

The Essential Role of States in Financing, Regulating, and Creating Accountable Care Organizations

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ABSTRACT

Health care payers are increasingly turning to accountable care strategies, linking payments to value for a defined population of patients across a continuum of care, as they seek to control costs and improve quality. We examined publicly available sources to identify and analyze state-led activity to promote accountable care. We found that 17 states are implementing accountable care strategies in Medicaid or state employee health programs. State activity runs the gamut from financing accountable care models to developing state standards that certify public and private accountable care organizations, to aligning accountable care principles with the creation of new community-based organizations or Medicaid managed care organization contracts. As more states begin to use their leverage as health payers, purchasers, and regulators to re-shape health care delivery, policymakers can learn from their accountable care design principles and early pilot results.

Controlling costs and improving quality in the health care system will require moving away from volume-based, fee-for-service payment toward value-based payment mechanisms.^{1 2} Bolstered by state legislative mandates, as well as provisions in the Affordable Care Act to reorient federal health spending to promote accountable care organizations (ACOs), 17 states are developing a variety of strategies to improve value—achieving better health outcomes at lower cost—and foster accountability for the care provided to a population of patients. As state ‘accountable care’ spreads, patterns have begun to emerge. Seven states are financing ACO models in their role as public payers, some in step with the Medicare Shared Savings Program provided under the Affordable Care Act.³ Three states are developing state standards that certify ACOs, and six states are fostering the creation of new community-based organizations or redefining managed care organization contracts that are aligned with ACO principles. See “State Accountable Care Activity” map.

This article describes the range of strategies taken by states to drive value-based payment mechanisms aligned with accountable care principles. This growing activity spans a range of political and policy environments and demonstrates the willingness of states to test new payment reform models. It also shows the power states have to influence financing of these models in Medicaid, state employee health programs, and commercial insurers’ plans, thus creating new opportunities for furthering provider participation.

