality and efficiency of the care they provide.[3]Previous analyses have sought to define Medicaid ACOs and discussed how states could promote their development.[4,5]However, there has been little analysis of how the current Medicaid context, including the unique profile of the populations the program serves and the delivery systems in place today, may influence the development of ACOs in Medicaid.

This brief examines the existing Medicaid payment and care delivery landscape in states undertaking Medicaid ACO initiatives to gain insights into how ACOs may be structured and fit into states' Medicaid programs, and to identify important differences between Medicaid ACOs and ACOs in Medicare and the private insurance market. Our analysis is based on a review of the literature on these emerging ACO programs and interviews with key informants in five states where Medicaid ACO initiatives are being developed.[6,7]

Background

The term "Accountable Care Organization" first appeared in 2007 as part of a discussion about targeting Medicare's pay-for-performance incentives not to individual providers, but toward potential new organizations comprising hospitals and their extended affiliated medical staff.[8,9,10]In this context, ACOs refers to formal provider organizations that might vary in structure but would take responsibility for the care of a defined group of beneficiaries, with care evaluated based on quality metrics. ACOs that performed well would be eligible to share in any resulting cost savings. Because, in many communities, care is delivered by autonomous, non-integrated fee-for-service (FFS) providers, the thought was that ACOs might be a more realistic reform than encouraging providers to aggregate into multi-specialty groups or convert immediately from FFS to full-risk arrangements. Being provider-led, with shared stakes in their performance, there also was hope that ACOs might be effective in helping providers work together to accept accountability for delivering coordinated care across care delivery settings and over time.[11]

Medicare ACOs were formally recognized in the Patient Protection and Accountable Care Act of 2010 (ACA) as entities eligible for the Medicare Shared Savings Program.[12,13]Subsequent regulations authorized a specific form of Medicare ACO, in which provider-based entities with at least 5,000 Medicare patients (in general) agree to manage the care of those patients, submit quality data, and share savings (bonus only), and possibly losses as well (considered a two-sided model).[14] Patients are assigned to a specific ACO if they obtain the plurality of their primary care from a provider belonging to that ACO. However, patients remain free to seek care from any provider, consistent with traditional Medicare policy, and the Centers for Medicare & Medicaid Services (CMS) will update the patient attribution periodically for purposes of calculating savings. Under the Medicare Shared Savings Program, scheduled to be implemented in 2012, providers continue to receive Medicare FFS payment as well as their share of any savings.

The ACA also authorized a demonstration project for the creation of pediatric ACOs within Medicaid and/or the Children's Health Insurance Program (CHIP). The demonstration is currently unfunded, but states have begun to plan and implement Medicaid ACO initiatives themselves.

ACOs within the Medicare, Medicaid, or commercial sector typically include three key elements—a provider organization as the base, accountability for patient outcomes, and the potential for shared savings—but, otherwise, ACOs models vary. For example, Massachusetts is planning to move its Medicaid program toward a capitated, multi-payer ACO model, while Vermont is creating a community-based ACO model.[15,16] In the commercial market, Aetna is working with provider organizations, such as Banner Health in Arizona, to offer risk-based ACO products.[17] UnitedHealthcare views a variety of arrangements with ACOs as critical to its efforts to promote "value-driven health care."[18] Medicare also allows for alternative ACO models within the ACO Pioneer Program, which is under the authority of the Center for Medicare & Medicaid Innovation. A review of the 32 current Pioneer ACOs reveals great diversity in both their scope and in their care delivery features.[19] Medicare Pioneer ACOs range from large, multi-market entities to relatively small, localized structures that may or may not include hospitals. A national survey by Leavitt Partners counted as many 164 ACO entities nationwide in all payer sectors.[20] These ACO entities included 99 based in hospital systems, 38 based within Independent Physician Association, and 27 based within an insurer.

Although ACOs models vary, all involve increased use of quality metrics focused on patient-centered care, increased coordination of care, and incentives designed to reward performance (i.e., improved outcomes). These are some of the same features of other Medicaid managed care strategies, including risk-based contracting with MCOs, and states contemplating a Medicaid ACO initiative typically consider their historical experience with managed care to assess whether and how ACOs fit into their Medicaid environment.

