

Early Experiences with Accountable Care in Medicaid: Special Challenges, Big Opportunities

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Abstract

Accountable care organizations (ACOs) and the more general movement toward accountable care, in which payments are aligned directly with improvements in quality and cost, are intended to increase the incentives and support for higher value in health care. As of mid-2013, there are over 4 million beneficiaries covered by Medicare ACOs, and large private payers continue to enter new ACO arrangements with providers in all parts of the country. An increasing number of states have approved and are implementing accountable care models for their Medicaid programs. A review of some of these early state adopters demonstrates how the features of Medicaid populations, Medicaid providers, and Medicaid financing create some distinct issues for implementing ACOs in Medicaid. Many states that have relied on Medicaid managed care plans are moving to accountable care through these private plans. Some states also are implementing accountable care reforms through direct reforms in their payments to Medicaid providers, both through specific providers and regionally-based contracts. Others are implementing a mixture of private plan and public management approaches. States are moving toward more comprehensive accountable care payments through patient-centered medical homes, episode-based payments, and patient-level accountable care payment reforms; these payment reforms can be sequential and synergistic. Accountable care in Medicaid involves some distinct considerations such as performance measures, additional complications in shared savings related to the federal-state Medicaid funding structure, and potential antitrust issues in cases where states are pursuing reforms with implications for most or all providers in a geographic area. The evidence on the impact of the various early approaches to accountable care in Medicaid is just beginning to emerge, and it is likely that the best course for states will continue to depend on the distinctive institutional features of their Medicaid programs and health care delivery systems. As in other parts of the health care system, accountable care in Medicaid is likely to continue to expand and to evolve. (*Population Health Management* 2013;16:S-4–S-11)

Introduction: Accountable Care and Accountable Care Organizations

ACCOUNTABLE CARE—in which payments to health care providers are tied to accountability for improving quality and simultaneously lowering costs—is expanding in private health insurance and Medicare payment systems for health care providers. Although there is still debate about how to define accountable care organizations (ACOs), they can be defined based on 3 core principles that amount to applying the notion of better care and lower costs at the level of a population of patients. In particular, ACOs are (1) provider-led collaborations with a strong base of primary care, which

may include physicians, hospitals, and other health service providers; (2) accountable for improving health outcomes and quality of care while slowing the growth of overall costs for a defined or “attributed” population of patients; (3) with payments increasing with measurable improvements in care, outcomes, and cost trends. Although a number of organizations can be considered ACOs—including integrated health care systems, organizations involving both physicians and hospitals, and physician groups—primary care is an essential element of any ACO.

Providers are taking up accountable care arrangements because they get more flexibility in deciding how to spend resources on behalf of their patients, including in

nontraditional ways; for example, to devote more resources to coordinate care, support wireless communications and telemedicine, and implement care teams involving nonphysician providers. Payers support these arrangements because they hold the promise of measurably better patient care while reducing cost growth. However, moving away from payments based on the volume and intensity of traditional health care services creates new kinds of financial risk for providers for which they may have little historical data (eg, on the overall costs of their patients) and little experience with managing. As a result, the reforms create new kinds of concerns about potential reductions in quality of care for patients, particularly in dimensions of quality that are not measured well.

As ACOs are still emerging and evolving, with limited evidence on systematic predictors of success, there is considerable variation in accountable care arrangements as providers adapt their baseline care delivery to the opportunities and challenges of becoming ACOs. A number of provider configurations are being utilized, including integrated delivery systems, primary care medical groups, hospital-based systems, and virtual networks such as independent practice associations.

