Accountable Care Organizations (ACOs) in Medicaid: Challenges and Opportunities for Advocates

An accountable care organization, commonly referred to as an ACO, is an entity that is made up of health care providers from across the continuum of care who agree to be held accountable for improving the health of their shared patients.¹ In an ACO, providers are rewarded for delivering high-quality care, rather than being paid based solely on the volume of services they provide. Furthermore, providers in an ACO share accountability for improving the health of their patients because a portion of their payment is tied to whether the whole group succeeds at improving patients’ care and health outcomes. If the ACO improves or maintains patient health while keeping the total cost of care below a defined benchmark, the providers keep a portion of the savings or receive other quality incentive payments. This payment structure creates a financial incentive for all providers in an ACO to work as a team to improve the way they deliver care.

Part of the promise of ACOs is that they are designed to change both the way care is paid for and how care is delivered. Implementing this model of care in a state’s Medicaid program has the potential to improve patient care and health while controlling costs. However, Medicaid ACOs will achieve these goals only if they are designed primarily to improve patient health and if they are equipped to overcome the long-existing barriers that make it difficult to provide coordinated, timely, and appropriate care to Medicaid patients.

This issue brief discusses why states may want to consider developing ACOs in their Medicaid programs and how to implement this type of ACO. It also discusses the role advocates can play in developing Medicaid ACOs, and it lays out some of the challenges and questions advocates will need to consider as their states develop ACOs for their Medicaid populations.
ACOs Can Address the Need for Health System Reform in Medicaid

Medicaid provides health coverage to people with some of the most complex health care needs. In addition, Medicaid patients often face significant social barriers to achieving good health, including lack of reliable transportation, language barriers, and homelessness.

Medicaid patients need coordinated care for their medical and social service needs.

In order to effectively manage Medicaid patients’ health, they must be provided with coordinated and personalized care that addresses all of their medical and social service needs. And ideally, doctors should work with patients to manage their health care and to prevent future health problems. However, many Medicaid programs currently struggle to provide coordinated care. This is in part because doctors and other health care providers are often paid through a fee-for-service system that rewards providers based on the quantity of services rather than the quality of care. Even in states that contract with managed care organizations (MCOs) to coordinate and pay for Medicaid patients’ care, providers are often still paid, to some extent, based on the volume of services.

This volume-based payment system does not reward providers for delivering high-value care. Instead, it incentivizes providers to treat patients’ individual health problems on a case-by-case basis. Furthermore, this system does not pay providers to spend time on low-cost but important services that can improve patients’ health and prevent complications, such as coordinating care with other providers and helping patients obtain community-based services and supports (ancillary social services such as housing or transportation assistance).

Limitations in states’ Medicaid programs also make it difficult for patients to get appropriate and timely care. For example, benefit exclusions or limits, unaffordable copayments, and lack of providers who see Medicaid patients can all make it hard to get necessary care. In addition, low-income patients can experience disruptions in care if their income fluctuates frequently and they churn in and out of Medicaid.

To offer Medicaid beneficiaries the high-quality, coordinated care they need, states need to financially incentivize providers to change the way they deliver care. An ACO model of care has the potential to achieve this, so long as it holds providers accountable for delivering high-quality care. To do this, ACOs must tie providers’ payments to real improvements in the quality of care, not just reductions in the cost of care. This means that before providers in an ACO can earn any incentive payments for lowering health care costs, they must meet certain quality metrics to demonstrate that they have made meaningful progress toward improving their patients’ health and quality of care. This type of payment and accountability system encourages providers to work together across settings to deliver more coordinated care and ensure that patients receive the right care at the right time and in the right setting.

A state’s ACO program must also address other longstanding barriers to obtaining coordinated care in Medicaid, which could limit an ACO’s ability to deliver high-quality care. As states design Medicaid ACOs, they will need to include policies to resolve these additional barriers.
Opportunities for Implementing ACO Models in Medicaid

There are multiple ways states can pursue ACO models of care in Medicaid. States can develop Medicaid ACO programs using state plan amendments or Medicaid waivers. Whether a program can be implemented through a state plan amendment or a waiver will depend on how a state designs its program. The Centers for Medicare and Medicaid Services (CMS) has released multiple state Medicaid director letters that provide guidance on how states can implement integrated care models, including ACOs, in their Medicaid programs.5 The Affordable Care Act also authorized limited demonstrations that allow states to test Medicaid Pediatric ACOs over a five-year period (2012-2016).6 While this demonstration has yet to receive funding, it may be another way for states to pursue ACO models of care in the future.

Multiple states are developing or implementing ACO models of care in their Medicaid programs. For example, Colorado developed an ACO model of care, called Regional Care Collaborative Organizations (RCCOs), which began enrolling Medicaid beneficiaries in 2011. Oregon’s Medicaid program includes ACOs, called Coordinated Care Organizations (CCOs), which began enrolling Medicaid patients in 2012. New Jersey and Utah are also in the early stages of implementing Medicaid ACOs. Throughout this brief, we will include examples from these states to show how states have addressed the challenges involved in setting up good programs.