Most Medicaid ACO Initiatives Are at an Early Stage of Development

While Medicaid ACOs have received increasing attention, very few of the initiatives that we examined in detail are currently operational. In the table, we summarize our findings from a review of documents and interviews with officials from five states with Medicaid ACOs initiatives, focusing on the historical context, the apparent motivation for the strategy, the details of the ACO model, and its current status. Among the five states, only Colorado has an operational Medicaid ACO, which is in the initial stages. Utah and Oregon hope to be operational sometime in 2012, while Oklahoma is still developing its approach. New Jersey's initiative has been authorized by the state legislature, but before it becomes operational, regulations must be promulgated.

Several factors may lengthen the timeframe required to operationalize a Medicaid ACO, including requirements in many states that the legislature authorize the program (perhaps requiring multiple actions), the time for the state to issue necessary implementation guidance or regulations, and the phase-in strategy. In New Jersey, for example, the legislature quickly authorized the initiative, but progress was delayed by practical challenges associated with integrating the ACO concept into the current Medicaid program, and with figuring out how to structure the related regulations. In contrast, Oregon engaged in an extensive and extended planning process to gather and incorporate stakeholder input, although implementation appears to be progressing rapidly now that authorizing legislation has been enacted.

Some states have combined ACO initiatives with other Medicaid reform strategies that may require federal waivers. The complexity of these reform packages can delay implementation of a state's ACO initiative for reasons having little to do with the ACO initiative itself. Oregon plans to include accountability for state-funded public health programs in the ACO program and to have the ability to

cap ACO payments. New Jersey has a pending comprehensive waiver that would allow the state to streamline what previously were a large number of diverse managed care waiver programs.[21]

States' Existing Medicaid Programs Shape the Features of ACO Initiatives

Current Risk-Based Arrangements Influence Development of Medicaid ACOs

Managed care has a much larger presence in Medicaid than in Medicare or the commercial sector. As of October 2010, nearly two-thirds of Medicaid beneficiaries were enrolled in managed care for all or most of their care, including 49.5% in comprehensive risk-based plans similar to health maintenance organizations (HMOs).[22]In contrast, in 2011,just a quarter of Medicare beneficiaries were enrolled in managed care plans and fewer than 20% of individuals with employment-based coverage were enrolled in an HMO (the commercial MCO analogue).[23,24]

Whether a risk-based managed care infrastructure exists or not appears to influence the approach payers take to establishing ACOs. In Medicare and, often, in the commercial sector, where risk-based arrangements are more limited, ACO initiatives are oriented toward providers practicing on a FFS basis who do not bear risk. In these ACOs, Medicare or the private insurer contracts directly with provider-based ACOs.

However, in many state Medicaid programs today, risk-based managed care is the predominant delivery and payment system. This factor has influenced the form that Medicaid ACOs have taken and the relationship between ACOs and MCOs. In some instances, MCOs coordinate with ACOs, and in others, they act as the ACOs. The boundaries between traditional risk-based managed care and ACOs can be difficult to discern in Medicaid.

- Utah, which previously converted most of its insurer- and provider-led health plans from full-risk to partial- and no-risk arrangements, is now planning to return to risk-based contracting, this time with the same organizations operating as ACOs charged with managing care delivery and bearing financial risk.
- Colorado's ACO initiative, the Accountable Care Collaborative, provides an exception during the initial stages of the initiative that allows for the continuation of existing managed care contracts with Kaiser Permanente.
- Oregon is implementing an ACO initiative based around Coordinated Care Organizations that will strengthen Medicaid requirements for community and provider engagement, but will allow existing Medicaid MCOs to apply to participate and gradually transition to meet the new requirements.
- Minnesota is shifting away from using Medicaid MCOs that subcontract with provider organizations. Instead, the state is adopting a strategy of contracting directly with large provider organizations using an ACO model, and will call for providers to absorb an increasing amount of risk over time.[25]

Failure to anticipate questions about how ACOs will work within the context of existing managed care programs may slow implementation of ACO initiatives. In New Jersey, regulations to implement ACOs are progressing relatively slowly because the legislature authorized a grassroots provider-based ACO initiative. The state wished to retain its extensive network of risk-based MCOs, which have the authority to specify the terms of provider contracts (including any gain-sharing component). Though the state envisioned that the MCOs would contract directly with the ACOs, the legislation did not address the

structure of these contractual relationships in detail. The forthcoming regulations will likely make MCO participation in the initiative voluntary, but the state expects that the intensive case management envisioned in ACOs will be attractive to at least some MCOs.