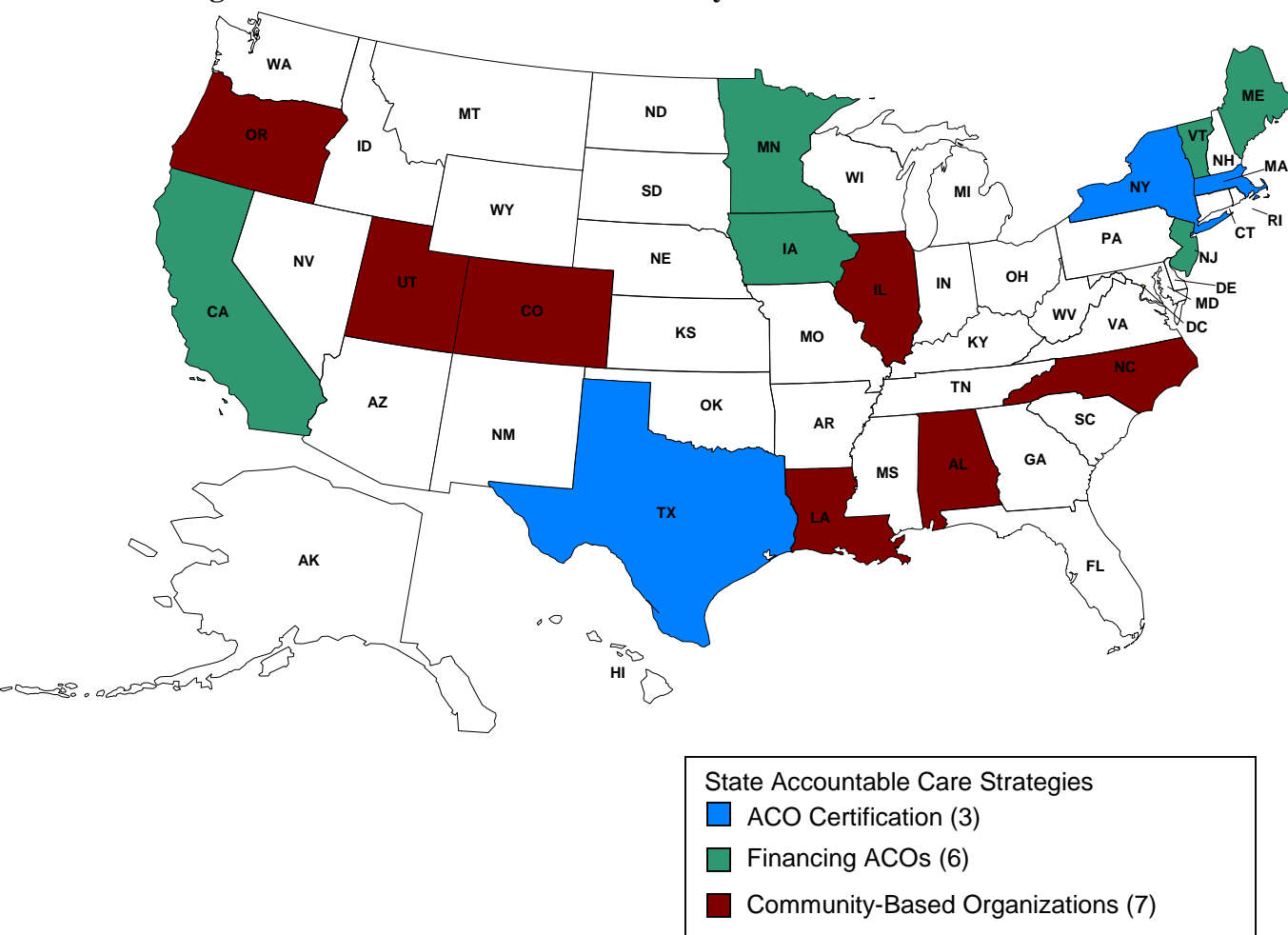
STUDY DATA AND METHODS

This article provides a descriptive review and analysis of state accountable care activity from October 2012 to February 2014. Information for this article was collected from a two-year project funded by The Commonwealth Fund to identify, track, and map state activity to promote accountable care. For the purpose of tracking this activity, we sought input from five national

experts representing federal agencies, national-based foundations, think tanks and consulting groups. We defined accountable care as “organizations or structures that assume responsibility for a defined population of patients across a continuum of care through payments linked to value and performance measurements that demonstrate that savings are achieved in conjunction with improvements in care”.⁴ Using search terms including “accountable care,” “value-based” “payment,” “ACO”, and “shared savings”, we scanned state and federal websites, gray literature, and health policy newsletters for data.⁵

We analyzed the activity on the map according to seven domains: project scope, authority, governance, criteria for participation in the initiative, payment, support for infrastructure, and measurement and evaluation. In addition, we identified approved legislation and regulations. We reviewed state applications approved by the Centers for Medicare and Medicaid Innovation State Innovation Model testing grants.⁶ The State Innovation Models initiative was launched by the Centers for Medicare & Medicaid Services (CMS) Innovation Center to support multi-payer payment and delivery system reforms at the state level.

Figure 1: State Accountable Care Activity



STATE INITIATIVES TO FINANCE ACCOUNTABLE CARE ORGANIZATIONS

States, through the purchasing power of Medicaid and state employee health benefits, wield considerable influence in their ability to finance and influence health care delivery system reform. Nationally, Accountable Care Organizations have proliferated in recent years under the Medicare Shared Savings Program, which offers hospital-led or physician-led groups of providers who partner to form ACOs an opportunity to share in savings achieved for their Medicare population. Like the Medicare Shared Savings Program, Medicaid ACOs also offer groups of providers meeting performance benchmarks the opportunity to accept moderate shared savings with no downside risk, or greater shared savings if downside risk is accepted. But unlike Medicare Shared Savings Program ACOs, Medicaid ACO programs may have more stringent requirements for maintaining working relationships with community partners including behavioral health services, integrating with existing Medicaid patient-centered medical home programs, and assuming responsibility (whether included in the ACO's spending target or not) for additional services like non-emergency medical transportation. Six states are supporting their own versions of accountable care organizations: California, Iowa, Maine, Minnesota, New Jersey, and Vermont. All but California are Medicaid-based ACOs.

Minnesota's Integrated Health Partnerships (IHP) Demonstration (formerly known as the Health Care Delivery Systems Demonstration) illustrates a Medicaid ACO financing strategy. In the first phase of this program nine ACO contracts were awarded to providers and other partner organizations, including several networks of clinics and hospitals, a coalition of Federally Qualified Health Centers, and a group of 12 counties and their local provider groups. Similar to the ACOs in the Medicare Shared Savings Program, Minnesota's IHP Demonstration offers two payment tracks: one track offers shared savings only, while the other offers the potential for greater shared savings in return for taking on downside risk.⁷ Minnesota will expand its Medicaid ACO contracts through its State Innovation Model work.⁸

At least one Medicaid agency is partnering with a commercial insurer on an accountable care initiative. Iowa is building off of a commercial ACO strategy that was launched by Wellmark Blue Cross Blue Shield in 2012 and now includes several health systems in the state.⁹ Iowa Medicaid's Health and Wellness Plan and its State Innovation Model planning will use Wellmark's model to serve Medicaid and Children Health Insurance Program beneficiaries, either via Medicaid directly contracting with Wellmark's ACOs or by designing a competitive bidding process for a regional ACO.¹⁰ ACOs under Iowa's Health and Wellness Plan will serve the Medicaid expansion population and are offered a pathway to transition to risk-adjusted global budgets with shared savings based on quality performance. In their first year of operation their participating primary care providers will be eligible for medical home bonus payments based on primary, secondary, and tertiary prevention scores, as well as indicators of capacity to manage disease and coordinate care.¹¹ To more closely link public and commercial ACO strategies, Iowa is relying on the same data contractor as Wellmark and plans to hold joint learning collaboratives between the state and Wellmark to document best practices for ACOs. Iowa signed agreements with two of the ACOs in April 2014 to begin work with the Medicaid expansion population.¹²