Next, we discuss six key challenges states may face when developing Medicaid ACO programs, as well as issues for advocates to consider when evaluating how these challenges can best be addressed.

The Role for Advocates

If Medicaid ACOs are going to be successful, they must be implemented in a consumer-friendly manner. Advocates should make sure that Medicaid ACOs are prepared to meet the needs of the populations they are expected to serve. Advocates will also want to make sure that their states build strong accountability requirements that ensure that ACOs are lowering health care costs by improving the quality and continuity of care, not by limiting patients’ access to care.

Advocates should be involved in every stage of the development and implementation of Medicaid ACO programs. This could mean the following:

- Participating in the state planning process to develop a Medicaid ACO program, such as attending stakeholder meetings
- Commenting on state proposals to implement Medicaid ACOs, including draft legislation, Medicaid state plan amendments or waivers, and requests for proposals, which outline the requirements that ACOs will have to meet in order to contract with the state
- Participating in a local ACO’s governing body as a consumer representative to ensure that the ACO meets the needs of the community it serves
What’s the Difference between an ACO and an ACO-Like Organization?

While there is no single, uniform definition of an ACO, the Centers for Medicare and Medicaid Services (CMS) and others often use the term to refer specifically to entities that are set up and paid based on the ACO model used by the Medicare Shared Savings Program. These ACOs are provider-led organizations that are paid through a shared savings model. This means providers within an ACO are paid upfront using a fee-for-service model—but the ACO is challenged to keep its total health care costs within a benchmark budget. If the ACO provides care within that budget while meeting certain quality metrics, providers have the opportunity to share in any savings they produce based on that benchmark budget.\(^7\)

However, ACOs can be paid in many different ways. Organizations that share the same goals and core functions as ACOs (see “Core Functions of ACOs” on page 8) but that are paid through an incentive payment model that is different from the Medicare Shared Savings Program are sometimes called ACO-like organizations. For example, an ACO-like organization could be an entity that carries out the same functions as an ACO but that is paid on a fully capitated basis, where it receives a single monthly payment for each patient it is responsible for and is expected to cover the full range of patients’ health needs within that budget.

For the purpose of this brief, the term ACO is used to refer broadly to both ACOs and ACO-like organizations, unless otherwise stated.

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**Challenges in Developing Medicaid ACOs**

**Challenge 1:**
Who will run the ACOs?

ACOs can be designed in multiple ways to fit within a state’s existing Medicaid program, whether it is a fee-for-service system or a managed care system. The major players that run an ACO will depend on the scope of responsibilities a state gives its ACOs. Typically, an ACO is run by a group of providers. A provider-led ACO could be a completely integrated health delivery system where most of the providers who work with the ACO are actually employed by the ACO. A provider-led...
ACOs should be tailored to meet the needs of the communities they serve.

ACOs could also be run by a smaller practice of health care providers that contracts to work with other providers to deliver services across the full continuum of care.

Provider-led ACOs can work in both fee-for-service Medicaid programs and Medicaid managed care programs. This kind of ACO is responsible for coordinating and providing care, but it often doesn’t manage payment for patient care. States will therefore need to ensure that provider-led ACOs have adequate administrative leadership, in addition to clinical leadership, and are capable of managing and allocating resources for health system improvement initiatives.

States that already contract with managed care organizations to coordinate and pay for Medicaid patients’ care could design Medicaid ACOs that incorporate these administrative and financial responsibilities. In this model, the ACO-like organizations are responsible for delivering and coordinating care, and they also take on some or all of the financial risk of paying for patients’ care.

These ACO-like organizations may include managed care entities in their leadership, but they should be meaningfully different from managed care organizations in a number of ways. If a state is considering this option, its requirements for ACO-like organizations must include certain core ACO components to ensure that they are truly different from managed care. Most importantly, all ACOs must have significant financial incentives in place for providers to improve how they deliver care. Therefore, states should require that ACO-like organizations that pay for care have value-based payment arrangements with all participating providers.

States should also establish robust quality metrics that ACOs must meet and sanctions that will be imposed if they don’t make meaningful progress toward meeting those predetermined metrics. Holding ACOs accountable using quality metrics ensures that ACOs drive down health care spending by improving health care quality and continuity of care, not by limiting care (see Challenge 6 on page 15). This accountability mechanism will be particularly important for ACO-like organizations that take on the risk of paying for care, because they will have a greater financial incentive to contain health care spending.

