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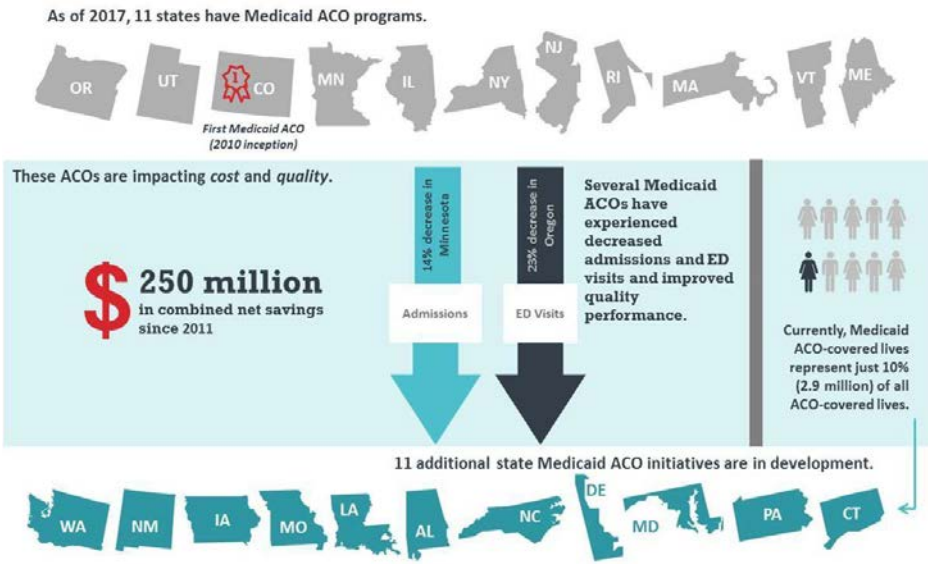
Accountable Care NEWS

ACOs: Is there Room for Medicaid?

by Liz Adler, Jim Ryan and Emma Mandell Gray

Public and private healthcare payers are making systematic shifts from volume- to value-based reimbursement models in an effort to reign in growing healthcare spend and improve the quality of care. In response, accountable care organizations (ACOs) that assume some degree of financial responsibility for overall value of care delivered to patients have emerged in droves, with a total of 838 in 2016.[1] This proliferation, however, has largely been concentrated in the Medicare and commercial markets, which account for 90% of ACO-covered lives.[2] Medicaid ACOs are just beginning to gain traction—and with promising results (see Figure 1).

Figure 1: Medicaid ACO Key Figures[3, 4, 5, 6, 7, 8, 9, 10, 11]



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Not all Medicaid ACOs are created equal, and they typically vary in governance structure, scope of services, degree of financial risk and quality measurement, among other factors. All ACOs, however, are held accountable for the value of care through alternative payment models and quality targets. Thus, provider organizations considering participation will explore a similar set of core questions.

The Checklist. Involvement in value-based reimbursement should be approached in a methodical, structured manner to set both the provider organization and the overall ACO on a path for success. Provider organizations can utilize the checklist below to evaluate participation in voluntary Medicaid ACO models and/or help to shape their state's Medicaid ACO program while it is still in development.

This checklist explores key aspects of ACO program structure and organizational strategy and capacity to help a provider organization most successfully engage in a Medicaid ACO model. Elements of this checklist would also be relevant to those participating in risk-based, Medicaid managed care arrangements.

Partners: A critical decision to execute a successful model is selecting the right partners. They might include payers, acute and post-acute healthcare providers, physician groups, community health centers, behavioral health (BH), long-term services and supports (LTSS) and social service providers and/or others.

- What are the key criteria for a partnership?
  - Are goals aligned (financial, investment levels, shared savings distribution methodology, governance and operations)?
  - Are resources (financial, staff and other) available to support an ACO in taking on risk?
  - Do the potential partners have experience in providing value-based care?
  - Do they currently serve the Medicaid population?
  - Is there a collaborative historical relationship?
  - Are they trusted and well respected in a community?

Total cost of care (TCOC) benchmark. For providers responsible for the total cost of services through shared savings and/or losses or capitated arrangements, it is important to understand how the TCOC benchmark is designed and what is included in a budget.

- How is a TCOC benchmark calculated?
- What is the scope of services (physical health, BH, LTSS, dental and/or pharmacy) included in a benchmark?
- Which services (e.g., hepatitis C treatments, deliveries) are excluded from the benchmark as carve-outs?
- How is a benchmark risk adjusted?
- What is the process for rebasing a medical budget, and how frequently will it be rebased?

Risk arrangement. Future-state, Medicaid ACO initiatives will likely employ a shared savings or capitated payment reimbursement mechanism. Thus, it will be critical to explore the extent of financial risk that a provider organization would assume under such arrangements.