California is unique among the state initiatives studied because the state's accountable care initiative is not within Medicaid but instead falls within the California Public Employees' Retirement System (CalPERS).¹³ CalPERS has partnered with Blue Shield of California, a physician group, and a hospital chain to form an ACO for a subset of CalPERS enrollees. Financial risk for various cost categories, including facility costs, professional costs, and mental health costs, is allocated among the initiative's partners. The ACO operates under a global budget and each partnering organization may share in the savings achieved within the cost category for which it is responsible.¹⁴

STATE INITIATIVES TO REGULATE ACOs

In addition to wielding considerable financial leverage to shape the development of the formation of ACOs, states also have opportunities to support ACOs in their role as regulators of insurance and health care markets. At present, ACOs are largely affiliated with a single payer, such as the Medicare Shared Savings Program. As federal, state, and commercially-supported ACOs continue to spread, payers and providers are increasingly considering opportunities for multi-payer ACO initiatives. Three states—Massachusetts, New York, and Texas—have committed to creating a regulatory framework for certifying ACOs that can contract with one or more payers. These certifications will facilitate the formation of ACOs and promulgate common standards for design and performance. In Massachusetts, ACO certification is voluntary.

New York authorized the development of an ACO certification process within its Department of Health in 2012 based on the state legislature's conclusion that promoting ACO formation would "reduce health care costs, promote effective allocation of health care resources, and enhance the quality and accessibility of health care."¹⁵ Basic criteria to be included in regulations governing the certification process are identified in statute, including identification of mechanisms by which the ACO will provide, manage, and coordinate quality care for patients (including potential incorporation of patient-centered medical home standards into the state ACO certification process) but final regulations implementing the program are forthcoming. The Department of Health is empowered to create an expedited review process for certification of organizations already approved by CMS to participate in the Medicare Shared Savings Program.

In Massachusetts, state-level health reform and cost containment law passed in 2012 will allow the state's new Health Policy Commission to certify ACOs.¹⁶ The details of this voluntary certification process are still being developed through the Commission's regulatory process. However, some criteria for certification are specified in statute, including requirements that prospective ACOs offer services across the care continuum and have advanced health information technology for care coordination and population management purposes. In New York and Massachusetts, ACOs are defined in statute to be provider organizations and will face scrutiny of their financial soundness and capacity to bear downside risk during the certification process.

In 2011, Texas authorized the development of a certification process for "health care collaboratives", groups of physicians and other health care providers that receive payments to arrange for medical and health care services.¹⁷ These ACO-like entities may contract with governmental or private entities to deliver services to their members using innovative payment

arrangements. Unlike New York and Massachusetts, Texas's health care collaboratives may also include licensed insurers or health maintenance organizations in addition to groups of providers. Therefore, Texas law requires that all health care collaboratives maintain "working capital and reserves sufficient to operate and maintain the health care collaborative and to arrange for services and expenses incurred by the health care collaborative."¹⁸ Regulations released by the Texas Department of Insurance in 2012 outline a certification application process for groups seeking to become health care collaboratives.

STATE INITIATIVES THAT CREATE COMMUNITY-BASED ORGANIZATIONS OR REDEFINE MANAGED CARE

As state Medicaid agencies often delegate responsibility for managing access and delivery of services for Medicaid beneficiaries to external organizations, they exert significant influence on service delivery through contracting and oversight relationships. Seven states—Alabama, Colorado, Illinois, Louisiana, North Carolina, Oregon, and Utah-- are creating new organizations or redefining contracts with existing risk-bearing organizations that are aligned with accountable care principles. What separates the ACOs of today with the managed care organizations from previous decades is the simultaneous focus on meeting costs and quality metrics, the greater sophistication of the data analytics to meet those metrics, and the emphasis on developing Medicaid services at the local level. Colorado and Oregon provide strong examples of this approach.