In addition, ACOs should always be community and provider-based. This means that ACOs should be tailored to meet the needs of the communities they serve. It also means that community providers should play a significant role in an ACO’s governance. States should require that the governing bodies of ACOs, including ACO-like organizations, have meaningful voting representation by patients, caregivers, and community providers (see Challenge 3 on page 9). In addition, ACOs should always ensure that patients and providers—not health plans or administrators—are in charge of making health care decisions. State contracts should restrict the ability of
ACO-like organizations to apply utilization management techniques that have historically been used by managed care organizations and that have created barriers to care. All of these requirements will help ensure that ACO-like organizations are, in principle and in practice, different from traditional managed care.

Challenge 2: Who will the ACOs serve?

In what part of the state will ACOs provide care?

A state could have Medicaid ACOs that serve patients across the entire state, or it could limit its Medicaid ACOs to only part of the state. For example, a state may choose to implement Medicaid ACOs in targeted counties or cities because that’s where the patients with the greatest health care needs who could most benefit from care coordination live. A state may also want to initially limit ACOs to certain counties or cities if only particular regions of the state have delivery systems that are prepared to support an ACO’s core functions (see “Core Functions of ACOs” on page 8). For example, if a rural region of a state has a limited health information technology (HIT) infrastructure and significant provider shortages, moving to an ACO model of care may be unrealistic and could put additional strain on providers.

Which types of Medicaid enrollees will the ACOs serve?

In addition to deciding which part of the state ACOs will serve, a state will need to decide which Medicaid populations the ACOs will serve. A state could include all Medicaid patients, or it could include only a specific Medicaid eligibility category, such as children. If a state and/or providers have limited infrastructure and resources to invest in ACOs, focusing the program on a specific population could allow ACOs to direct those resources to addressing the particular health care needs of that population.

It is important to note, however, that the more limited the scope of the ACO program, the less likely the program will be to drive meaningful changes in the way care is delivered or to produce significant health care savings. This is because providers who participate in an ACO will have less of an incentive to change how they provide care if they are accountable for improving health outcomes for only a small subset of their patients.

Issues for Advocates

- Is the ACO provider-led? If so, do the providers have the administrative and financial expertise to run an ACO?
- Does the ACO model use ACO-like organizations that are responsible for paying for patient care, similar to a capitated MCO that is paid a single monthly payment to cover all of a patient’s health care expenses for that month? If so, do state requirements ensure that ACO-like organizations are community-based and provider-led and that they are held accountable for improving the quality of patient care?
- Does the state require ACO-like organizations to have value-based payment arrangements with their providers?
Will the state expand its Medicaid ACO program over time?

A state could initially implement an ACO program that is limited in scope and expand the program to more Medicaid enrollees over time. This is one strategy a state could use to transition its delivery system to one that is equipped to provide integrated, patient-centered care. If a state opts to gradually implement an ACO model of care, it needs to have a long-term plan for expanding the program to serve the majority of Medicaid patients, particularly those with the most complex care needs and the highest health care costs. This plan must include clear strategies to strengthen the workforce and infrastructure of the state’s delivery system to ensure that ACOs are prepared to provide patient-centered, coordinated care to the entire Medicaid population.

In their first year, Colorado’s Regional Care Collaborative Organizations (RCCOs) could serve only a limited number of Medicaid enrollees in parts of the state that already had coordinated delivery systems with strong connections among health providers and community resources. The state required RCCOs to have a plan to expand their capacity over time to serve the Medicaid population across larger regions of the state. RCCOs were allowed to expand their program to serve more Medicaid patients so long as they were able to meet state benchmarks for controlling health care spending within their first year.9

States that want to expand their ACO programs over time should strongly consider requiring ACOs to first demonstrate that they have made meaningful progress in implementing their expansion plans and have met predetermined quality metrics, rather than basing the decision solely on whether they successfully control health care spending. This will ensure that ACOs are prepared to provide high-quality, coordinated care to additional patients.

Issues for Advocates

- Will ACOs serve the entire state or only certain regions? Is the state’s delivery system sufficiently resourced to provide patient-centered, coordinated care to the populations the ACOs are expected to serve?
- Which eligibility categories of Medicaid patients will the ACOs be expected to serve? Is this a large enough population to incentivize providers to significantly change the way they deliver care?
- If a state decides to expand the scope of its ACOs over time, how will the state and the ACOs strengthen the delivery system’s workforce and infrastructure so that the ACOs can serve more patients?
Core Functions of ACOs

ACOs have three main goals: improving health care quality, improving patient outcomes, and helping bring rising health care expenditures under control. To achieve these goals, an ACO must be able to perform the following core functions:

- Establish an organizational structure and develop relationships with a robust network of providers, including providers of community-based services and supports and community-based public health organizations
- Facilitate communication and information sharing among providers across care settings and among medical and community-based settings
- Manage a budget and allocate resources across the organization
- Perform administrative functions, including negotiating contracts with participating providers, receiving quality incentive payments, and distributing shared payments across participating providers
- Identify and share health care best practices that advance the goal of delivering high-quality, coordinated care
- Use health information technology (HIT) to manage the health of its patient population, identify and engage high-risk populations, coordinate care, and assist providers in delivering evidence-based care
- Collect, monitor, manage, and report on health quality measures
- Analyze population health data and develop organizational goals based on those data
- Give participating providers technical assistance to help them improve the way they deliver care (this could include training staff in case management or helping medical practices effectively use electronic medical records)
- Connect patients with health education and support resources, through either the ACO or a community-based partner
- Have the capacity to manage financial risk (if participating in an ACO program that asks ACOs to bear some financial risk for providing care)
- Provide leadership in defining clinical guidelines and driving change in the culture of how care is delivered
**Challenge 3:** How will ACOs meet the community’s needs?

