



HIGH-PERFORMANCE HEALTH CARE FOR VULNERABLE POPULATIONS

A POLICY FRAMEWORK FOR PROMOTING
ACCOUNTABLE CARE IN MEDICAID

Deborah Bachrach, William Bernstein, and Anne Karl
Manatt, Phelps & Phillips, LLP

NOVEMBER 2012

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Abstract: The Affordable Care Act and state Medicaid reform efforts present opportunities to reengineer health care payment and delivery systems to promote higher performance. This opportunity will be squandered, however, unless Medicare and Medicaid work collaboratively to develop a common framework for providers. This report explores how state Medicaid agencies might align with and build on the Medicare Shared Savings Program, which rewards groups of providers that meet cost and quality benchmarks by working together to coordinate patients' care in accountable care organizations (ACOs). While the Shared Savings Program applies only to fee-for-service Medicare beneficiaries, federal policymakers recognize that the ACO infrastructure can be leveraged to other populations. Indeed, ACOs are most likely to succeed if they deploy care management strategies across all patient populations. Medicaid beneficiaries could benefit from payment and delivery system reform initiatives aligned with the Shared Savings Program, and state Medicaid programs could reap considerable savings.

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EXECUTIVE SUMMARY

Both the federal and state governments are adopting new payment and delivery system models aimed at improving the quality of health care services and reining in costs. In addition to a wide range of reforms enacted in the Patient Protection and Affordable Care Act, there are several state policies supporting these goals. An emerging challenge for policymakers is to create alignment among these initiatives so that the proliferation of payment and delivery system models does not lead to conflicting financial incentives and burdensome reporting requirements for providers, thus undermining the goal of achieving coordinated, effective, and efficient care.

Medicaid could play a significant role in harmonizing the various delivery system reform initiatives and driving change that fosters greater accountability and improved performance across the health system and across payers. First, the sheer size of Medicaid—by 2019, up to 25 percent of Americans could receive coverage through the program, and it could account for as much as 20 percent of national health care spending—makes it vitally important to the success of any initiative. Second, states have a financial imperative to contain Medicaid costs: Medicaid accounts for over 70 percent of states' health care expenditures, and is the first- or second-largest item in every state's budget. Implementing coordinated, accountable delivery systems could help contain costs and achieve better outcomes for Medicaid beneficiaries.

The Centers for Medicare and Medicaid Services (CMS) recognizes the importance of having state Medicaid programs align with other payment and delivery system reform efforts, as evidenced by the recent Center for Medicare and Medicaid Innovation (CMMI) State Innovation Models initiative, which provides funding for states to design and test multipayer delivery system and payment reforms. Medicare and Medicaid must articulate a shared vision and adopt policies that are aligned in their support of providers working together to maximize the value of care they deliver to their patients and communities.

This report focuses on the Medicare Shared Savings Program (MSSP) as an example of how Medicaid might build on delivery system and payment reform programs in Medicare. While the MSSP program is designed to create accountable care organizations (ACOs) for fee-for-service Medicare beneficiaries, CMS has explicitly recognized that the ACO infrastructure can be leveraged to care for Medicaid populations, and that ACOs will be most successful if they deploy their infrastructure across all of their patient populations. In this report, we propose a policy framework for states to create ACOs for their Medicaid populations.

Landscape for Payment and Delivery System Reform in Medicaid

The Medicaid program has taken several steps to strengthen primary care, which is the essential foundation for any delivery system reform efforts. First, under the Affordable Care Act, Medicaid must pay providers at least the Medicare payment rate for primary care services provided during 2013 and 2014. The additional payments will be fully funded by the federal government, resulting in an estimated investment of \$8.3 billion.