Colorado, under its Accountable Care Collaborative program, has taken the unmanaged fee-for-service for hundreds of thousands of Medicaid beneficiaries and rolled out Regional Care Collaborative Organizations under its Accountable Care Collaborative program) that are responsible for providing medical management, care coordination, and support to providers including technical assistance to build medical home competency.¹⁹ Regional Care Collaborative Organizations operate regionally, each covering one of seven distinct areas, and are accountable for quality through incentive payments linked to performance on four key quality indicators, as seen in Figure 2. The program began in 2011 and by the summer of 2013, nearly half of Colorado's Medicaid beneficiaries were enrolled.²⁰ Colorado is also financing a statewide data contractor to provide data and analytical support to primary care providers and Regional Care Collaborative Organizations, including predictive modeling of risk for Medicaid beneficiaries.²¹ The state is seeking federal approval for a shared savings component to the program, which will be effective retroactively to October 2013.

Oregon has approached reform from the opposite direction, transitioning from an existing managed care program to community-based entities. The state has launched a statewide network of Coordinated Care Organizations that provide integrated and coordinated health care for Oregon Health Plan enrollees under global budgets.²² By early 2014, 15 Coordinated Care Organizations were integrating and coordinating physical, mental, behavioral, and dental health care for 90 percent of Medicaid enrollees statewide. A new Transformation Center provides grants to Coordinated Care Organizations for projects that include bolstering data and information technology infrastructure. In addition, Oregon's approach links its statewide medical home initiative, known as "patient-centered primary care homes" to the Coordinated Care

Organizations. Coordinated Care Organizations are required to develop a network of patient-centered primary care homes to the extent feasible.²³

Other states, including Illinois, Louisiana, Utah, are redesigning Medicaid managed care using accountable care principles as well. For example, Illinois is rolling out “Care Coordination Programs” in response to a state legislative mandate that half of publicly insured beneficiaries be enrolled in risk-based coordinated care based on value-based purchasing approaches, evidence-based practices, and a medical home foundation by January 1, 2015.²⁴

EMERGING THEMES IN STATE ACO STRATEGIES

Accountable care initiatives often build on medical homes initiatives.

Accountable care initiatives are often a logical next step to further evolve medical home initiatives; medical homes seek to enhance access and better coordinate care by expanding primary care provider accountability for a range of preventive, acute, and chronic care services. Using this strong base of primary care, accountable care initiatives encourage closer relationships between as well as shared accountability among primary care providers, specialists, hospitals, and other non-medical providers and resources.²⁵ States have been active in building medical home infrastructure through Medicaid programs over the past decade.²⁶ States including, Maine, Minnesota, North Carolina, Oregon, and Vermont all have robust statewide medical home initiatives that provide a ready platform of state or nationally qualified medical home providers as well as data support and other services – all which may contribute to the success of accountable care payment arrangements. For instance, MaineCare’s Accountable Communities initiative created a shared savings program in Medicaid and is aligning with principles guiding the state’s Patient-Centered Medical Home Pilot.²⁷ Vermont has a Medicaid Shared Savings Program that builds on its statewide medical home initiative and leverages the state’s health information technology infrastructure—both established under the Vermont Blueprint for Health.²⁸

Attribution models are needed to define patient populations for the purpose of facilitating accountability.

Accountability requires identifying the provider to which a patient's cost and quality outcomes should be attributed. Analysis of patient claims data or patient enrollment—either through patient selection of a provider or automatic enrollment—are often used to attribute patients to ACOs. States relying on regional community-based organizations, either administrative or risk-bearing in nature, tend to use active enrollment by beneficiaries to help define the population cared for by the ACO. In Illinois, Medicaid enrollees after selecting an Accountable Care Entity or a Care Coordination Entity are locked into their choice for 12 months and can change entities during an open enrollment period.²⁹ Similarly, Medicaid beneficiaries in Oregon are auto-enrolled into a Care Coordination Organization using a computer algorithm.³⁰ ²³Colorado’s Regional Care Collaborative Organizations and Alabama’s Regional Care Organizations (pending CMS approval) require enrollment based on geographic location.³¹

States that are supporting more ACO-like models based at the provider level will use claims analysis to attribute beneficiaries to providers participating in the accountable care initiative. Maine plans to use prospective assignment to its Accountable Communities based on beneficiary history with primary care physicians or specialists.³² Others will use retrospective attribution models that assign beneficiaries based on claims history over some look back period. Vermont's Medicaid Shared Savings Program will use a 12-month look back period, assigning beneficiaries to the ACO in which the practice where they had the greatest number of qualifying claims participants.³³

Payment models are providing pathways to shared accountability.

State accountable care initiatives are employing payments aimed at fostering innovation and transitioning away from strict fee-for-service arrangements, often offering safety net providers a pathway into risk-based payment models. Shared savings approaches are dominant, layering new incentives for efficiency and quality on top of fee-for-service reimbursement. Shared savings are often viewed as a transitional payment model that will ready providers for full-risk or global payment models. Shared savings, some patterned after the Medicare Shared Savings Program, will be used in Vermont's Medicaid Shared Savings Program, Minnesota's Integrated Health Partnerships, and the ACO-style models being fostered in Maine, Massachusetts, New York, and New Jersey. Savings below a target amount are shared with the ACOs, provided quality thresholds are met.