How will ACOs identify the needs of the populations they serve?

A state should help determine which parts of the state have the workforce and infrastructure necessary to support an ACO model of care. However, it is each ACO’s job to identify the needs of the population it serves and develop a plan to meet those needs. For example, an ACO should know the primary languages and demographics of its population so it can provide culturally and linguistically appropriate care. It should also understand the population’s main health and social service needs so it can build a provider network that is prepared to meet those needs.

To fully understand the community’s needs, ACOs must seek input directly from the communities they serve. To foster meaningful community engagement, ACOs should develop working relationships with community organizations that directly serve or closely work with those populations.

States can help ensure that ACOs identify population needs by requiring every ACO to conduct a community needs assessment. This assessment should examine the population’s demographics, its main health and social service issues, and the primary barriers to care and good health it faces. These assessments can also identify existing community resources that ACOs should use to address these problems. In addition, needs assessments can inform what types of providers an ACO should partner with and which health problems and barriers an ACO must be prepared to address. States can also require ACOs to engage community-based organizations and the populations the ACO expects to serve when developing and carrying out a community needs assessment, and when creating an actionable health improvement plan to address unmet needs.

**FROM THE STATES**

Oregon requires all of its Coordinated Care Organizations (CCOs) to conduct community health assessments and community health improvement plans to help guide their actions. States that adopt similar requirements should consider including accountability mechanisms to ensure that ACOs make progress in implementing their community health improvement plans.

How will states ensure that ACOs have adequate provider networks?

Medicaid ACOs should have provider networks that are equipped to provide patient-centered care that addresses the full range of Medicaid patients’ health and social service needs. It’s particularly important for Medicaid ACOs to have strong networks of primary care providers and key specialty providers, such as mental health providers, who can address chronic health problems that affect significant segments of the Medicaid population. Medicaid ACO networks must also include specialists that provide services that Medicaid patients have historically struggled to obtain, such as oral health providers.

In addition, states should require ACOs to partner with the majority of safety net providers, also called essential community providers, in their communities. These
providers include federally qualified health centers (FQHCs) and other community clinics, rural health clinics (RHCs), family planning clinics, Ryan White HIV/AIDS providers, Hemophilia Treatment Centers, and others. Providers like these are already trusted sources of care for many Medicaid patients and have a good understanding of their needs.

In addition to their medical provider networks, ACOs should have strong relationships with providers of community-based services and supports who can help address unmet social service needs. These providers could include social workers, housing assistance programs, transportation service providers, food assistance programs, and other ancillary service providers.

Ensuring that Medicaid ACOs have robust provider networks may not be easy. In states that have experienced Medicaid provider shortages, advocates should think critically about how the Medicaid ACO program could be used to incentivize more providers to participate in Medicaid. Advocates should also urge their states to set robust and measurable network adequacy requirements for Medicaid ACOs. This will ensure that ACOs partner with a sufficient number of providers across key specialties and settings, including social service settings.

George Washington University has developed model contract language for states to use for the Children’s Health Insurance Program (CHIP) managed care plans that includes robust requirements that plans must contract with safety net providers. The Affordable Care Act also established a broad requirement for qualified health plans to contract with a sufficient number of essential community providers. Because of this requirement, some states have set robust standards for how many essential community providers qualified health plans must contract with in order to participate in the new health insurance marketplaces. States could look at the model contract language for CHIP managed care plans and at states’ qualified health plan standards as starting points for developing requirements for ACOs to partner with essential community providers.

New Jersey state law created measurable network adequacy standards that Medicaid ACOs will have to meet, including partnering with at least 75 percent of the primary care providers in the region they serve.

Who will participate in the ACO’s governance structure?

An ACO’s governance structure should be an important mechanism for ensuring that the ACO meets the needs of its community. To this end, advocates should ensure that states require ACOs’ governing bodies to include voting representation of patients, caregivers, essential community providers, community-based service providers, and other key community stakeholders. This will help ensure that the ACO is responsive to its local environment.
It is important that patients be able to receive care from the provider of their choice.