Second, at least 17 states have launched patient-centered medical home initiatives in their Medicaid programs that provide incentive payments to primary care providers that act as medical homes. Through the Affordable Care Act, several other states are also creating "health homes" in which providers receive a per member per month fee to provide care coordination services for patients with chronic conditions. Medicare is also taking steps to strengthen primary care for its beneficiaries through programs such as CMS's Multipayer Advanced Primary Care Practice Demonstration and CMMI's Comprehensive Primary Care Initiative, both of which promote alignment of Medicare, Medicaid, and commercial payers to improve care coordination for Medicare beneficiaries. Such programs are examples of federal support for multipayer delivery system reform efforts.

Finally, several states already have taken steps to establish ACO programs for their Medicaid populations. For example, Oregon has launched coordinated care organizations for its Medicaid population and plans to transition all beneficiaries currently enrolled in Medicaid managed care plans into these ACO-like entities.

While states have taken steps to strengthen primary care and experiment with accountable care strategies, the far more dominant trend is for states to expand their use of managed care to try to control costs and improve quality in their Medicaid programs. Nationally, as of 2010, 48 percent of Medicaid beneficiaries are enrolled in a fully capitated managed care plan. This will increase to 62.4 percent by 2019. States are also using managed care and ACO-like models to improve quality and reduce costs for their dually eligible populations.

The Roles of ACOs and MCOs in Medicare and Medicaid

Policymakers have largely viewed ACOs and managed care organizations (MCOs) as distinct approaches, even though both seek to provide high-quality, cost-effective care. ACOs and MCOs may be viewed as two poles on a continuum: at one end, a managed care organization receives a monthly capitation payment and oversees patients' comprehensive care through a contracted network of participating providers; at the other end, an accountable care organization takes on responsibility for a designated patient population and receives fee-for-service payments, shares in any savings from meeting spending targets, and in some cases takes on risk for exceeding targets. While a range of models exists on the spectrum between these two poles, there is a "sweet spot" where the entity bearing financial risk is successfully integrated with the delivery system; well-known examples include Kaiser Permanente, Geisinger Health System, and Denver Health. This point can be achieved regardless of whether the starting point is an ACO or MCO; the challenge for states is to ensure that providers are supported, given appropriate incentives, and

held accountable for achieving integrated, efficient, and effective care.

Policy Recommendations for Building an ACO Framework in Medicaid

This report offers the following policy framework for states to establish ACOs in their Medicaid programs by building on the MSSP model, adapting program requirements where appropriate to accommodate the unique characteristics of the Medicaid population, the needs of Medicaid providers, and market conditions.

1. **Getting the strategy right.** At the outset, states should develop a core strategy for achieving their goals of containing costs and improving quality in Medicaid and decide whether supporting ACO formation is central to this strategy.
2. **Translating strategy into action.** States will need to ensure that fee-for-service and managed care policies are aligned within their Medicaid programs, as well as with Medicare policies to the extent possible. States using primarily fee-for-service payment structures may want to model their ACO programs on the MSSP. States with sizable Medicaid managed care programs may want to adopt contracting guidelines governing the relationship between MCOs and ACOs to support a more integrated care model. Over time, states will want to minimize their use of fee-for-service contracts and develop payment models that combine quality metrics with capitation or shared savings that reward providers for high performance.
3. **ACO certification.** States should adopt a streamlined certification procedure that builds on the MSSP certification process and accounts for the needs of the Medicaid program, which provides care to a vulnerable patient population. States may facilitate certification of Medicaid ACOs by several means, including: deeming ACOs participating in the MSSP certified for the purposes of Medicaid ACO participation; creating a supplemental certification process; or creating a parallel state certification process for providers not applying for

certification as a Medicare ACO. States also may consider working with an outside accreditation body to develop certification criteria that bridge the requirements of both Medicare and Medicaid.