Brief History of ACOs Outside of Medicaid

The ACO model of today follows many previous initiatives intended to improve care and lower costs, including steps to implement integrated care and shifts toward capitated health insurance payment systems, as well as more incremental reforms in care delivery and payment. In 2005, the Centers for Medicare and Medicaid Services (CMS) launched the Physician Group Practice (PGP) Demonstration, a major “shared savings” demonstration program for paying more to organizations of physicians in Medicare who were accountable for a population of Medicare beneficiaries. The 5-year demonstration included 10 provider organizations and physician networks, ranging from freestanding PGPs to integrated delivery systems. In addition to receiving their usual fee for service payments, the providers also received bonus payments if their efforts to improve care through better care coordination and other delivery reforms translated to slower risk-adjusted growth in overall Medicare Part A and Part B spending along with improved performance on most of the established quality metrics. Providers faced reductions in future bonus payments for a portion of spending that exceeded benchmarks. In the fifth performance year, all 10 of the physician groups achieved benchmark performance on at least 30 of the 32 measures established by Medicare, while 7 achieved benchmark performance on all 32 measures. Seven of the physician groups shared in savings during at least 1 of the 5 performance years.¹

In 2007, the Engelberg Center for Health Care Reform at the Brookings Institution and The Dartmouth Institute for Health Policy and Clinical Practice began a collaboration with health care providers and payers to foster the early and successful adoption of ACOs to improve care quality and reduce costs. In 2009, they launched the Brookings–Dartmouth ACO pilot program, which involved five diverse provider groups who agreed to take responsibility for overall quality and costs of care for their patients, had a committed

payer partner, and had sufficient patient population to support comprehensive care coordination and performance measurement. In addition to providing technical consultation and support, Brookings–Dartmouth conducted case study evaluations of four of the organizations to inform providers, payers, and policy makers about the process of ACO formation,² and developed a Learning Network of emerging ACOs and supporting organizations and companies.

The enactment of the Patient Protection and Affordable Care Act (ACA) further accelerated the expansion of accountable care arrangements. The ACA included provisions that established ACOs as an option for provider payment in traditional Medicare—the Medicare Shared Savings Program (MSSP). The ACA also enabled the “Pioneer” ACO pilot program for advanced ACOs to receive partial-capitation payments associated with quality improvements for a population of patients, as part of the payment reform pilots undertaken by the Center for Medicare and Medicaid Innovation (CMMI). As Medicare was developing its ACO options, many private payers expanded their initial pilots into larger components of their payment strategies, in many cases implementing “accountable care” offices or divisions to oversee a growing number of ACO contracts.

Current State of ACOs

By mid-2013, Medicare included over 250 ACOs that were accountable for more than 4 million traditional Medicare beneficiaries.³ The MSSP offers 2 incentive options to ACOs: a “1-sided” model in which ACOs obtain bonus payments if their costs are substantially below their per-beneficiary spending target and quality improves on most measures, with no penalties if spending exceeds the target; and a “2-sided” model that offers greater bonuses for reduced per-beneficiary spending trends, but also requires the ACO to pay a portion of the costs that exceed spending targets. There are currently 221 ACOs in the MSSP program in 48 states, the District Columbia, and Puerto Rico. About half of the Medicare ACOs are hospital-based organizations or health care systems, and about half are physician-led organizations, in some cases supported by private insurers or other sources of capital and tools for decision support and care coordination. The Advance Payment ACO program is a CMMI pilot project that provides some up-front federal funding to help 35 smaller and less well-capitalized physician organizations, a subset of MSSP, make some of the investments needed for ACO formation.

The CMMI Pioneer ACO program is a pilot program that began with 32 organizations, which are required (1) to bear at least some degree of “downside” risk for per-beneficiary spending that exceeds spending targets, and (2) to transition to substantial risk bearing over the 3-year contract period. The initial Pioneer contracts envisioned the organizations receiving at least half of their overall payments (Medicare, plus other payers) through performance-based payment mechanisms that placed the organization at financial risk for failure to improve measured quality and lower cost trends. In total, Medicare ACOs now cover approximately 4 million beneficiaries across the country.

Private sector ACO implementation also has grown at a rapid pace, with large ACO programs established by most

major payers across the country. For example, as of mid-2013, Cigna was engaged in more than 50 ACO initiatives in 22 states and aimed to reach 1 million customers by 2014 through expansion to 100 arrangements. Aetna had over 20 ACO agreements in place and announced plans to enter into hundreds of ACO arrangements over the next 3 years. A growing number of ACOs across the country have implemented or are developing ACO contracts with both public and private payers.