Passive enrollment automatically assigns Medicaid enrollees to an ACO based on either the geographic region where patients live or patients’ existing primary care providers. Each of these factors has benefits and drawbacks. Assigning patients to an ACO based on where they live could help engage new patients with the primary care setting, but only if those patients understand how to obtain primary care through their ACO. Also, assignment based on geography can disrupt continuity of care if a person is already receiving care from a provider in another ACO. Passively enrolling patients in an ACO based on their existing primary care providers preserves patient-provider relationships and continuity of care. However, this method runs the risk of not capturing patients who don’t have a usual source of care and who could likely benefit most from coordinated care.

If a state chooses to passively enroll Medicaid patients in an ACO, it will need to clearly notify those patients about their assignment and give them the opportunity to opt out of or to change ACOs. Advocates should ensure that this notification is written in plain language, that it clearly explains what being in an ACO means, and that it provides information on how patients can opt out of or change the ACO they are enrolled in if they prefer to receive care through another provider.15

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Issues for Advocates

- Does the ACO understand the needs and demographics of the community it’s serving, and does it have a plan to ensure it can meet those needs? Does it have a strategy for community engagement?

- Does the ACO have relationships with an adequate number and appropriate types of providers, including community-based service providers and safety net providers? Is the ACO’s network equipped to provide culturally and linguistically appropriate care?

- Does the ACO’s governance structure include adequate voting representation of patients, caregivers, community-based service providers, and key specialty service providers, including mental health and substance use disorder providers?

Challenge 4:
How will patients be assigned to ACOs?

Will patients actively or passively enroll in ACOs?

In order for an ACO to be held accountable for providing high-quality care, it must know which patients it is responsible for. There are two ways a state can assign patients to an ACO: passive enrollment and active enrollment.

Passive enrollment automatically assigns Medicaid enrollees to an ACO based on either the geographic region where patients live or patients’ existing primary care providers. Each of these factors has benefits and drawbacks. Assigning patients to an ACO based on where they live could help engage new patients with the primary care setting, but only if those patients understand how to obtain primary care through their ACO. Also, assignment based on geography can disrupt continuity of care if a person is already receiving care from a provider in another ACO. Passively enrolling patients in an ACO based on their existing primary care providers preserves patient-provider relationships and continuity of care. However, this method runs the risk of not capturing patients who don’t have a usual source of care and who could likely benefit most from coordinated care.

If a state chooses to passively enroll Medicaid patients in an ACO, it will need to clearly notify those patients about their assignment and give them the opportunity to opt out of or to change ACOs. Advocates should ensure that this notification is written in plain language, that it clearly explains what being in an ACO means, and that it provides information on how patients can opt out of or change the ACO they are enrolled in if they prefer to receive care through another provider.15
In active enrollment, a state requires each Medicaid patient to actively enroll in an ACO, so patients must select the ACO they want to join. Active enrollment allows patients to select an ACO based on who they want to have as their primary care provider. However, patients who do not already have a usual source of care may be less likely to select an ACO.

If a state decides that Medicaid patients must actively enroll in an ACO, it will need to have an outreach campaign to educate patients about what an ACO is and to encourage patients to enroll in one. The state will need to develop specific outreach strategies designed to reach patients who do not already have a usual source of care, and it should develop assistance programs to help people select and enroll in the ACO that’s right for them.

Will patients still have freedom of choice of provider?

Regardless of how patients enroll in an ACO, it’s important that they be able to receive care from the provider of their choice. It’s also important that patients have the option to change their ACO if they do not like the care they are receiving or if they move. States should avoid instituting policies that require patients to enroll in an ACO without being able to opt out (mandatory enrollment) or that prevent patients from changing their ACO or leaving their ACO for a certain period of time (lock-in periods). States should also avoid policies that prevent patients from receiving care from providers outside their ACO’s network, at least initially. All of these policies can create barriers to obtaining timely and quality care. These policies also undermine the goal of holding ACOs accountable for delivering patient-centered care, because providers wouldn’t have to worry about patients leaving their ACO or switching to a different provider if they were dissatisfied with the care they were receiving.

If a state is considering whether or not to restrict patients from getting care outside their ACO, it should do so only after the program has been operating for a number of years, and only if the ACO has demonstrated that it meets robust network adequacy standards. Even then, it will be critical that states have a clear appeals process for patients who still want to get care from a provider outside their ACO (see “Which Patient Protections Should Be Included in Medicaid ACOs?” on page 13).

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### Issues for Advocates

- How will Medicaid patients be assigned to ACOs? How will patients be informed that they are part of an ACO? How will a state connect patients who do not already have a usual source of care to ACOs?
- Do Medicaid patients have to participate in ACOs? Can they opt out of or change their ACO?
- Does the state’s Medicaid ACO program limit patients’ choice of providers? What processes are in place to overcome these limitations?
Which Patient Protections Should Be Included in Medicaid ACOs?

Notice of the Right to Appeal

As states create ACOs, they need to ensure that patients understand who can resolve their complaints (also called grievances) if they believe they have been denied benefits or want to get care outside their ACO. State fair hearing and internal appeals processes are designed to give patients avenues for recourse if they feel they have been unfairly denied coverage for or access to necessary services.