4. **ACO governance and ownership.** States should align any ACO governance and ownership requirements with those set forth in the MSSP in order to avoid imposing conflicting standards on providers participating in both programs. While one such requirement is that clinical providers lead and own a majority stake in the ACO, the success of ACOs depends on the formation of partnerships with entities having expertise in areas such as information technology and care coordination. ACO implementation requires significant capital investments to put these elements in place. States should consider how to support safety-net organizations, in particular, in their efforts to form ACOs.
5. **Assignment to an ACO.** For Medicaid fee-for-service patients, it may make sense to follow MSSP's lead and assign patients retrospectively, based on where they receive a majority of their primary care in each year. However, retrospective assignment may not be ideal in Medicaid since fee-for-service beneficiaries are not restricted to a fixed network of providers, and since Medicaid beneficiaries experience more frequent disruptions in insurance coverage than do Medicare beneficiaries. Retrospective assignment also may be less effective for treating Medicaid beneficiaries who have complex medical and behavioral health needs. States may want to consider prospectively assigning individuals with complex needs to ACOs in order to reach out to and closely manage these individuals. States also may want to use a prospective assignment system for Medicaid managed care beneficiaries, based on enrollees' assigned primary care provider.
6. **Opt-out.** To avoid imposing conflicting standards for beneficiary notification and consent on organizations participating in both Medicare and Medicaid ACO initiatives, states should not allow Medicaid beneficiaries to opt out of assignment to an ACO.
7. **Exclusivity of primary care providers.** States will likely want to follow Medicare's lead and limit primary care providers to participating in only one ACO for each tax identification number under which they bill Medicaid. However, states should ensure that this requirement does not impede access to care for Medicaid beneficiaries.
8. **Financial model.** To make participation in a Medicaid ACO program more appealing to providers, particularly safety-net providers who may have limited resources to invest in ACO infrastructure, states should follow the MSSP approach in developing a financial model that allows ACOs to be eligible for shared savings, but not shared losses, during their first three-year contract with the state. States also should consider the extent to which they share savings with providers and MCOs. For example, states should permit Medicaid ACOs to share in the first dollar of savings, so that ACOs may recoup their investments in ACO infrastructure. States also should require MCOs to share a portion of their savings with the state, so that Medicaid programs benefit from greater efficiencies in care.
9. **Benchmark calculation and trending.** In order to compare actual ACO spending to a benchmark—an estimate of what would have been spent on the ACO's assigned beneficiaries—states may want to adapt three core features of the methodology used to calculate benchmark expenditures in the MSSP. First, the MSSP uses claims data from beneficiaries who are not necessarily assigned to the ACO, which will pose challenges for Medicaid programs that are expanding to the newly eligible population of childless adults with incomes below 133 percent of the federal poverty level. For this reason, states may want to exclude the newly eligible populations for the first year to avoid inaccurate benchmarks. Second, the MSSP methodology risk

adjusts benchmarks based on beneficiaries' health status. States that do not risk adjust Medicaid managed care capitation rates should develop a risk adjustment methodology for the Medicaid ACO program that adjusts benchmark expenditures to account for the health status of individuals. If this is not technically feasible, states could adjust the benchmark using only demographic and geographic factors. Third, in calculating benchmarks the MSSP uses trend factors based on the growth in national health care spending for Medicare beneficiaries. States should apply statewide trends in Medicaid spending to adjust the benchmark in their Medicaid ACO programs.

10. Compensation of ACO participating providers.

The MSSP gives ACOs considerable flexibility in determining how to distribute shared savings (or shared losses) among providers. States should follow this lead in order to encourage innovation and collaboration among providers participating in Medicaid ACOs. States also may want to require that ACOs distribute a fixed percentage to safety-net providers to further Medicaid's mission of ensuring access to care for low-income individuals.

11. Quality metrics. The MSSP and Medicaid ACO quality metrics should be aligned to the extent possible to ensure consistency across programs and to enable ACOs to create systemwide quality improvement initiatives. States should adopt relevant MSSP quality metrics and add additional metrics for core services provided to Medicaid beneficiaries, such as measures assessing the quality of pediatric, obstetric, and behavioral health care.