For states in which there is minimal risk-based managed care within the Medicaid program, ACOs may be viewed as part of the natural evolution of current delivery systems toward increased coordination of care and realignment of provider incentives. For example, North Carolina's medical home program already incorporates some features of ACOs, including diverse quality metrics and provider networks to promote accountable care in Medicaid, as well as for Medicare and other payers in the state.[26,27]

Development of Medicaid ACOs is Affected by Complex Care Delivery Arrangements in Medicaid

State Medicaid programs provide health care and social supports to beneficiaries through a complex array of care delivery arrangements and authorities. These care delivery arrangements are, in part, a result of states' efforts to address the complicated health care needs of a diverse beneficiary population, including low-income pregnant women, people with physical and mental disabilities, people with chronic diseases, and seniors.[28] In recent years, many states have exempted or excluded certain subpopulations from some care delivery programs or covered specific benefits through mandatory managed care arrangements.

These complex care arrangements bear on which subpopulations the state includes in a Medicaid ACO initiative and the benefits for which the ACOs are at risk. In Colorado, for example, beneficiaries residing in state psychiatric institutions or nursing facilities were initially excluded from enrollment in the Accountable Care Collaborative. Utah specifically excludes mental health services, substance abuse treatment services, nursing facilities, and emergency transportation from its ACO program.[29]These exclusions remain in place under the ACO initiatives.

In other states, however, an ACO initiative may be viewed as an opportunity to integrate services that had previously been carved out from managed care. For example, Oregon plans to use the ACO program to merge previously separate medical care and behavioral health care risk arrangements, ultimately also folding in risk for dental care. Colorado, which uses five regionally-based Behavioral Health Organizations to operate a state-funded mental health program, determined that these geographic areas were a good starting place for the development of the seven Regional Care Collaborative Organizations (RCCOs) within the Medicaid ACO program. To date, all RCCOs are required to coordinate and collaborate with the existing local Behavioral Health Organizations and with most regional substance use disorder Managed Service Organizations.[30]

Medicaid Beneficiaries who are Eligible for Medicare Raise Special Issues

In 2008, 15% of Medicaid beneficiaries were also enrolled in Medicare; these low-income individuals are known as "dual eligibles."[31] Medicare provides coverage for most acute health care needs, while Medicaid provides assistance with Medicare premiums and cost-sharing, and covers critical benefits not provided by Medicare, especially long -term services and supports. On average, dual eligibles are sicker and poorer than other Medicaid and Medicare beneficiaries, accounting for nearly 40% of total Medicaid expenditures. Compared to other Medicaid beneficiaries, dual eligible represent a particular challenge to Medicaid programs due to their high medical spending, complex health needs, and high utilization of institutional and long-term care services.[32]

Dual-eligible beneficiaries' reliance on both Medicare and Medicaid means they pose special challenges to states implementing Medicaid ACO initiatives. For example, while states may mandate enrollment in such ACOs as a condition for receipt of Medicaid benefits, such a mandate is not allowed in Medicare. Dual eligible enrollment in ACOs also raises questions of how to distribute any savings between state Medicaid agencies and Medicare.

States with ACO initiatives have adopted various strategies regarding dual eligible beneficiaries:

- Oregon is developing separate plans for dual eligibles with a grant from CMS to improve integration of Medicare and Medicaid services.
- New Jersey's ACO legislation generally excludes dual eligibles but state officials believe that the ACO program may include any duals that are currently enrolled in Medicaid MCOs.
- Oklahoma has a PCCM program for most Medicaid beneficiaries that excludes dual eligibles. At the time of our interview, the state was considering including dual eligibles in a Medicare-based ACO initiative in the Tulsa area. The state hoped that doing so would generate Medicaid savings by reducing utilization and, thus, Medicaid's obligations for Medicare cost-sharing amounts.
- Colorado had an ambitious cost savings goal for its Year 1 pilot and was concerned that any savings due to improved care for dual eligibles would accrue to the Medicare program rather than the state. The state decided that dual eligibles would be neither explicitly excluded nor actively enrolled in the first year of the enrollment-limited ACO program.