Under federal law, Medicaid patients in every state have the right to address these types of grievances through an appeals process with their state Medicaid agency called a fair hearing. The right to a fair hearing also applies in states that establish ACO programs. If a state’s Medicaid ACO program contracts with ACO-like organizations to pay for care, under federal law, these ACO-like organizations must have the same internal appeal rights that protect beneficiaries in Medicaid managed care.

ACOs should be required to provide clear and timely notices to beneficiaries that explain their rights and how to file grievances, both within the ACO and directly with the state. Advocates should make sure such notices explain which types of grievances an ACO can address versus which types the state Medicaid agency must resolve. Any notice should inform patients of their right to a state fair hearing if they believe they have been wrongly denied benefits (even if they also have the right to an internal appeal through their ACO) and should provide contact information for consumer assistance programs, such as a Medicaid ombudsmen program.

Quality of Care Grievances

States should also establish grievance processes where patients can submit complaints about the quality of care they receive. These types of grievances are important indicators of patients’ experience of care and can help hold ACOs accountable for delivering high-quality care.

States should require Medicaid ACOs to have internal grievance processes for complaints about quality of care and should set uniform standards for what this process should look like across ACOs.

ACOs should also be required to keep a record of grievances they receive and how they were resolved and to regularly submit this information to the state Medicaid agency. States should also have a standard way for beneficiaries to file quality of care grievances directly with a state’s Medicaid agency.

Advocates should ensure that states have a strategy for reviewing reported grievances and a process for sanctioning ACOs based on grievances. For example, a state could limit an ACO’s incentive payments if it didn’t resolve grievances about quality of care.

* If a state’s Medicaid ACO program contracts with ACO-like organizations that pay for patients’ care, federal law requires them to have an internal grievance process for quality complaints, as is required in Medicaid managed care. States may want to establish additional standards, such as stronger requirements for reporting internal grievances.
**Challenge 5:**
How will ACOs deliver better-quality, coordinated care?

What infrastructure will ACOs need to improve care delivery?

Providers may need to make significant investments to better coordinate their patients’ health care. For example, practices may need new health information technology (HIT) to improve how they coordinate treatments and communicate with other providers. Practices may also need to hire additional staff to provide care coordination services. And ACOs will need data collection and analytics technology to track their progress toward improving their patients’ health.

Providers that disproportionately serve Medicaid patients may be unable to afford these upfront investments in technology and staff on their own. States and ACOs should work together to ensure that ACOs have the resources necessary to perform their core functions (see “Core Functions of ACOs” on page 8). States could provide services to ACOs, such as collecting and analyzing data on population health, or providing additional staff to assist with care coordination. States could also make upfront funding available for ACOs and individual providers to cover necessary investments.

The second brief in this series, *Holding Medicaid ACOs Accountable for High-Quality Care: Payment and Quality Measurement*, will discuss in more depth how to design Medicaid ACO payment models to accommodate upfront funding needs.

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**FROM THE STATES**

**Colorado** uses a state-wide external data and analytics contractor to provide all RCCOs with core analytic support functions. These include collecting, “cleaning,” and aggregating Medicaid claims data, as well as giving providers, RCCOs, and the state access to aggregate data in useful formats.¹⁶

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**How will ACOs change the culture of how care is delivered?**

ACOs will need to drive changes in the culture of health care for providers and for patients. Providers must learn how to better communicate and work with their colleagues across care settings, as well as how to work with community-based service providers. Patients and providers must learn to work together as active partners in making health care decisions.

Achieving these changes will not be easy. It will require ACOs to learn from one another’s successes and failures. States can help promote this culture change by creating formal learning collaboratives where providers from different Medicaid ACOs can discuss best practices and learn from each others’ experiences.¹⁷

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**How will ACOs overcome existing barriers to coordinating care?**

Medicaid ACO programs must be able to address long-existing barriers that have made it difficult to deliver coordinated and timely care. For example, benefit limits or exclusions of essential services can prevent providers from delivering the most appropriate care to their patients. Coordinating care for Medicaid beneficiaries can also be more difficult because low-income individuals often “churn” in and out of Medicaid as their incomes fluctuate.

States should develop policies that enable ACOs to address these barriers. Such policies could include giving ACOs the authority to provide services not typically covered by Medicaid, or giving ACOs the flexibility to develop care transition plans for patients who move from Medicaid to different sources of coverage.¹⁸
Challenge 6:
How will ACOs be held accountable for delivering quality care?

How will states measure whether ACOs are delivering quality care?

States must require Medicaid ACOs to meet meaningful quality metrics in order for the ACOs to receive incentive payments for lowering health care spending. ACOs should never receive incentive payments based solely on lowering health care spending and/or reducing use of certain services. Tying incentive payments to meeting quality metrics ensures that an ACO is saving money by better coordinating care and improving patients’ health, not by withholding necessary care. This protects Medicaid beneficiaries and ensures that ACOs are not falling into the same bad practices as managed care organizations—limiting care to produce short-term savings.

