

MEDICAID ACOS: UNDERSTANDING DIFFERENT STATE APPROACHES

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EXECUTIVE SUMMARY

Medicaid accountable care organizations (ACOs) differ from state to state. To understand these differences, Leavitt Partners developed a framework that explains four approaches states take to establish ACO programs. The framework considers the level of state engagement with the ACO based on whether a Medicaid managed care organization (MCO) exists in the state and the MCO's degree of involvement. The framework can assist a variety of stakeholders, including states considering a Medicaid ACO approach, policymakers seeking to encourage the growth of accountable care, and researchers evaluating different ACOs' performance.

BACKGROUND

ACOs are groups of providers who together agree to assume financial responsibility for the cost and quality outcomes of a defined population of patients.¹ Just as Medicare and commercial payers are increasingly adopting accountable care contracts as a method for addressing unsustainable cost growth and variable outcomes, states are also pursuing similar strategies that aim to fundamentally transform payment and delivery systems in ways that benefit the state, its provider community, and the Medicaid population. Population-based models like ACOs have the potential to help contain Medicaid costs while maintaining quality of and access to care by incentivizing and enabling providers to deliver more efficient and coordinated care, thereby reducing the use of unnecessary health care services.

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¹ Muhlestein, D. et al, "[The Accountable Care Paradigm: More Than Just Managed Care 2.0](#)," Leavitt Partners, June 24, 2013.

As of July 2018, 13 states have implemented Medicaid ACO programs, covering 3.6 million beneficiaries, and at least 10 more states are exploring accountable care initiatives for Medicaid.² Given the increased interest in Medicaid ACOs, it is important to understand how these Medicaid ACOs deviate from state to state. Although all ACOs meet the same definition and adhere to common principles, approaches to accountable care can vary significantly, differing by provider configurations, performance measurement, payment methods, and more. This variation is particularly evident across Medicaid ACO programs, as states pursue certain strategies based on their unique circumstances and needs. Unlike standardized federal ACO programs – such as the Medicare Shared Savings Program or Next Generation ACO Model – classifying Medicaid ACO models can be challenging.

MEDICAID ACO APPROACHES

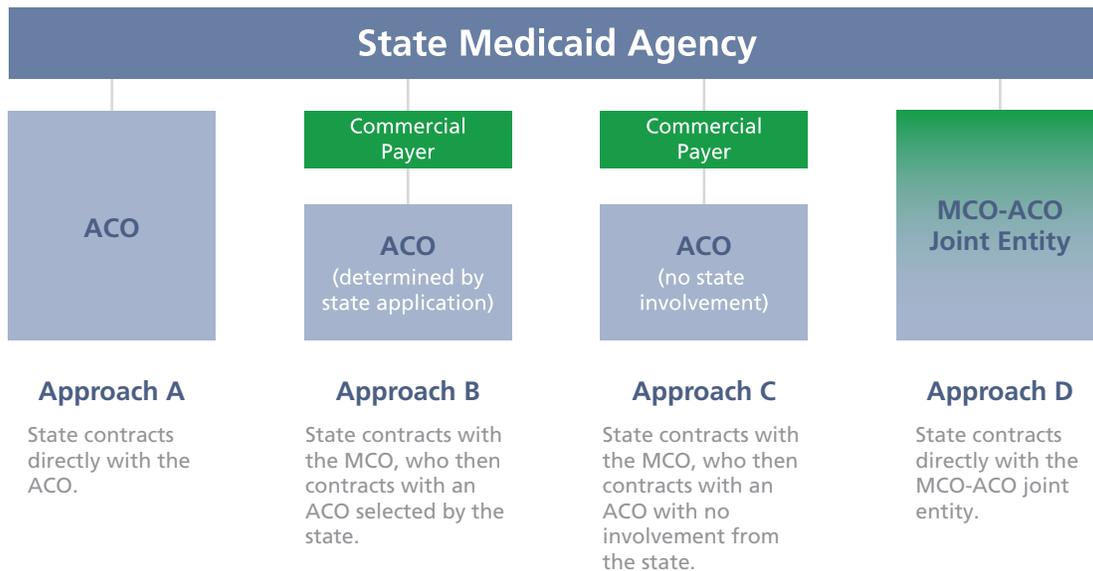
There are many ways to classify and compare Medicaid ACO programs, such as by the authority used, the scope of services included, and the payment methods involved. The Leavitt Partners framework takes a new approach to classifying and comparing Medicaid ACO programs by analyzing the relationships between the state, the provider participants, and Medicaid MCOs, if applicable.³ Figure 1 depicts the four common approaches states have pursued with their Medicaid ACOs, based on the level of state involvement and interaction.