Opportunities and Challenges for Medicaid ACOs

Medicaid is the largest insurance program by covered lives in the United States. It is the principal coverage source for low-income Americans, now covering over 62 million Americans with lower incomes with an expectation of 15 million or more to be added with ACA coverage expansions in 2014. This includes 1 in 3 children and over 40% of births. Medicaid also covers 16 million Americans with disabilities, and over 9 million low-income “dually-eligible” Medicare beneficiaries. It covers more than 60% of people living in nursing homes. Medicaid funds about a sixth of total national spending on personal health care, and is particularly important for safety net hospitals and health centers that also serve low-income uninsured Americans across the country.⁴

With the coming expansions of Medicaid coverage, pressures on financing, and the seemingly extensive opportunities for better care coordination, an increasing number of states are looking for new ways to pay for care for Medicaid beneficiaries to promote better coordination, better care, and lower costs, including the adoption of accountable care models. The reasons for interest in ACOs are similar to those that have led to the expansion of ACOs in Medicare and private insurance. ACOs may be able to coordinate the care of beneficiaries who may not have access to reliable primary and preventive care. ACO arrangements also could help Medicaid achieve better-coordinated care that effectively supports complex health needs for some of the most vulnerable patient populations, including dually-eligible beneficiaries. ACOs can potentially improve beneficiaries’ health through better support for quality care and coordination, while states may see reductions in overall costs as the health care system moves toward greater value.

Alongside these opportunities for gains from ACO reforms in payment and delivery are some distinct challenges for Medicaid ACOs. Medicaid’s system of federal-state financing complicates the assessment and distribution of shared savings and other cost reductions related to quality improvements. The federal match for state spending is at least 50%, but states with lower per capita income have higher federal match rates. Assuming that any savings are shared proportionally, a state will receive less than half of the overall savings from programs such as ACOs, even though primary responsibility for implementing the payment and delivery reforms lies with the states, subject to federal oversight.

State implementation of Medicaid reforms to improve quality and reduce costs is not new. All states operate their Medicaid programs under waivers from many of the specific statutory requirements of benefits, provider payments, and other aspects of coverage, subject to federal determination

and oversight that core requirements for coverage are being met at no higher cost to the federal government. Waivers have been widely used to expand access to “optional” populations, to modify benefits and cost sharing, and to change provider payment. However, states have had much more experience with other types of Medicaid reforms—including use of managed care, case management, and benefit changes—than with ACO reforms. And although the federal government has issued guidance for implementing ACO-type coverage reforms for dually-eligible beneficiaries, there is no standard template or much guidance yet on how ACO reforms could be implemented.

Finally, as has been the case with past Medicaid reforms like capitated managed care plans, reductions in payment rates, and greater flexibility in the coverage of specific services for patients, ACO reforms also have raised concerns about potential adverse impacts on quality and access to care for vulnerable beneficiaries, particularly those with high costs, given the stronger financial incentives for providers to reduce utilization. Further, the payment rates in Medicaid—compared to Medicare and especially private insurance—may mean that improving quality while reducing costs as is required in ACO arrangements is more difficult.

Framework for Describing Early State Experiences with Accountable Care in Medicaid

The early steps by states to implement ACOs and accountable care reforms more generally is beginning to provide a foundation to assess the potential impact of ACOs in Medicaid. By mid-2013, at least 9 states have approved and adopted an accountable care model for providing care to their Medicaid beneficiaries. These states—Colorado, Utah, Oregon, Arkansas, Iowa, Illinois, Vermont, Minnesota, and New Jersey—have approached the conceptualization, implementation, and organization of their respective programs differently. A key initial decision for states implementing accountable care is whether to rely on private insurance plans or to engage in a direct state role in contracting with providers. For example, Colorado and Utah used a CMS “Section 1915” waiver to initiate reforms that provide accountable care services through managed care delivery systems, while Oregon applied for a CMS “Section 1115” waiver to initiate a new state role in financing and delivering accountable care Medicaid services.⁵ States have turned to private managed care plans in the past to increase the predictability of state expenditures (the plans typically are capitated and thus bearing some or full financial risk for patient care) and to limit state administrative expenditures. However, some states do not have extensive managed care penetration and competition, and there are concerns about the quality of care in managed care plans. Either way, given the general trends toward better data and measurement of quality and toward accountability for quality as well as costs, it is likely that states will increasingly need to take steps to measure quality of care and implement those steps either through private-plan contracting or payment redesign to achieve higher quality.