12. Health information technology and exchanges.

Although the effective exchange of health information is indispensable to the success of ACOs, the MSSP does not require that ACOs participate in health information exchanges in their states. States thus have a unique opportunity to promote the interoperability of electronic medical records by building requirements into the Medicaid ACO certification process related to data sharing

and use of public health information exchanges to support care coordination. Special consideration must be given to safety-net organizations, which may lack the capital needed to invest in a robust health information technology infrastructure. States should consider whether additional support is needed to ensure that safety-net providers can meet certification requirements related to data sharing and use of health information exchanges.

13. Federal fraud and abuse provisions. Fraud and abuse waivers remove several barriers to creating an ACO for entities participating in the MSSP, and they apply to all arrangements between MSSP ACOs and other payers. States can request that CMS and the Office of the Inspector General extend the same waivers to Medicaid ACOs to reduce barriers to participation among groups that are not also participating in the MSSP.

14. Antitrust guidance and the state action doctrine.

To protect Medicaid ACOs from antitrust scrutiny for actions taken to further the ACO's efforts, states may request that the Department of Justice and the Federal Trade Commission extend antitrust provisions in the MSSP program to Medicaid ACOs. Alternatively, states could employ the "state action doctrine," which would protect ACOs formed under a state-created ACO program from federal antitrust scrutiny, provided the state maintains an active role in overseeing the ACOs.

15. State laws and levers. States should examine which state laws pose roadblocks to the implementation of Medicaid ACOs and follow the federal lead by issuing waivers or establishing guidance that supports ACO development and growth. States also should consider whether Medicaid supplemental payment policies or their certificate of need programs need to be restructured to align with the goals of Medicaid and Medicare payment and delivery system reform.

HIGH-PERFORMANCE HEALTH CARE FOR VULNERABLE POPULATIONS: A POLICY FRAMEWORK FOR ACCOUNTABLE CARE IN MEDICAID

INTRODUCTION

Both the federal and state governments are adopting new payment and delivery system models aimed at improving the quality of health care and reining in costs. There is a wide range of reforms enacted in the Patient Protection and Affordable Care Act and new state initiatives targeting these goals, including support for patient-centered medical homes, health homes for individuals with chronic conditions, bundled payment demonstration programs, promotion of accountable care organizations, and reduced payments for potentially preventable readmissions and complications.¹ At the same time, Medicaid managed care programs are rapidly expanding, fueled by the desire of the federal and state governments to control growth in health care spending and improve health care outcomes for beneficiaries.

This proliferation of models could lead to conflicting financial incentives and burdensome reporting requirements for providers, undermining the goal of

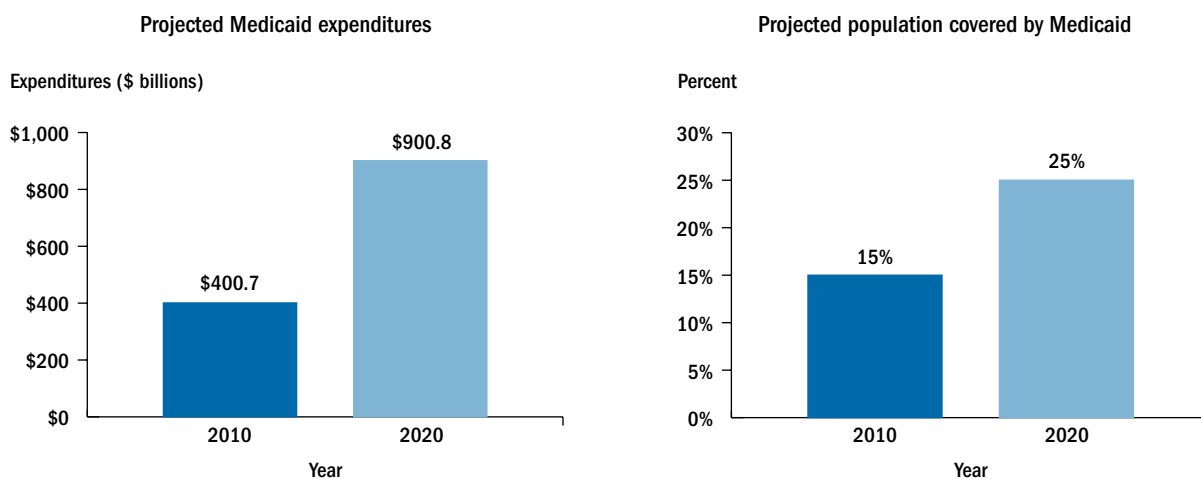
achieving coordinated, effective, and efficient care. To promote the success of the payment and delivery system reform programs under way, policymakers and purchasers should consider how best to align incentives and metrics within and across public and private programs.