States like Iowa, Illinois and Maine will phase in new payment models for ACOs over time to give providers time to prepare to assume risk. In Illinois, the shared savings in Accountable Care Entities are accompanied by care coordination payments and will transition to global payments with pay-for-performance incentives over time.³⁴

Performance measurement strategies are needed to ensure accountability.

Accountable care strategies are tied closely to performance measurement, as they increasingly link payment to performance on defined quality metrics. What these approaches have in common is a reliance on robust performance measurement to hold entities accountable for the cost and quality of services delivered. State efforts to pay for value are linking reimbursements to performance indicators that draw from a range of data sources, including structural, process, and outcomes measures, as well as patient experience measures drawn from surveys of patient perspectives on their care. States are using performance indicators not only to provide financial incentives for high-quality care, but also to supply providers with the information they need to target improvements.

Some states, like Maine and New York, are seeking to align performance measurements with the Medicare Shared Savings Program.³⁵ Aligning with national measure sets or program requirements reduces the reporting burden on providers and creates opportunities for ACOs to participate in multiple payers' initiatives. Others states will rely more heavily on standardized measure sets identified at the state level. Massachusetts has a Statewide Quality Measure Set, updated annually, to assess quality and performance of providers and for use by health plans in

tiered network products, while Minnesota will use components of its existing Statewide Quality Reporting and Measurement System for Integrated Health Partnership reporting.^{36 37}

Measurement is also being used by states to gauge performance at the program level. Evaluation of the effectiveness of accountable care initiatives is important for improving program designs and replicating successful models. Some initiatives will use different sets of measures for rewarding value and for monitoring the initiative; Vermont's Medicaid Shared Savings Program will use a Core Measure Set used to distribute shared savings payments to providers and a separate Monitoring and Evaluation Set for programmatic monitoring and evaluation.³⁸

Support for infrastructure is needed to succeed.

Recognizing that taking on risk, coordinating and managing care, and building and sustaining relationships between disparate providers may require capacity that entities, many of them safety net providers, do not already have. Therefore some states are providing supports for participants, as seen in Figure 2. The information-sharing and data analysis requirements implicit in the accountable care concept require investments in health information technology and exchange. Much of the support states are offering focus on data and information technology. Examples of this include the previously mentioned Statewide Data Analytics Contractor in Colorado. Vermont is also planning to produce an integrated health data system in the state to support ACOs and other delivery system innovations. This data system includes a multi-payer claims dataset, a statewide health information exchange, a central clinical registry, and personnel who work with provider sites to improve information technology capacity.³⁹

States are also providing broader support for infrastructure development. For instance, Illinois has developed a matchmaking database to connect potential partners in its care coordination initiatives. The state is also providing an option under one of its new accountable care models for entities to advance a portion of their care coordination fees to cover upfront costs.⁴⁰ The Oregon Health Authority has launched a Transformation Center that provides technical assistance, learning opportunities, and grants designed to help Coordinated Care Organizations adopt a model.⁴¹

Early internal and external evaluation results are promising.

Most of the accountable care initiatives highlighted in this paper have not yet reached the operational phase or sufficient maturity to publish results. However, three initiatives that launched in the past few years have shown promising early results on a number of metrics.

An external analysis of the CalPERS ACO showed both a reduction in the use of health care resources and slower increases in the unit cost of reimbursements after its implementation. Independent evaluations of the ACO found that it saved CalPERS \$37 million in its first two years of operation (2010-2011).⁴²

According to a quarterly report released at the end of 2013, Colorado's Accountable Care Collaborative has seen double-digit reductions in hospital admissions for beneficiaries with chronic obstructive pulmonary disease, hospital readmissions, and high-cost imaging services, as

well as slower growth in emergency room utilization.⁴³ Overall, the initiative saw \$44 million gross (and \$6 million net) in cost avoidance in FY2012-13.

In Oregon, evaluation results released in November 2013 found that the beneficiaries enrolled in the state's Coordinated Care Organizations have seen reductions in emergency department utilization, reductions in hospitalizations for congestive heart failure and chronic obstructive pulmonary disease, and increases in primary care visits.⁴⁴

SUMMARY

As major payers and purchasers, through Medicaid programs and public employee benefits, and as regulators, states have significant leverage to support transformation of the health care system. State-led accountable care initiatives are spreading rapidly, joining a growing movement also supported by federal and private-sector efforts to realign payment policies and health care delivery toward promoting value. States are increasingly leveraging their purchasing and regulatory power to reshape care delivery to reward efficiency and drive out unnecessary or inappropriate service volume.