Whether a state manages the ACO arrangements directly or does so through private plans, as in other cases of ACO implementation, states or their managed care plans may choose to implement accountable care through a set of

incremental and supporting steps. As will be described in more detail, some states have implemented primary care medical homes with some accountability for some aspects of quality of care and costs (typically those most related to primary care) or episode-based payments with accountability for quality and cost within the episode. Both of these approaches potentially could expand to the full patient-level accountability of ACOs. Outside of Medicaid, these payment reforms have been implemented as preludes to or in conjunction with ACO reforms with accountability for all aspects of care and costs. For example, primary care providers in an ACO arrangement may receive some of their compensation in the form of a per-patient medical home payment, and also share in the savings from reducing overall cost trends for these patients (while improving measured quality). Figure 1 illustrates how these different reforms can progress and fit together.

States interested in pursuing accountable care models for their Medicaid populations must consider some additional key issues in accountable care implementation criteria when making decisions about ACOs. These include: program scope, state authority, governance structure, criteria for participation, quality and cost measurement, how quality measures and cost reductions translate into additional payments to providers (and conversely, whether and how providers are penalized for higher costs or quality gaps), data and other support for providers, and program evaluation.⁶

Descriptions of State Accountable Care Reforms

States adopting accountable care reforms vary in how far along they are in implementation and accumulation of results. All of these programs are relatively new, and some of the states that will be mentioned just passed the enabling legislation in 2012 or 2013.

Colorado

Colorado launched the Accountable Care Collaborative in May 2011 through its Department of Health Care Policy and Financing.⁷ At the time of the program’s inception, 85% of Colorado’s Medicaid patients were in an unmanaged fee-for-service (FFS) system that had experienced rapid cost growth and evidence of quality problems. The state had previously tried and rejected a capitated managed care program. Given this history, the Department proposed a primary care case management program linked to features of accountable care payments and organized around four principles: (1) ensure access to focal point of care (ie, a medical home), (2) coordinate medical and nonmedical care, (3) improve member and provider experiences, and (4) provide necessary data to support providers to achieve these goals. This program would not change the Medicaid benefit package but rather organize care delivery through one of seven Regional Care Collaborative Organizations (RCCOs).⁸ RCCOs are distinct geographic locations that serve as care coordination sites that assist patients in connecting to both Medicaid health care providers and community and social supports. As of June 2012, Colorado had enrolled 132,227 Medicaid patients (48,382 children and 83,845 childless adults) in the seven RCCOs.⁹ To measure the program’s impact, the Department selected 3 widely-used performance measures that will be used for program incentive payments beginning in March 2013: inpatient hospital readmissions, emergency room utilization, and high-cost imaging services. Although providers did not have accountability incentives related to reducing overall costs (and thus this program is more like a medical home model), the 3 performance measures all relate to utilization and population costs.

In early 2013, the Colorado Department of Health Care Policy and Financing reported that all RCCOs demonstrated