- Is there both upside and downside risk (shared savings and losses)?
- Is a minimum savings rate and/or a minimum loss rate (percentage of benchmark) applied before an ACO shares in savings and/or losses?
- Is the level of downside risk appropriate for a provider organization based on previous risk-based performance and reserve funding available to repay losses?
- If not, is there a way to limit downside risk, either through arrangements with health system or payer partners or through other avenues?

Quality measurement. Organizations will want to assess how quality performance is measured and, taking into account all aspects of a contract's incentive structure, develop a financial model to estimate payment.

- How many measures must an ACO report? Which of these measures are linked to payment?
- How are quality scores used to determine the share of savings and losses?
  - Do the quality scores determine what percentage of total possible savings/losses an ACO earns?
  - Or if quality scores simply meet a minimum threshold, does the ACO earn 100% of the possible savings/losses?

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- Are proposed performance thresholds attainable?
- Are quality measures standard (e.g., endorsed by the National Quality Forum)? Do they align with those of other value-based initiatives in which a provider organization is already engaged (e.g., Centers for Medicare & Medicaid's Merit-Based Incentive Payment System)?
    - If not, is a provider organization able to capture requested data?

Network. It is important to consider network requirements as successful ACOs ensure patients are receiving the right care at the right time in the right place.

- Does state policy allow an ACO to define its provider network and referral circle?
- Are there network adequacy standards? Can an ACO meet them?

Membership. An ACO will need to be able to estimate the number of members to whom it will provide care to appropriately plan and scale its operations.

- How are members attributed to an ACO?
    - Does membership size promote economies of scale without detrimentally increasing the costs of managing care?
- Are there minimum membership requirements? Can an ACO meet them?

Care Management (CM). Because CM is a key lever in managing quality and cost performance, it is important to delineate CM responsibilities and identify a funding structure to support them. Provider organizations should assess their own capacity to assume CM functionality and how it could positively affect not only a Medicaid ACO, but also all value-based, care delivery initiatives.

- Will a CM model be centralized (i.e., be consistent across an entire ACO) or localized (i.e., use different models to meet the needs of patients and providers in different locations)?
- Which entities (payers, providers, community-based organizations and/or others) will be providing CM services?
- If providers are responsible for a provision of CM services, will they receive a supplemental per member per month CM payment?
- If so, how is this payment constructed? Is it based on actual CM expenses?

Social Supports. A Medicaid patient population differs from that of Medicare and commercial payers. Addressing the social determinants of health could eliminate barriers to care, paving the way for improved quality and reduced cost.

- Are there resources available to support the social needs (transportation, housing, utilities, food/nutrition) of a Medicaid population?
- Are innovative tools, such as a healthcare platform provider for non-emergency medical transportation, being considered to reduce barriers to care?

Organizational strategy and capacity. While the above sections of the checklist largely pertain to ACO program structure, it is also important to assess organizational strategy and capacity.

- Is a provider organization ready to take on value-based reimbursement? The previously explored questions pertaining to network adequacy, CM capabilities, organizational support, financial resources and risk-based experience will help an organization answer this question. In addition, an organization should consider the following:
    - Is provider compensation tied to the goals of an ACO (i.e., improving quality and value for a Medicaid population)?
    - Does an organization have IT resources to allow for data exchange and performance reporting?
- Will participation in a Medicaid ACO program further an organization's overall value-based strategy?
    - Are incentive funds (e.g., federal Delivery System Reform Incentive Payment funds) available that could, if invested wisely, benefit all value-based initiatives?
- Would non-participation threaten a provider organization's revenue from Medicaid, safety net funding, mission and/or reputation?
- Is there broad political support for a state's Medicaid ACO program such that it would be maintained largely in its current form by new governors, legislators and administrators?

"U.S. healthcare spend [is] projected to grow at an average annual rate of 5.6%..."

With U.S. healthcare spend projected to grow at an average annual rate of 5.6%, the recent passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the threat of block grants to the Medicaid program, providers can anticipate accelerated movement away from traditional volume-based (fee-for-service) payment.[12,13] Organizations with sizable Medicaid populations (e.g., safety-net hospitals, community-based health centers) that have not yet begun the transition to value-based reimbursement might consider starting with a Medicaid ACO, given the significant opportunity to promote appropriate utilization of care and, in turn, share in savings.

For those already transitioning to value-based reimbursement for the Medicare and commercial populations, a natural next step is targeting a Medicaid population. This change would incentivize quality improvement and cost containment for an entire patient population, as opposed to certain segments, resulting in a more consistent and coherent care model and value-based strategy. A systematic analysis of program structure and organizational readiness is essential to ensure provider involvement is deliberate, well-planned and effective.

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