Despite the range of approaches states are implementing, these models all exhibit the features we are using to define accountable care: responsibility for a defined population, payments linked to value for care provided to that population, and reliable performance measurement to accurately gauge value. States are seizing on opportunities offered by state legislation, federal grant opportunities such as the State Innovation Models initiative, and Medicaid waiver authorities like those being used in states seeking alternative approaches to Medicaid expansion. Accountable care innovations are evolving rapidly in states. Their potential to improve health care quality and slow the growth of costs for participants throughout the health care system, particularly in concert with other public and private payers' ACO initiatives, will likely only grow with time.

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Figure 2: Domains of State Accountable Care Activity

Name of Initiative	Key Design Feature	Scope of services	Governance	Payment	Measurement & Evaluation	Support for Infrastructure
Alabama Medicaid Regional Care Organizations (RCOs) ¹	Regional risk-bearing organizations will be accountable for a continuum of services for Medicaid beneficiaries within a geographic area and use value-based purchasing strategies	Full scope of Medicaid benefits, including physical and behavioral services	Each RCO will have a 20-member governing board of directors, including medical and community representatives	RCOs receive a capitated payment and are expected to use value-based purchasing payment models in their contracts with providers	Outcome and quality measures to be determined	Reimbursement for RCO upfront investments (e.g., developing joint governance models, staff to connect patients with providers and train care managers, IT for providers)
California Public Employees' Retirement System ACO ^{2 3}	ACO pilot within state employee benefits that is limited to a specific hospital chain and physician group that agreed to hold 2010 costs to 2009 levels.	Participating providers are responsible for physician services, mental health, pharmacy, ancillary, and inpatient and outpatient hospital	Shared governance model involving executive leadership of participating payers and providers	Global spending target with shared risk and savings between ACO partners based on spending in discrete "cost categories" of services	ACO participants commit to preserving or improving quality; particular emphasis is given to tracking quality metrics that include hospital admissions, re-admissions, generic prescription drug use rate, and procedure-specific information	None specifically from the state
Colorado Medicaid Accountable Care Collaborative ⁴	Seven community-based organizations (Regional Care Collaborative Organizations, or RCCOs) selected competitively are accountable for quality	RCCOs manage and integrate services across a continuum of care, including primary care, inpatient care, and post-acute care	RCCOs must create Performance Improvement Advisory Committees with provider and member	RCCOs receive a PMPM and a performance-based incentive. Providers also receive a PMPM performance-based incentive.	RCCOs and providers are measured on four "key performance indicators" <ul style="list-style-type: none"> Hospital all-Cause 30 day re-admissions 	Statewide Data Analytics Contractor provides data analytics and reporting capacity to support care management and quality

	and cost of services to Medicaid beneficiaries are responsible for providing medical management, care coordination among providers and services, and support to providers		representation.	State plans to add shared savings (for both RCCOs and providers) ⁵	<ul style="list-style-type: none"> • Well child visits • emergency room visits • High cost imaging services 	improvement ⁶
Hawaii Accountable Health Care Alliance of Rural Oahu ⁷	ACO formed among 6 Federally Qualified Health Centers that are clinically integrating and jointly contracting with Medicaid managed care plans to share cost savings from coordinating and improving care.	Services offered at participating FQHCs.	Interagency agreement among FQHCs, each with its own community-elected governing board, transitioning to formal corporate body with equal representation of FQHC members.	Members projected to receive PMPM with up to 50-75% of shared savings based on each member's respective performance.	Medicaid managed care plans performance measures include: <ul style="list-style-type: none"> • 4 measures of facility costs (e.g., decrease hospitalizations or 30-day re-admissions) • 2 measures of drug costs (e.g., improve medication adherence) • 1 other measure (increase advanced directives on file) • 6 HEDIS quality metrics for clinical integration 	Medicaid managed care plans provide matching funds for IT, data exchange between plans and FQHCs as well as funding to develop common electronic platform to capture and analyze clinical data.
Illinois Medicaid Care Coordination Programs (e.g., Accountable Care Entities, Care	Risk-based coordinated care programs supporting several provider-organized accountable care models for Medicaid populations	Entities must be able to coordinate care across the spectrum of the health care system with a particular emphasis on managing transitions between	Entities must create new corporate body or designate a lead governing body with providers representing	Entities receive: PMPM care coordination payments with quality-based withholds, shared savings, and a pathway	Accountable Care Entities draft measures include: <ul style="list-style-type: none"> • Access and utilization (8) • Prevention and screening (9) • Appropriate care (6) 	Matchmaking database for prospective partners in care coordination programs, ⁹ a portion of care coordination fees may be advanced to an