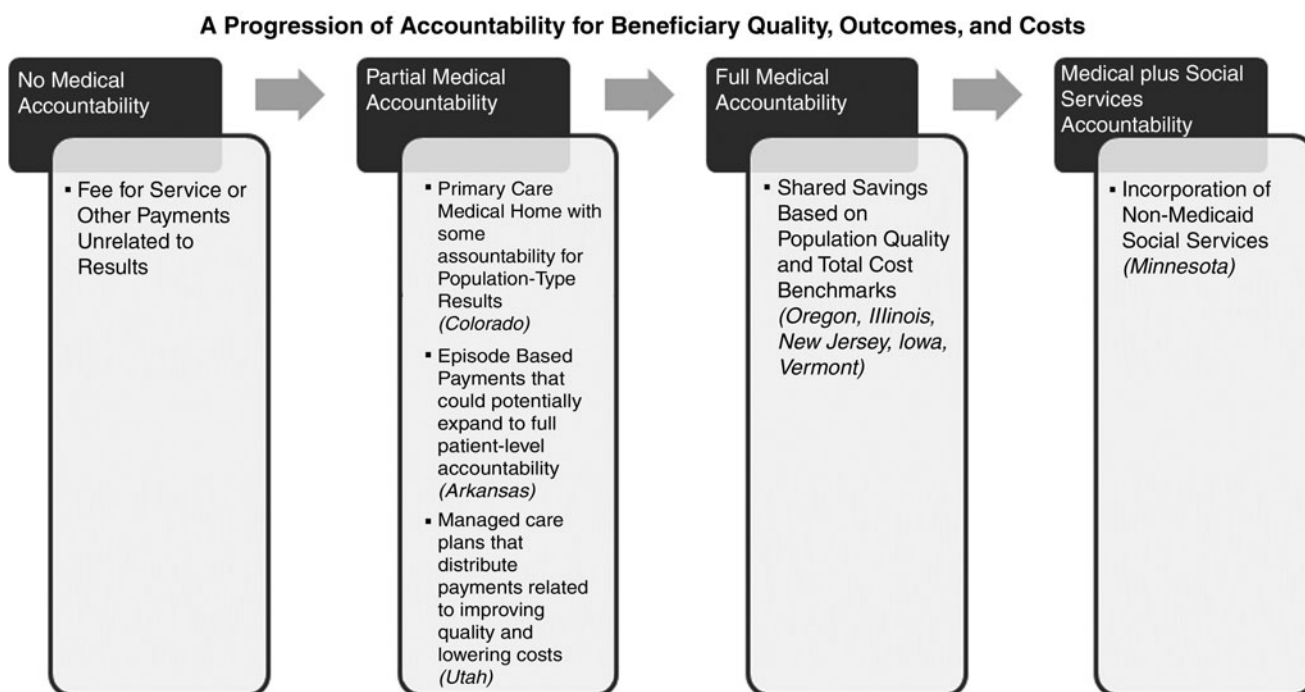


FIG. 1. Stages of Medicaid ACO Development and Implementation.

quality improvement in 1 of the 3 measures, with 6 achieving reduction in 2 of 3 measures, in July–September 2012. Thus, both the RCCO and the primary care providers are expected to receive per member per month incentive payments that range from \$11,418.00 to \$100,762.64.¹⁰ As a result of these reforms, the Department estimated approximately \$30 million in savings for FY2011-2012, which exceeded the original savings prediction of \$4.8 million.¹¹

Utah

Utah recently reformed its Medicaid program by using a new 1915(b) waiver to modify 3 of their Medicaid managed care organization (MCO) contracts with ACO contracts.¹² The contracts provide a monthly risk-adjusted, capitated payment to cover all services for enrolled beneficiaries, as in its traditional managed care plan, but explicitly considers ACO features related to quality and distribution of payments.¹³ In particular, the state uses the following criteria for ACO consideration: (1) distribute payments related to improving quality and lowering costs across the continuum of scope of service providers, and (2) meet the quality standards under contract.¹⁴ The state plans to include additional quality measures each year as the program progresses; even though the additional measures are still under development, the managed care ACO plans will be held accountable for meeting the measures in the future. Although the program is still in its infancy, Utah hopes to build on this effort by integrating mental health and long-term support services into their ACOs and expanding ACOs to rural areas.¹⁵