Medicaid can play a significant role in harmonizing the various delivery system reform initiatives and driving change that fosters accountability and higher performance across payers. First, the sheer size of the program makes its efforts to reform payment and delivery systems vitally important. By 2019, up to 25 percent of Americans could receive coverage through Medicaid and the program could account for as much as \$900.8 billion—20 percent of national health care spending (due primarily to the expansion in coverage, rather than growth in per capita costs) (Exhibit 1).²

Second, Medicaid has the market power and financial imperative to advance payment and delivery system reform initiatives. Medicaid is the first- or second-largest item in every state's budget. States continue to face significant budget deficits—23 predict a budget shortfall of at least 10 percent for fiscal year 2012—making cost containment in Medicaid a top priority.³

The Centers for Medicare and Medicaid Services (CMS) has emphasized the importance of having state Medicaid programs align their efforts with other payment and delivery system efforts. In a July 2012 letter to state Medicaid directors, CMS stated

Exhibit 1. Projected Medicaid Expenditures and Percentage of Population Covered by Medicaid



Source: Centers for Medicare and Medicaid Services, National Health Expenditure Projections 2010–2020, 2011, p. 2, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2010.pdf>.

that it will issue a series of letters describing policy considerations for states creating payment and delivery system reform initiatives “to ensure that Medicaid reaches its fullest potential as a high performing health system and aligns with promising delivery system and payment reforms under way in the private and public sectors.”⁴ Thereafter, the Center for Medicare and Medicaid Innovation issued a new funding opportunity announcement, *State Innovations Models: Funding for Model Design and Testing Assistance*, to enable states to plan and test new payment and service delivery models through state-sponsored State Health Care Innovation Plans. These Innovation Plans target better health, better care, and reduced costs and specifically recognize the unique power of state governments, governors, and their executive agencies working with CMS and other stakeholders to “accelerate community-based health system improvements with greater sustainability and effect, to produce better results for Medicare, Medicaid, and CHIP [the Children’s Health Insurance Program].” Notably, state Innovation Plans will be required to build on and coordinate with other CMS health care reform initiatives taking place within the state, particularly those issued under Section 1115 of the Social Security Act.

Achieving the goals of better health, better care, and reduced costs requires an accessible, organized, and accountable delivery system supported by a wide swath of payers.⁵ Medicare and Medicaid should articulate a shared vision and adopt policies that, while not necessarily identical, are at least aligned in their support of providers that work together to maximize the value of the care they deliver to their patients and communities. Such an approach will benefit both programs and ultimately all Americans.

This report focuses on the Medicare Shared Saving Program (MSSP) and discusses how state Medicaid agencies could align with and build on this program. The MSSP is not the only initiative states should consider in crafting their Medicaid strategy, but it is important for three reasons. First, the MSSP is to date the most detailed and far-reaching national delivery system reform initiative, and it was crafted

by CMS with considerable input from stakeholders. Second, providers are embracing the MSSP—as of July 2012, 116 accountable care organizations (ACOs) in 33 states have been approved to participate.⁶ Finally, the MSSP includes waivers of fraud and abuse laws, as well as unique treatment under antitrust laws, that enable it to be leveraged across payers—providing a platform on which states can build multipayer reform strategies.