Stakeholder Consultation within States' Planning Process Varies

The nature and extent of stakeholder engagement in developing an ACO initiative varies across the states. In Oregon, Medicaid reform efforts typically involve structured consultations with diverse stakeholders in an open process. The state's strategy to establish Coordinated Care Organizations included presentations at eight community meetings attended by 1,200 Oregonians, refinement by four workgroups comprising 133 governor-appointed members, and opportunity for public feedback through multiple open comment periods.[33] State policymakers view this public process as valuable in creating champions, both in the legislature and on the local level. In Colorado, stakeholder engagement through consultation is part of the normal policy development process and was cited by state officials as a reason why one key group that initially opposed the ACO initiative came to support it.

Still, some states are developing Medicaid ACOs with less stakeholder consultation. These states may view the ACOs as a strategy to transition from managed care to a new Medicaid delivery model, and to make the conversion relatively invisible from the perspective of enrollees in MCOs that continue to have market presence. However, minimizing stakeholder consultation could prove problematic to the extent it leads to miscommunication. As an experienced state official noted, discussing the development and implementation of a Medicaid ACO initiative, "if you have one miscommunication, it will spread like wildfire,[taking] weeks [of work] trying to correct it."

Need to Contain Costs Influences Formation of Medicaid ACOs

Facing ongoing economic challenges, many states are under considerable budget pressure and seek immediate savings.[34] Because Medicaid programs account for a large share of state spending, they are often the focus of state cost-containment efforts. In Oregon, for example, state policymakers have

made clear that they would like to derive savings by getting better value for their Medicaid dollars. If successful, the transformation to an ACO model will help Oregon reduce future health care spending, stabilize the delivery system, and preserve available services.[35]

Interest in Medicaid ACOs appears to be fueled partly by a belief that ACOs have potential to both deliver higher quality care and to improve efficiency and value. Most states applying the ACO concept in Medicaid have focused on strategies designed to increase provider engagement and accountability for care and to realign financial incentives over time. States may seek to distinguish this strategy from prior managed care initiatives that were seen as oriented towards insurers and cut costs by denying care or reducing provider payments.[36]To differentiate these new arrangements from MCOs or HMOs, states may embrace the newer terminology of ACOs, including state-specific variations such as Coordinated Care Organizations as in Oregon.

Colorado had a managed care program that was repealed because the state officials perceived that "concerns over the adequacy of managed care rates detracted from the ability of the program to focus on broader health care issues." Using ACOs, Colorado hopes to return to a model of managed care that delegates management authority to seven regional organizations, which are responsible for achieving improved health outcomes, creating a network of primary care providers, and assisting the providers in delivery care in a medical home setting. Colorado's initial phase of the program, to test the model's ability to generate savings, included 60,000 beneficiaries, but the state doubled the enrollment target almost immediately to address a short-term hole in the state's budget.

Utah is another example of a state that mostly abandoned capitated Medicaid managed care, in part because MCOs objected that the state did not adjust rates to keep pace with increases in medical expenses. Utah's current ACO plan appears to focus more on improved care delivery than on direct cost reduction. However, the ACO initiative is embedded within a broader reform strategy that would allow benefits to be cut based on a priority list if savings are insufficient to meet state revenue constraints and that would allow health ACOs considerable flexibility to determine how they will share savings with contracted provider partners.

Conclusion

The structure of early Medicaid ACO initiatives appears to be strongly influenced by states' Medicaid managed care environments and experiences, and by whether the states with managed care currently have risk-based contracts with MCOs or have moved away from that model. In addition, states are exploring how Medicaid ACOs would mesh with the complex care delivery arrangements in place now, as well as the unique challenges associated with serving dual eligibles. It will be some time before it is clear whether Medicaid ACOs can succeed in improving quality and outcomes and restraining spending growth.

States with nascent Medicaid ACO initiatives appear to be aware of, and responding to, the operational issues and pitfalls associated with past managed care strategies. These states have emphasized the role of providers, established performance metrics, and/or focused on closer alignment of financial incentives with policy goals. At the same time, state officials have noted that the new accountable care approach brings its own technical challenges, such as methods for attributing patients to ACOs, allocation of shared savings and development of appropriate risk adjustment methodologies. States vary in the resources they have available to address these challenges.

Promoting transformation in the way services are delivered in Medicaid is not straightforward, and the time and investment required may run counter to states' fiscal imperatives. Arguably, this tension between rapid cost containment and delivery reform was one reason that some earlier Medicaid managed care initiatives proved unsuccessful.[37,38] How states build on their experiences with managed care and how they address the challenges associated with developing and implementing Medicaid ACOs may determine whether this renewed emphasis on outcomes and accountability will fundamentally affect state Medicaid programs.