For quality measures to be truly meaningful and drive improvements in health and health care, they need to be tailored to the health needs and risks of the population an ACO serves. Advocates will need to make sure that their state adopts robust quality measures that are relevant to the particular Medicaid populations ACOs are serving.

There are several sets of existing quality measures that states and advocates can look at as starting points for developing quality measures for Medicaid ACO programs. The National Quality Forum (NQF) has endorsed measures that evaluate performance on a range of health care quality components, including measures that examine care coordination, health care disparities, and cultural competency. The National Center for Quality Assurance (NCQA) has compiled many sets of quality measures, including a core set of ACO performance measures. CMS has also established sets of core quality measures for Medicaid–eligible adults and children.

Advocates should also look at the Consumer Assessment of Health Care Providers and Systems (CAHPS) Surveys, a tool that is commonly used to measure patients’ experience of care or how care is provided. The CAHPS survey has a core set of measures and several supplemental sets that align well with the goals of ACOs. These include a health literacy set that measures how well providers ensure that patients understand and feel confident communicating about their care. The second brief in this series, Holding Medicaid ACOs Accountable for High-Quality Care: Payment and Quality Measurement, will provide more information on existing sets of quality measures and take a closer look at designing quality metrics for Medicaid ACOs.

Issues for Advocates

- What investments will ACOs need to make to perform their core functions? How will states help ACOs make necessary investments or connect to critical support services?
- How will states facilitate shared learning across ACOs?
- Does the state’s ACO program enable ACOs to overcome past barriers to coordinating care and managing patient health?
How will states reward ACOs that deliver high-quality care?

States will need to decide how to structure the incentive payments for those ACOs that meet established quality metrics. First and foremost, these payments must be large enough to induce providers to deliver high-quality, coordinated care rather than delivering more services. There are many different types of payments that states could use to achieve this goal. Some of these payment models continue to pay providers for each service but give providers bonus payments for meeting certain quality and savings goals. Other payment models require providers to take on some financial risk for providing care. These types of models ask ACOs to provide a certain scope of services within an agreed upon budget. If an ACO’s total health care spending exceeds this benchmark budget, the ACO must cover some or all of this additional cost.

When deciding on which payment method to use, states will need to consider how providers are currently paid by Medicaid and whether they have the capacity to take on some financial risk for providing care. Some Medicaid programs may already be asking providers to take on some of this financial risk or to contract with managed care entities that have experience with managing financial risk. In these states, providers or other leaders within the ACO (such as a managed care entity) may be able to manage a payment model that asks the ACO to bear some risk for providing care. However, states should not ask providers to take on financial risk before they are ready: If providers take on financial risk prematurely, they could face financial problems or go out of business. Other providers may simply choose not to participate in Medicaid if they are asked to take on too much risk before they are ready. These outcomes would obviously make it more difficult for Medicaid patients to get the care they need.

Issues for Advocates

- Does the state’s ACO program have rigorous quality metrics that ACOs must meet to receive any incentive payments? Are the selected quality measures relevant to the health risks of the Medicaid population in that community?

- Does the ACO’s payment structure provide a large enough financial incentive for providers to deliver care based on quality rather than quantity?

- Is the ACO taking on any portion of the financial risk of providing care? If so, are appropriate safeguards in place to ensure that the ACO is prepared to take on this risk?
Conclusion

In order for states to improve the quality of care in their Medicaid programs while controlling program spending, they will need to make major changes to the ways Medicaid provides and pays for care. Medicaid ACOs are one model states could use to better incentivize providers to work together to deliver high-quality, coordinated care. ACOs also have the potential to help control health care spending if they induce providers to deliver more efficient, coordinated care, thereby reducing the use of unnecessary or avoidable health care services.

If Medicaid ACOs are to achieve these objectives, they must be designed with the primary goals of improving the quality of care that Medicaid patients receive and their overall health. Moving forward, states and advocates must also think critically about how to build Medicaid ACOs that effectively address the existing challenges that Medicaid populations face in getting the right care at the right time.

The second brief in this series takes a closer look at designing quality metrics and incentive payments for Medicaid ACOs.
Endnotes

1 This continuum ideally includes primary and specialty care, acute care, long-term care, oral health care, and mental health care. For more information on ACOs, see Families USA’s brief, Making the Most of Accountable Care Organizations: What Advocates Need to Know (Washington: Families USA, updated February 2012), available online at http://familiesusa2.org/assets/pdfs/health-reform/ACO-Basics.pdf.


4 Churning refers to when people move in and out of coverage due to changes in their Medicaid eligibility. Medicaid patients may experience multiple changes in income over the course of a year that can lead them to lose and then regain Medicaid multiple times.


6 Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010), as modified by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (March 30, 2010), Title 2, Subtitle I, Section 2706.