Arkansas

In 2012, Arkansas created the Health Care Payment Improvement Initiative in an attempt to move away from FFS payments toward an accountable care model that rewards value and outcomes. The program is an example of a partial step toward accountability for quality and cost, in that certain episodes of care are included in the accountable care program, but not all care. The Arkansas initiative includes all providers participating in Medicaid and two large private insurers, Arkansas BlueCross BlueShield and Arkansas QualChoice.¹⁶ In the program, payers have a mechanism for designating a principal accountable provider who is responsible for cost and quality of care for a beneficiary throughout each included episode of care, covering care provided by all providers in the patient's care team. These episodes of care include attention deficit/hyperactivity disorder, upper respiratory infections, congestive heart failure, hip and knee replacements, and perinatal care. Providers will continue to submit claims for all care they deliver and continue to be reimbursed based on existing fee schedules, but they also will be eligible for shared savings and shared risk based on average cost of care per episode. In order to share fully in savings, providers must achieve certain quality indicators, which differ for each episode type. Providers who are able to achieve appropriate average per-episode costs, but fail to achieve these quality standards, will not receive shared savings payments.¹⁷

Oregon

Using an 1115 waiver, Oregon was approved to administer the Coordinated Care Organization (CCO) program.

Defined by Oregon statute and certified through the Oregon Health Authority, CCOs resemble Colorado's regionally-based RCCOs; however the CCOs are accountable directly for overall costs of care, as well as quality in each region. To date, there are 15 CCOs, which are geographic areas tasked with providing and coordinating care for Oregon's Medicaid and Children's Health Insurance Program (CHIP) beneficiaries. The CCOs receive a single budget to cover medical and mental health services (and in the future, dental care) that grows at a fixed rate.¹⁸ The federal waiver, however, also requires these organizations to achieve a 2% reduction in the rate of growth in per capita Medicaid spending by the end of the program's second year. In exchange, the federal government will provide approximately \$1.9 billion over 5 years to support the program, but the state is at considerably greater financial risk if the required savings are not achieved.¹⁹

Illinois

Illinois' recent Medicaid reform law required that at least 50% of beneficiaries—with the goal of 2 million out of the 3 million Medicaid clients—enrolled in risk-based coordinated care programs by January 1, 2015. Care coordination will be provided by 3 types of financial arrangements that tie payments to improvements in quality and cost trends: traditional insurance-based health maintenance organizations accepting full-risk capitated payments, with performance measures; Managed Care Community Networks (MCCNs), which are provider-led entities accepting full-risk capitated payments; and Care Coordination Entities (CCE), which are provider-led networks providing care coordination for risk and performance-based fees, but using FFS for medical and other services. The CCEs may choose from 3 risk-based payment models: a care coordination fee, paid on a per member per month basis for each population; a shared savings model that makes the CCE eligible for up to 50% of annual savings below project cost baseline if quality targets are met; or an interagency payment flexibility option in which the CCEs are encouraged to develop innovative payment methodologies.²⁰ In April 2013, 5 CCEs and 1 MCCN were awarded contracts under the Illinois Department of Healthcare and Family Services Care Coordination Innovations Project. Illinois planned to expand its care coordination program in 2014 to other Medicaid-eligible populations, including children, their parents, and those newly eligible under the ACA.²¹

Minnesota

Minnesota has launched two Medicaid 3-year accountable care demonstration projects. Under state statute, their Department of Human Services was authorized to develop and test innovative health care delivery models that "provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement."²² Their Health Care Delivery Systems (HCDS) Demo has 9 sites, covering 150,000 enrollees in the Twin Cities metropolitan area. HCDS includes 2 payment and delivery models: virtual and integrated. The virtual model consists of 10 federally-qualified health centers (FQHCs) that have formed a primary care organization that is unaffiliated with a hospital or integrated system. The 8 sites in the integrated

model are a part of an integrated delivery system. In both models, the HCDS attributes enrollees in a total cost of care (TCOC) calculation based on past provider encounters and a core set of services. Base TCOC includes services provided and ordered through primary care entities and whose utilization is affected by care coordination—this ranges from home health to midwife services.²³ During the demonstration, existing provider payments continue but with gain- or loss-sharing payments made on risk-adjusted TCOC performance, including quality performance. Both models start with shared-savings features. In the virtual model, savings relative to projected per-beneficiary thresholds are shared 50–50 between the payer and the delivery system. In the integrated model, savings beyond the minimum threshold are shared between Medicaid and the provider organization at a prenegotiated rate, and risk is phased in during the second and third year. Minnesota also has launched the Hennepin Health safety net ACO demonstration project in Hennepin County with 4884 enrollees (adults aged 21–64 years with incomes at or below 75% of the federal poverty line). Organizing care delivery through a patient-centered model, Hennepin Health goes further to integrate primary health care with behavioral health services and other social services such as housing. The accountable care payments, and thus the shared savings, are based partly on cost measures that go beyond Medicaid costs, such as uncompensated care, social services, public health costs, and correctional expenses.²⁴ This extension provides a financial incentive to integrate these other nonmedical services with medical care delivery with the goal of lowering overall costs for each beneficiary as a result.