Coordination Entities) ⁸		levels of care and coordination between physical and mental health and substance abuse.	primary care, specialty care, hospitals, and behavior health	to global payment with pay-for-performance incentives	<ul style="list-style-type: none"> Behavioral health measures (4) Maternity measures (3) 	entity (at the state's discretion) for upfront costs of Care Coordination Entities
Iowa Health and Wellness Plan ACOs ¹⁰	ACOs built on a medical home foundation will be one of three delivery models serving Medicaid beneficiaries under the Iowa Health and Wellness Plan	Comprehensive, commercial-like benefit package based on State Employee Plan benefits and satisfying Affordable Care Act essential health benefit requirements, plus supplemental dental benefits	ACOs establish separate governing body to set policy, develop and implement a model of care, establish best practices, and set and monitor quality goals with input from a consumer advisory board	ACOs initially eligible for performance-based bonus payments (including for adopting medical home principles in primary care); risk-adjusted global budgets with shared savings will be phased in over time	<p>In Year 1, ACOs receive bonus payments for medical home characteristics in key domains:</p> <ul style="list-style-type: none"> Primary & secondary prevention Tertiary prevention Disease progression Chronic & follow-up Continuity of care Efficiency <p>Additional quality metrics (to be determined) will be added in subsequent years</p>	ACOs will be provided with periodic cost and utilization reports, and dashboards to track quality metrics
Louisiana Coordinated Care Networks with Shared Savings ^{11 12}	Medicaid beneficiaries are enrolling in organized health care delivery systems, based on a medical home system of care, that will be accountable for ensuring access to a continuum of care	Physician, inpatient and outpatient, ancillary, basic behavioral health, transportations, chiropractic, rehabilitation therapy, home health	Coordinated Care Networks contract with the state; each has a governing body, though no specific requirements were specified in the state's	Coordinated Care Networks receive monthly PMPM enhanced primary care case management fees with lump sum shared	<p>Coordinated Care Networks quality metrics include:</p> <ul style="list-style-type: none"> Access and availability of care Effective of care Use of services Prevention quality indicators Satisfaction and 	Technical support to primary care providers, transformation incentives for practices

			request for proposals	savings payments	outcomes <ul style="list-style-type: none"> Others (including administrative measures) 	
Maine Accountable Communities Initiative ¹³	Medicaid shared savings program in which integrated delivery systems and provider groups contract with the state as ACOs	26 core services (with additional optional services), including primary care, behavioral health, inpatient and outpatient services, pharmacy, hospice and home health	Accountable Communities do not need to be incorporated entities, but each must designate a lead body to contract with the state and a governance structure that includes at least two Medicaid members	Accountable Communities have the choice of two tracks: <ul style="list-style-type: none"> Shared savings-only with maximum of 50% shared savings Shared savings and risk with maximum 60% shared savings 	Accountable Communities proposed measures fall into the following quality domains: <ul style="list-style-type: none"> At-risk populations (14) Care coordination/patient safety (7) Patient experience (1) Preventive health (4) 	Quarterly reports data analytics for Accountable Communities, learning collaborative
Massachusetts ACO Certification ¹⁴	Massachusetts Health Policy Commission will certify ACOs; voluntary certification standards will include requirements that the ACO have interoperable information technology systems	Continuum of services, including physical (e.g., primary care, inpatient, and ambulatory) and behavioral	ACOs have a governance structure that includes an administrative officer, medical officer, and patient or consumer representative	ACOs must receive reimbursement through alternate payment methodologies in contracts with third party payers, which may include shared savings, bundled payments, and global payments	ACO measures may be drawn from Massachusetts' Statewide Quality Measure Set	Healthcare Payment Reform Fund to support technical assistance to be determined
Minnesota	Medicaid shared	34 categories of	Integrated	ACOs have the	ACO measures are	Providers receive

Medicaid Integrated Health Partnership ¹⁵	savings/risk program in which integrated and virtual delivery systems and provider groups contract with the state as ACOs	service, including physician services, inpatient hospital, prescription drugs, services at FQHCs, and certain outpatient behavioral health services	Health Partnerships have organizing body, shared governance structure	choice of two tracks <ul style="list-style-type: none"> • Shared savings-only with maximum of 50% shared savings • Shared savings and risk with levels of savings and risk negotiated between the state and ACO¹⁶ 	drawn from Minnesota's Statewide Quality Reporting and Measurement System and include: <ul style="list-style-type: none"> • Clinical quality measures (5 clinic, 3 hospital) • Patient experience (2) 	monthly claim-level data feedback, care management reports, and quarterly financial performance information ¹⁷
New Jersey Medicaid Accountable Care Organization Demonstration ¹⁸	Three-year demonstration project in which ACOs assume responsibility for Medicaid beneficiaries in a defined geographic area	Full scope of Medicaid benefits, including physical, behavioral, pharmacy and dental services	ACOs establish separate governing body with representation from providers and consumers	ACOs to receive shared savings	ACOs mandatory measures cover several domains: <ul style="list-style-type: none"> • Prevention/effectiveness of care (2) • Acute care (1) • Behavioral health (2) • Chronic conditions (2) • Resource/utilization (7) • CAHPS/Satisfaction (7) ACOs must also choose from a menu of voluntary prevention and	None from the state at this time