Under the program, groups of health care providers agree to work together to provide overall care for fee-for-service Medicare beneficiaries. ACOs that demonstrate their ability to provide more effective and efficient care will be able to share in the savings they achieve. While the MSSP program applies only to fee-for-service Medicare beneficiaries, CMS explicitly recognized that the infrastructure providers use to participate can be leveraged to care for other populations—and that ACOs will be most successful if they deploy that infrastructure across other populations. Indeed, in the final MSSP rule, CMS noted that “we stated our belief that the more patients an ACO sees for which it is eligible to receive performance-based incentives, such as shared savings, the more likely it is that the ACO will adopt substantial behavior changes conducive to improved quality and cost savings.” In the case of the Pioneer ACO program, CMS went so far as to require successful applicants to commit to having ACO-like contracts affecting at least 51 percent of participating providers’ revenues by the end of the second year of the program.⁷ (See the [Appendix](#) for an overview of both Medicare ACO programs.)

Medicaid beneficiaries—including those who are sick and vulnerable, such as special needs children, disabled individuals, frail elders requiring long-term care services, and mentally ill patients—are likely to benefit from payment and delivery system reforms aligned with the MSSP. As demonstrated in a number of delivery system reform efforts, high-performance, provider-led delivery systems are especially important for improving the care of low-income and medically vulnerable beneficiaries. ACOs are well positioned to manage the care of those with multiple chronic conditions.⁸ ACOs also could improve care for dual eligibles,

the 9 million Americans covered by both Medicare and Medicaid who account for 15 percent of Medicaid enrollees but 39 percent of its costs.⁹

This report examines the attributes of the MSSP program and suggests how states could build on this framework to catalyze cost containment and quality improvement in their Medicaid programs. First, we describe the landscape for payment and delivery system reform initiatives, highlighting Medicaid initiatives in the Affordable Care Act and the steps states have taken to promote payment and delivery system reform. Then we advance policy recommendations for states to build on the MSSP model, thereby facilitating a common framework for Medicare and Medicaid to promote high-performance delivery systems.

PAYMENT AND DELIVERY SYSTEM REFORM IN MEDICAID

Medicaid has taken various steps to promote payment and delivery system reform. First, largely spurred by the Affordable Care Act, states have taken steps to strengthen primary care, which is the foundation for any delivery system reform effort.¹⁰ Under the health reform legislation, state Medicaid programs must pay providers at least the Medicare payment rate for primary care services provided during 2013 and 2014.¹¹ Medicaid managed care plans also must pay the Medicare rate for primary care services during 2013 and 2014. The additional amounts states invest in primary care rates will be funded 100 percent by the federal government during this two-year period. It is estimated that these enhanced payments will result in an investment of \$8.3 billion, laying the groundwork for other initiatives that depend on a robust primary care infrastructure.¹²

Additionally, some states have created incentive payments to promote care coordination, further strengthening the foundation on which states can create ACO programs. At least 17 states, including Colorado, Maine, and Nebraska, are providing payments (either enhanced fee-for-service rates or per member per month fees) to primary care providers that act as patient-centered medical homes.¹³

Other states, including Iowa, Missouri, New York, North Carolina, Oregon, and Rhode Island, have created “health homes” for individuals with certain complex conditions.¹⁴ Under the Affordable Care Act, health homes are required to link care coordinators with a network of cooperating primary care behavioral health care providers, as well as social and community support services, to ensure that patients’ full range of needs are met. Health homes generally receive a per member per month care coordination fee for providing these services to beneficiaries with chronic illnesses. States will receive federal funds to cover 90 percent of the cost of the care coordination payments for eight quarters.¹⁵ To further encourage health homes to improve efficiency through care coordination, New York is offering, and Missouri will consider offering, limited shared savings payments.¹⁶

In addition to these efforts, through CMS’s Multipayer Advanced Primary Care Practice Demonstration, Medicare has joined existing efforts involving Medicaid and commercial payers in eight states (Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont) to improve access to medical homes for Medicare beneficiaries. Under this demonstration, CMS will pay medical home providers a monthly fee to provide care management services to Medicare beneficiaries.¹⁷ The Center for Medicare and Medicaid Innovation is also supporting the Comprehensive Primary Care Initiative, another multipayer effort involving Medicare, Medicaid, and commercial payers in which CMS will pay a monthly fee to 500 primary care practices in eight states (Arkansas, Colorado, Kentucky, New Jersey, New York, Ohio, Oklahoma, and Oregon) to improve care management for Medicare fee-for-service beneficiaries. After two years, participating practices will be eligible to share in any savings generated.¹⁸ These initiatives demonstrate support at the federal level for increasing alignment among Medicare and Medicaid to achieve broader delivery system and payment reform goals.

