Joint Legislative Oversight Committee on Health and Human Services

Medicaid Accountable Care Organizations in Other States

David Rice
Fiscal Research Division

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Accountable Care Organizations (ACOs) Overview

- Provider-led organizations with a focus on primary care/medical homes/care coordination
- At least some payment contingent on improving quality and reducing costs
- 9 states have approved an ACO for Medicaid: CO, UT, OR, AR, IA, IL, VT, MN, and NJ
- Most of these states are just beginning to implement Medicaid ACOs, with the earliest Medicaid ACO beginning in 2011

Accountable Care Organization (ACO) Overview

- Review of three state Medicaid ACO models:
  - Colorado Accountable Care Collaboratives
  - Utah Medicaid ACO Model
  - Oregon Coordinated Care Organizations

- Note: Not a recommendation nor a list of options for reform

Colorado Medicaid Accountable Care Collaborative (ACC)

- First state Medicaid ACO model; implemented in May 2011
- Seven Regional Care Collaborative Organizations (RCCOs), Primary Care Medical Providers (medical homes), and Statewide Data and Analytics Contractor
- Passive enrollment with opt-out, based on pattern of use with provider. 350,000 (47%) Medicaid enrollees as of Nov. 2013

Colorado Medicaid Accountable Care Collaborative (ACC)

- Medical homes that help clients access additional services through RCCOs such as behavioral health care, long-term services, housing assistance, food assistance, etc.
- Excludes beneficiaries dually-eligible for Medicare/Medicaid or in an institutional setting

Colorado Medicaid Accountable Care Collaborative (ACC)

- FFS payments to providers plus $4 PMPM to primary care providers; up to $13 PMPM to RCCOs for provider support and member care coordination
- $1 of PMPM payments to primary care providers and RCCOs conditional; based on reduced readmissions, ER visits, and high-cost imaging

Colorado Medicaid Accountable Care Collaborative (ACC)

Department of Health Care Policy and Financing Analysis:

- FY 2011-12: $20 million in gross savings; $3 million in net savings
- FY 2012-13: $44 million in gross savings; $6 million in net savings ($1.8 million in budgeted savings)
- FY 2012-13: 15-20% reduction in readmissions; 25% reduction in high-cost imaging; slower rate of ER utilization growth

FY 2012-13 Report:
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1233759745246

Colorado Medicaid Accountable Care Collaborative (ACC)

- Summer 2014 – Colorado will begin a two-year pilot project with one RCCO to accept full-risk global payments including physical health, behavioral health, and substance abuse services

Utah Medicaid ACO Model

- CMS waiver July 2011; began January 1, 2013
- Utah considers an ACO any organization that can:
  - 1) Manage risk and accept capitated payment
  - 2) Distribute payments to providers
  - 3) Meet quality standards
- Modified existing Managed Care Organization (MCO) contracts to ACO contracts

Utah Medicaid ACO Model

- Risk-adjusted, capitated payments based on enrollees historic costs and trend
- More flexibility for ACOs in provider reimbursement
- Adds quality requirements to typical managed care contracts

Utah Medicaid ACO Model

- Primary care provider medical home
- Covers physical health
- 70% of Medicaid beneficiaries
- Excludes beneficiaries in an institutional setting
- Plans to integrate behavioral health and long-term care in future years

Oregon Coordinated Care Organizations (CCOs)

- "ACO on Steroids"
- CMS Waiver: July 2012 through June 2017
- CMS provides $1.9 billion over 5 years to implement program

Oregon Coordinated Care Organizations (CCOs)

- 16 CCOs that coordinate care for Medicaid and CHIP beneficiaries in their region
- Global budget (excludes long-term care)
- Coordinate physical, mental, and dental health
- Includes beneficiaries dually-eligible for Medicare and Medicaid

Oregon Coordinated Care Organizations (CCOs)

- 90% of Medicaid enrollees in a CCO; may add public employees in future
- One percent of capitated payments withheld for quality reporting; additional quality bonus pool

Oregon Coordinated Care Organizations (CCOs)

- Baseline: CY 2011 trended at 5.4% per year
- PMPM growth must be 1 percentage point below the 5.4% baseline trend in FY 2013-14 and 2 percentage points below the 5.4% baseline trend in future years
- If targets not met, CMS reduces following year implementation funding by $54-$68 million
- If demonstration is not at least budget-neutral, State reimburses CMS for excess federal funds

Comparison of Medicaid ACOs

	Colorado	Utah	Oregon
Delivery System	FFS plus PMPMs for networks and providers	Capitated payments	Capitated payments
Payment at risk based on quality?	Yes, small amount of PMPM at risk based on quality/utilization targets	No, but contract requires quality performance	Yes, additional bonus pool for quality performance
Services Included	Help beneficiaries access behavioral health, long-term care (but those services not part of payment)	Physical health	Physical health, Behavioral health, Dental health
Populations Excluded	Excludes Medicare/Medicaid dual-eligible beneficiaries and those residing in an institution	Excludes beneficiaries residing in an institution	Excludes Program for All-Inclusive Care for the Elderly (PACE)
Mandatory enrollment?	Passive enrollment with opt-out	Yes, for four most populous counties	Yes
Percent of Medicaid enrollees	47%	70%	90%

Takeaways

- ACOs are a new construct in Medicaid
- The term "ACO" can apply to a wide range of delivery systems
- May be able to reduce costs and improve quality over time, but fiscal impacts are uncertain
- Require some level of upfront cost
- Most States increase shared savings/downside risk over time as providers adjust to model

Key Questions for States Considering a Medicaid ACO

- What type of ACO/delivery system?
- How much risk does the ACO bear?
- What services will be included in the ACO payment?
- What populations will be served by the ACO? Required/Opt-in/Opt-out?
- Timeline for implementation?

Questions?

Fiscal Research Division

Room 619, LOB

919-733-4910

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