This brief was prepared by Marsha Gold and Jessica Nysenbaum, of Mathematica Policy Research, and Sonya Streeter of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

Table: Summary of Selected State Medicaid ACO Initiatives

State	Historical Context	State Motivation	ACO Model	Status
Colorado's Accountable Care Collaborative	Moved away from risk-based MCO program and instead emphasized primary care case management strategy within a FFS environment. Capitated behavioral health carved-out on a regional basis.	Interested in re-engaging MCO to address health care cost concerns. Sought model which allowed the state to avoid past controversies that resulted in lawsuits over capitation rates.	Three components: (1) primary care medical providers (PCMPs) receive FFS payments plus $4 per member per month (PMPM) to provide medical home services (beginning July 1, $3 PMPM and $1 toward an incentive payment pool); (2) seven regional care collaborative organizations (RCCOs) receiving up to $13 PMPM to manage provider networks and supporting PCMPs with care delivery; and (3) data analytics contractor to build a data repository and provider portal for PCMPs and RCCOs to assess performance metrics and facilitate quality improvements.	In 2011, began pilot of 60,000 passively enrolled beneficiaries to demonstrate if the model would meet budget goals. Enrollment will double by mid-2012.
New Jersey's Medicaid ACO Demonstration	MostMedicaid beneficiaries currently enrolled in risk-based MCOs. State in the process of streamlining waivers and enhancing programs. ACO initiative arose independently from provider-based community.	Concept based on Camden Coalition, a local provider group that focused on high utilizers to reduce emergency room use and improve outcomes.	Three-year demonstration for community-based ACOs that serve 5,000+ beneficiaries and contract with at least 75% of providers, 100% of hospitals in region, and four mental health providers. MCOs can contract with ACOs. The ACOs will be eligible for shared savings, according to the contract with the MCOs, if quality metrics. ACO initiative appears similar to population-based high cost enrollee case management.	Authorizing legislation passed in 2011. State regulations regarding implementation under development. Next step includes solicitation for ACO applications.
Oklahoma' s Accountable Care Organization for Dual Eligibles	Medicaid program emphasized PCCM program, and since 2009 medical homes for children, pregnant women and adults; dual eligibles excluded.	Exploring strategies to integrate Medicare and Medicaid financing for duals, partly to reduce Medicaid spending. Oklahoma University in Tulsa interested in improving care for chronically ill patients and promoting teaching objectives.	State currently exploring range of strategies for duals, including University's proposal of geographically-based ACO. Based on CMS consultations, University created a 501c3 and applied to be a Medicare ACO, hoping to wrap around state funding for the Medicaid component.	As of winter 2012, contemplating a Medicare ACO; financing plan for Medicaid share of duals was under discussion
Oregon's Coordinated Care Organization Plan	Medicaid program had used risk-based MCOs, along with carve-outs for behavioral and dental health on a regional basis. State has history of using a coverage priority list to generate savings and expand coverage.	Returning governor sought to redesign Medicaid delivery system to generate savings to meet budget shortfalls and to improve care delivery and outcomes.	Coordinated Care Organizations would be risk-bearing entities paid under a global budget that grows at a fixed rate. Current MCOs eligible to apply, but must integrate medical and behavioral health (and ultimately dental health) and transition to a governing structure that includes more provider and community involvement and focuses on community health. Initiative includes quality management and shared incentives.	Authorizing legislation enacted in early 2012, with operational plan currently under development. Implementation expected beginning in mid-2012.
Utah's Accountable Care Organization Program	Moved away from risk-based model with multiple large provider systems that provided PCCM or acted as limited benefit capitation plans.	Goal is to improve control of state spending on health care. Sponsoring legislator consulted with state and CMS to develop initiative, and also works for MCO with large state presence.	State hopes to renew contract with health plans/large provider systems as ACOs on a comprehensive risk basis in Salt Lake City. ACOs would be authorized to pay providers incentive payments. State is seeking authority to use a priority list if the state's general fund does not grow at the same rate as the Medicaid program's needs.	Pending CMS waiver approval; hoping to be operational by October 2012.

Source: Mathematica Policy Research and KCMU interviews and review of documents

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