Through both demonstrations, the Department of Human Services has enumerated and sought to address various considerations deemed important to the success of the reforms: overcoming limited data-sharing capabilities to integrate person-level data across different systems to support better coordinated services, reconciling different payment methods (ie, FQHCs are reimbursed through a prospective payment system and an alternative payment methodology that affects the TCOC calculation), and adapting to different quality measurement systems and collection processes.

New Jersey

New Jersey has passed legislation and signed into law a Medicaid Accountable Care Organization Demonstration Project. Ushered in by a broad coalition of stakeholders including community organizations and the New Jersey Chamber of Commerce,²⁵ this statute establishes a 3-year, geographically-based demonstration project allowing New Jersey to assess the feasibility of an ACO as an alternative to MCOs. The goal of the program is to better coordinate care for Medicaid enrollees who are often high-risk, high-cost utilizers, while including services beyond the health care sector to promote health and wellness. Per the legislation, the New Jersey demonstration requires the ACO to collect and meet measures of quality, utilization, and access to participate in shared savings. The entity responsible for coordinating care must be a nonprofit organization that serves a minimum of 5000 Medicaid beneficiaries within a designated region. In addition, the ACO is required to contract with 100% of the hospitals, 75% of the primary care providers,

and at least 4 mental health providers within the intended service region. The demonstration project has not yet been implemented.

Iowa

More recently, in conjunction with their plans to expand Medicaid because of the ACA, CMS recently awarded Iowa a State Innovations Model (SIM) grant along with a renewed 1115 waiver to implement the Healthy Iowa Plan. With implementation planned for January 2014, this waiver sets up a regionally-defined ACO for Medicaid beneficiaries that will be responsible for coordinating care through a medical home led by a primary care provider. Although Medicaid providers will be paid for services based on FFS rates, each regional ACO will be allocated a global budget amount. When the ACO meets cost and quality targets, they will be eligible to share in savings created through care coordination. Conversely, if ACOs exceed their global budget, they will be at risk for reduced future payments.

Vermont

Similarly, Vermont has submitted a SIM grant application for its Medicaid and commercial payers to test 3 different health care delivery and payment models beginning in January 2014, including the shared savings model. In the proposed application, the shared savings model would be extended to the full Medicaid population, including children covered under CHIP and dually-eligible Medicare beneficiaries. As in other states, the ACO would be provider led and take responsibility for the quality and costs of care for a defined population. These organizations would be able to share in generated savings contingent on the requisite measures being met. The Vermont model also would include 6 of the state's 8 FQHCs.²⁶

Implications of Initial State Experiences with Accountable Care in Medicaid

These early experiences of states that are implementing accountable care models for Medicaid populations show a diversity of approaches and do not yet provide much evidence on the best way to proceed with accountable care. Even with the limited experience to date, the diversity of new approaches and the limited evidence about their impact suggest both obstacles ahead and the likelihood of further financing and delivery reforms to achieve the goals of accountable care. Here, we review a few common themes from the state reforms.

All of the reforms suggest a challenging balancing act of reforming incentives without too much cost or potential for disruption of current care delivery models. On the one hand, providers in these states need increased incentives and support to make it worthwhile for them to invest in the changes in care necessary for the accountable care models to succeed. On the other hand, too much new accountability for costs or quality improvement may deter participation or risk quality problems. Thus, the Medicaid accountable care models often have started with incremental steps, and upfront support such as medical home payments, intending to build in more population-level financial risk over time. This is similar to the ACO strategy being implemented by many

private payers and Medicare. Indeed, some states are matching or extending ACO strategies used by other payers, or are seeking to coordinate with private payers and even Medicare. Such approaches have considerable promise for reducing the costs and risks at the provider level of moving to accountable care payment systems.