7 For more information about the Medicare Shared Savings Program, see Centers for Medicare and Medicaid Services, Medicare Shared Savings Program (Baltimore: CMS, November 2012), available online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/index.html?redirect=sharesavingsprogram/.

8 Prior authorization, where a patient or provider is required to obtain prior approval from a managed care organization before a certain service can be provided, is an example of a utilization management technique that has historically created barriers to obtaining timely and necessary care. Peter J. Cunningham, “Medicaid Cost Containment and Access to Prescription Drugs,” Health Affairs 24, no. 3 (May/June 2005): 780-789.


10 Oregon Health Authority, Division of Medical Assistance, “Division 141: Oregon Health Plan Section 141-3145: Community Health Assessment and Community Health Improvement Plans,” Oregon Administrative Rules (Salem: Oregon Health Authority, December 14, 2012), available online at http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/oar_410_141_3000-3430.html; Oregon Health Authority, Community Health Assessments and Community Health Improvement Plans: Guidance for Coordinated Care Organizations (Salem: Oregon Health Authority, May 11, 2012), available online at https://cco.health.oregon.gov/Documents/resources/CHA-guidance.pdf.

11 For more information on CHIP model contract language related to contracting with safety net providers, see George Washington University School of Public Health and Health Services, “Section 508: Traditional Providers,” Managed Care for SCHIP Pediatric Purchasing Specifications (Washington: GWUMC School of Public Health and Health Services, April 2002), available online at http://ephhs.gwu.edu/departments/healthpolicy/chpr/newsps/SCHIP/.

12 Starting in 2014, all qualified health plans that are certified to offer coverage in the new health insurance marketplaces must include in their networks “a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP’s service area.” This requirement was sufficient by the Department of Health and Human Services in 45 CFR 156.235(a). The Secretary of HHS was granted the authority to establish this requirement under section 1311(c)(1)(C) of the Affordable Care Act. For more information, see Department of Health and Human Services, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule,” Federal Register 77, no. 59 (March 27, 2012); 45 CFR Parts 155, 156, and 157, § 156.235; available online at http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf.

13 For examples of these standards, see Claire McAndrew, Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States (Washington: Families USA, January 2013), available online at http://familiesusa2.org/assets/pdfs/health-reform/Consumer-Friendly-Standards-in-Exchange-Plans.pdf.


15 For more information on designing consumer-friendly notices for beneficiaries who are enrolled in ACOs, see Michealle Gady,


17 The Center for Health Care Strategies (CHCS) has developed a Medicaid Accountable Care Organization Learning Collaborative to help six states develop ACO models. Oregon also requires all contracting Medicaid CCOs to agree to participate in a state-based learning collaborative that was originally formed under its patient-centered medical home program. For more information on the center’s learning collaborative, see Center for Health Care Strategies, Advancing Medicaid Accountable Care Organizations: A Learning Collaborative (Hamilton, NJ: Center for Health Care Strategies, July 2012), available online at http://www.chcs.org/usr_doc/Medicaid_ACO_LC_Overview.pdf. For more information on Oregon’s requirements for CCOs to participate in a learning collaborative, see Oregon Health Authority, Division of Medical Assistance, “Division 141: Oregon Health Plan Section 141-3015: Certification Criteria for Coordinated Care Organizations, Subsection 22,” Oregon Administrative Rules (Salem: Oregon Health Authority, December 14, 2012), available online at http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_141_3000-3430.html; and Oregon State Laws 2011, vol. 11, chapter 442, section 210, Patient Centered Primary Care Home Program, subsection 3.

18 A state could also consider implementing a 12-month continuous eligibility policy, which allows the state to waive the federal requirement to immediately act on changes in family income that affect eligibility for Medicaid and instead allow beneficiaries to retain coverage in these programs for a full year, regardless of fluctuations in family income. Federal law gives states the option to implement this type of policy for children in Medicaid and CHIP. States also can seek authority to implement this type of policy for their adult Medicaid populations through Section 1115 waivers. To learn more about 12-month continuous eligibility policies, see Medicaid and CHIP Payment and Access Commission, “Chapter 2: Eligibility Issues in Medicaid and CHIP: Interactions with the ACA,” Report to the Congress on Medicaid and CHIP (Washington: MACPAC, March 2013).

19 The portion of additional costs that an ACO will be responsible for will depend on its payment model. For example, a Medicaid ACO that is paid through a fully capitated global payment model would be responsible for covering all expenses that exceed its agreed upon budget. In a shared savings/shared losses model, an ACO would have to pay back only a portion of its expenses that exceed its agreed upon budget, and the Medicaid program would cover the remainder. The second brief on quality metrics and payment models, Holding Medicaid ACOs Accountable for High-Quality Care: Payment and Quality Measurements, will discuss these issues in more detail.
Accountable Care Organizations (ACOs) in Medicaid: Challenges and Opportunities for Advocates

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