In approach A, the state contracts directly with the ACO providers, which distinguishes it from the other Medicaid ACO structures that include an MCO – or other health care organization contracted to pay for beneficiaries' Medicaid health services. While this approach provides the state with the most control and flexibility to determine the model parameters that best align with its goals (e.g., payment methods, quality measurement, provider eligibility/participation requirements, risk levels, etc.), the state also bears the significant operational and administrative responsibilities associated with facilitating

² Leavitt Partners Torch Insight analytics database

³ MCOs are entities that contract with the state to provide for the delivery of health care services to Medicaid beneficiaries for a set, often capitated, payment, though the specific involvement of the MCO can differ from state to state.

Figure 1 Medicaid ACO Structures



the program – including design, roll-out, evaluation, and maintenance. Oregon, Minnesota, Vermont, Colorado, and Maine are a few examples of states that have implemented this structure.

In approach B, the state may remain highly involved in developing the model—even selecting the ACO’s participants—but the contract is between the MCO and ACO. In some cases, the state may require that its Medicaid MCOs contract with an ACO or the state may certify the ACOs with which an MCO may contract. Typically, the MCO will receive a capitated payment from the state and then determine which payment model to use between the MCO and the ACO. However, some states choose to remain involved in selecting the payment model. In contrast to approach A, under approach B ACOs typically have less control over aspects of care delivery, quality measures, and financial elements and must rely more on MCOs as an intermediary between the state and the care delivery system. States that incorporate this structure include Rhode Island, Michigan, New Jersey, and Massachusetts.

Under approach C, the state contracts with the MCO and the MCO independently chooses to contract with an ACO. Under this approach, the state involvement ends with the capitated payment to the MCO. The state is not involved in deciding whether to contract with an ACO but rather

the MCO has determined it is advantageous to pursue an alternative payment model with an ACO. Approach C can be seen in California, Missouri, and Massachusetts.

Under approach D, the MCO and the provider organization partner to create an ACO as a joint entity. The payer and the providers continue to split responsibilities appropriate to their expertise but work together toward common goals. The state contracts with the joint entity and is generally involved in determining the payment model and program components. Massachusetts and Utah use this type of partnership structure approach.

It is important to note that in some instances, Medicaid ACOs exist in states that do not have a state Medicaid ACO model. In these states, the formation of Medicaid ACOs are driven by the provider or payer communities (rather than the state) and are determined by their interests. These types of approaches have been developed in Ohio, Tennessee, Arkansas, Florida, and California.

REASONS STATES CHOOSE DIFFERENT APPROACHES

State ACOs differ in their organizational structures, governance, provider eligibility requirements, covered populations, scope of services, required functions, payment models, and quality measures, all of which influence which type of Medicaid ACO approach the state may choose to implement. Additionally, which Medicaid

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ACO approach the state elects depends on the level of control and ownership over the ACO the state wishes to retain, the state's appetite for accepting additional administrative burden, and whether the state already has active managed care organizations in place. Although most states only use one Medicaid ACO approach, in some cases a state may choose to implement multiple approaches simultaneously instead of just one, such as Massachusetts has done.

Under approaches A and D, the state retains the greatest levels of control and ownership because it can define the payment terms and other program components as well as select the contracting ACO. However, increased state control and ownership are also accompanied by increased administrative burden on the state. Thus, states seeking to minimize this burden may choose approach B or C that involve an MCO as an intermediary. In addition, if ACOs prefer to rely on MCOs for administrative functions and responsibilities, especially financial elements, they may also prefer approach B or C. In approaches B and C, states retain less control and ownership. However, the state may retain more control and ownership in approach B if they decide to remain involved in choosing the ACOs.