					chronic condition measures	
New York ACO Certification ¹⁹	New York Department of Health will issue certifications for ACOs, including expedited review for Medicare-only ACOs participating in the Medicare Shared Savings Program	Covered benefits are not specified in statute	ACOs establish separate governing body with representation from publicly insured, privately insured, and uninsured consumers; ACO participants must control at least 75% of the governing body	ACOs will develop novel payment methodologies through contracts with third party payers; payment strategies may include full or partial capitation	ACO performance measures will be defined through rulemaking process	Technical assistance will be provided to health care providers participating in an ACO; ACOs can receive capital grants for delivery system improvement
Oregon Medicaid Coordinated Care Organizations (CCOs) ^{20 21}	Statewide network of community-based organizations selected competitively are providing integrated and coordinated care for Medicaid beneficiaries under a global budget	Full scope of Medicaid benefits, including physical, behavioral, and dental services	CCOs maintain governance body with community representation (including use of community advisory councils)	CCOs receive a global budget s that include PMPM, transformation incentive payments, and Medicare funds for dual eligible patients; CCOs themselves are expected to use value based payments when contracting with health care providers	CCOs have 17 incentive measures across quality improvement focus areas including: ²² <ul style="list-style-type: none"> • Improving access • Improving primary care • Improving physical and behavioral health coordination • Reducing unnecessary utilization • Ensuring appropriate care • Addressing discrete health issues 	Patient-centered medical home learning collaborative convened by the state, Transformation Center provides grants and technical assistance to Coordinated Care Organizations ²³

					<ul style="list-style-type: none"> • Perinatal and maternity care • Electronic health record adoption • Reducing preventable re-hospitalizations • Patient satisfaction 	
Texas Health Care Collaboratives ²⁴	Texas Department of Insurance is certifying new ACO-like entities that may contract with public or private payers	Medical, chiropractic, dental, hospitalizations, and pharmaceutical services	Health Care Collaboratives governed by board of directors composed of physicians and providers reflecting the composition of the collaborative	ACOs will develop novel payment methodologies through contracts with third party payers, which may include episode-based, global, or pay-for-performance	ACO quality measurement can be specified in contracts with third-party payers	None from the state at this time
Utah Accountable Care Contracts ^{25 26}	Medicaid re-negotiated managed care contracts to include accountable care principles to promote the restructuring of the fee-for-service payment relationships that exist between managed care companies and provider organizations	Physician services, inpatient and outpatient hospital services, home health, and pharmacy	Managed care entities contract with the state Department of Health, which retains oversight responsibility	Managed care entities receive per person per month global, risk-adjusted payments, with flexibility to pursue innovative payment mechanisms in contracts with providers	Managed care entities performance and quality outcome measures are currently under review by the Utah Division of Medicaid and Health Financing	None from the state at this time
Vermont Medicaid	Shared savings program within	Medicaid-covered services, including	ACOs establish separate	ACOs have the choice of two	Medicaid ACOs recommended Year 1	Integrated health data system

Shared Savings Program ²⁷	Medicaid aligning with both the Medicare Shared Savings Program and a commercial ACO pilot	medications, dental, transportation, waiver services, and services administered through the Department of Education	governing body with practitioner and Medicaid beneficiary representation; 75% of the board must be chosen by ACO participants	tracks <ul style="list-style-type: none"> • Shared savings-only with maximum of 50% shared savings • Shared savings and risk with maximum 60% shared savings 	payment measures, include measures derived from: ²⁸ <ul style="list-style-type: none"> • Claims (13—11 overlap with commercial ACO measures in the state and 3 overlap with the MSSP) • Clinical data (7—all overlap with commercial ACO measures in the state, 5 overlap with the MSSP) • Patient experience data 	(including a multi-payer claims data set, health information exchange, central registry, and technical assistance to practices on IT issues)
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Source: Authors’ analysis of state websites. “Value-based purchasing” is the linking of some portion of health care reimbursement to performance on quality or cost indicators. “MSSP” refers to the Medicare Shared Savings Program, through which the federal government is recognizing and distributing shared savings to accountable care organizations. “PMPM” is a per-member per-month payment to an organization or provider. “Dual eligible” refers to beneficiaries eligible for both Medicare and Medicaid benefits. The “matchmaking” database in Illinois allows organizations wishing to join or form a Care Coordination Entity to search for prospective partner organizations based on organization type and location in the state.

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