Medicaid ACOs also must face some unique challenges because of the complexity and vulnerability of their beneficiary population. For example, reforms to integrate social services and behavioral health services may be less relevant for other payers, but can provide critical support and much larger opportunities for coordination and cost reduction in Medicaid. Further, Medicaid often involves payers that disproportionately or uniquely treat Medicaid beneficiaries. In these areas, identifying what works in the early experiences of Medicaid ACO programs will be particularly important, because there is much less evidence from other payers.

Some Medicaid ACO reforms are being implemented at the geographic level across multiple or all providers, reflecting the unique authority of states to influence system-wide care delivery within their borders. Given this, states and providers will need to be cognizant of potential antitrust issues. For example, New Jersey's ACO proposal requires the support of 100% of the general hospitals and at least 75% of the primary care providers within the ACO's designated area in order to ensure that all providers are invested in the care of vulnerable populations; other states such as Oregon, Colorado, and Iowa have regionally-based ACOs. Ultimately, these arrangements must encourage innovation and efficiency without harming competition between providers and payers.

As Tara Ragone has noted, these antitrust concerns can be overcome.²⁷ First, clinical integration is a means to an end—improved quality at lower costs—that the agencies have largely recognized as necessary for rule of reason treatment under federal antitrust laws. (See “Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program.” *Federal Register*, 76:209 at 67027; “A rule of reason analysis evaluates whether the collaboration is likely to have anticompetitive effects and, if so, whether the collaboration's potential procompetitive efficiencies are likely to outweigh those effects. The greater the likely anticompetitive effects, the greater the likely efficiencies must be for the collaboration to pass muster under the antitrust laws.”) Second, states have state action immunity from federal antitrust laws so long as they clearly articulate how a policy meets a certain state goal and actively supervise anticompetitive activity undertaken by private actors. But just because states can articulate reasons why antitrust concerns should be set aside does not mean that the ACO reforms will achieve real improvements in quality and efficiency that outweigh potential anticompetitive effects on quality and price.²⁷ Our experience with ACO implementation suggests that states may be able to avoid antitrust concerns by being transparent about how their accountable care models will reduce costs and improve quality of health care, and then ensure that they are collecting timely and relevant evidence that these intended effects are occurring—not just in Medicaid, but for all populations in the state. Because ACOs will produce measures of population-level quality and cost, and because other payers who are implementing ACOs also are interested in similar

performance measures, it should be possible to use ACO performance measures to determine whether a state's approach is actually leading to better performance. Given the limited evidence and diversity of approaches being undertaken by states, authorities should be watching closely and should be ready to modify their approach to antitrust and other key design issues based on the emerging evidence from these reforms.

Finally, Medicaid programs inherently involve shared savings with the federal government on top of any shared savings arrangements developed with providers. Further steps to assess the best way to maximize overall savings for the federal government and the states while achieving the greatest improvements in quality are needed. We have described a possible alternative approach in a recent Brookings report, in which states receive a disproportionate share of the overall payer savings (state plus federal) when they implement effective accountable care reforms. This approach provides more financial support for states to implement reforms, thereby increasing the impact on quality of care and overall savings—and possibly even savings to the federal government.²⁸ Some recent Medicaid waivers, as in the case of Oregon described, reflect a similar principle and can be implemented within current law.

Conclusion

The transition of Medicaid payment systems toward accountable care models and other approaches that promote better, more efficient care seems likely to continue, as concerns about cost continue to rise, as evidence grows on the best ways to improve quality in Medicaid, and as the use of accountable care systems expands outside of Medicaid. As states take further steps toward accountable care in Medicaid, they must continue to assess their performance goals and the capabilities of their providers and managed care plans, consider the growing evidence on the challenges and successes of previous states' efforts, and work with other payers to help build the system infrastructure and other provider and beneficiary supports that can make it easier to achieve the goals of high-quality, low-cost, innovative care.

Author Disclosure Statement

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