Whether a state has an active managed care program also factors into which Medicaid ACO approach the state chooses. Approach A may make the most sense for states that do not have an active managed care program; however, states without an active managed care program will have less experience and capabilities to manage an ACO program. If a managed care program is in place, it may be untenable to exclude the MCO from the process, thereby removing approach A as the sole possibility.

PROVIDER INFLUENCE AND PERSPECTIVE

A state's provider landscape can also influence its approach to Medicaid ACOs. States may select approach A or D because much of the provider community is already engaged in value-based contracting with other payers and therefore has more experience and infrastructure already in place. Alternatively, a state may choose approach B or C because the providers are skeptical of value-based contracting and/or lack experience coordinating care with other providers. Approach B, for example, allows the state to leverage the administrative support of an MCO but keep the authority to select the ACO participants.

Providers' experiences differ based on which Medicaid ACO approach the state uses. Approaches A (state contracts directly with ACO) and D (state contracts directly with the MCO-ACO joint entity) not only give the state more control over the ACO but also allow providers more control over aspects of the ACO. For example, under both approaches A and D, providers may experience more influence over components of care delivery and quality measures. However, under both approaches the providers and state may experience more administrative burden. When the state has more control over the ACO, providers may have additional reporting requirements, including submitting data to state-sponsored care quality and care cost repositories. In contrast, because the MCO intermediary plays a larger role, approaches B and C may afford providers less control over aspects of care delivery, quality measures, and financial elements.

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UNIQUE MEDICAID REGULATORY ENVIRONMENT

It is also important to understand how a state's unique Medicaid regulatory environment factors into which approach a state chooses. State Medicaid agencies

have the flexibility to develop and outline their ACO programs; however, they are limited by the authority permitted them in the Social Security Act (Act) and the policy guidance outlined by the Centers for Medicare & Medicaid Services (CMS) on integrated care models. However, federal authorities may allow states to waive certain Medicaid requirements, including implementing managed care in specific areas or regions rather than the whole state, providing different benefits to individuals enrolled in managed care, and requiring individuals to receive Medicaid services from managed care plans. Depending on existing structures and the approach that is ultimately decided on, a state may seek certain authorities to waive or broaden the scope of services, the populations served, and/or the payment methodologies and incentives. Looking at the current landscape of Medicaid ACOs, states have used one or a combination of these federal authorities to develop a Medicaid ACO program: Section 1115 waivers, state plan amendments, and managed care authority (1915a and 1915b).⁴

Section 1115 Waivers

Section 1115 waivers are used when states seek to implement experimental, pilot, or demonstration projects or to waive specific requirements of the Act in order to implement their programs. For example, in some cases Oregon's Coordinated Care Organizations (CCOs) can restrict enrollees' choice of payer. For this reason, an 1115 waiver was required. 1115 waivers are used to expand eligibility to those otherwise ineligible for Medicaid,

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State Plan Amendments

State plan amendments (Section 1932(a)) are used when the proposed changes to Medicaid health care delivery do not require waiving any requirements in the Act. This authority allows states to require certain categories of Medicaid beneficiaries to enroll in managed care plans. Maine, Minnesota, and Vermont are examples of states that used state plan amendments to develop their Medicaid ACO programs.

Managed Care Authority

Managed care authority (Section 1915(a) and (b)) permits the implementation of state ACO programs: 1915(a) waivers allow states to implement a voluntary managed care program through contracting with entities using a competitive procurement process while 1915(b) waivers allow states to restrict Medicaid enrollees to receive services from a managed care plan, use cost savings to provide additional services to beneficiaries, and restrict the providers from which Medicaid beneficiaries can obtain services. Minnesota and Rhode Island used managed care authority to implement their Medicaid ACOs.

CONCLUSION

A variety of factors influence why states choose different approaches, including a state's desired amount of control and ownership, a state's willingness to accept additional administration burden, and the state's managed care and regulatory environments. Classifying Medicaid ACOs into the four approaches can help stakeholders understand the differences between Medicaid ACOs across states and assist organizations interested in forming Medicaid ACOs realize the structures, responsibilities, and investments that may be needed in their particular state. Finally, by organizing different state approaches into these four categories, policymakers and researchers are better positioned to evaluate and improve Medicaid ACOs.

⁴ [Medicaid.gov. Authorities](https://www.medicaid.gov/authorities). Accessed on June 13, 2018.



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