States also have begun exploring the ACO concept as a way to promote quality and efficiency in Medicaid. Several, including Colorado, Connecticut,

Florida, New York, Utah, Vermont, Washington, and Wyoming, have passed statutes either authorizing ACOs or requiring a state agency to study how the state might launch an ACO initiative.¹⁹ The Connecticut statute, for example, authorizes the Commissioner of the Department of Social Services to implement policies that would enable the state to participate in pediatric ACOs for its Medicaid population. Washington, similarly, created a demonstration project to modernize Medicaid by, among other things, testing innovative reimbursement models, including ACOs. Other states have taken a more limited approach and authorized the study of ACOs. Wyoming, for example, created an

advisory committee to estimate the cost of restructuring the state's Medicaid program, including by implementing options such as ACOs.

A handful of states have taken significant steps to develop ACO programs for Medicaid populations. For example, Oregon launched an ACO-like program for its Medicaid population (see box), including the roughly 78 percent of beneficiaries who are currently enrolled in Medicaid managed care plans.²⁰ These CCOs will be jointly governed by a risk-bearing entity, providers, and the community and subject to global budgets, meaning that they will bear full financial risk for the cost of medical services rendered. Oregon will

OREGON COORDINATED CARE ORGANIZATIONS

In May 2012, CMS approved Oregon's request to move Medicaid beneficiaries from managed care organizations (MCOs) to coordinated care organizations (CCOs). Key features of the CCO program include:

- *Shift away from MCOs.* Currently, 78 percent of Oregon's Medicaid beneficiaries are enrolled in fully capitated MCOs. Beginning in July 2012, Oregon plans to transition all of these beneficiaries into CCOs. Many MCOs, however, will sponsor CCOs, using their existing provider networks and plan infrastructure to coordinate and deliver care.
- *Direct Contract Between State and CCOs.* Rather than require that MCOs contract with CCOs (or enter into another ACO-like payment structure with providers), Oregon chose to move its direct contracts from MCOs to the CCOs.
- *Multi-Stakeholder Governance Structure.* CCOs will be governed by providers, community members, and risk-bearing entities. In many regions of the state, the existing MCOs will join forces with local health care providers and community members to create the CCOs.
- *Assignment.* Beneficiaries will enroll in one of the CCOs in their geographic region.
- *Global Budget.* CCOs will be held to a global budget for all physical, mental, and dental health care. During the initial implementation of the program, CCOs will receive a fixed per member per month capitation payment to cover the costs of services currently provided by physical health, mental health, and by 2014, dental care organizations. The CCOs also will be held accountable for the costs of physical, mental, and dental health care services that are not covered under existing managed care arrangements, though the exact methodology for paying CCOs for this noncapitated portion of the global budget may vary. The global budgets will be adjusted to account for the geographic region in which the CCO will operate. If a CCO operates in an area with little managed care experience, then its capitation payments will be risk-adjusted based in part on a population-based methodology.
- *CCO-Specific Licensure.* Since the CCOs will bear financial risk, Oregon is currently developing a new category of license that CCOs will need to obtain.

use quality metrics that are aligned with existing federal programs, such as the MSSP and the Hospital Value-Based Purchasing Program. Many existing MCOs will sponsor CCOs, leveraging their provider networks and infrastructure within the new governance structure and financial model. By shifting Medicaid beneficiaries from MCOs to CCOs, Oregon expects to achieve total savings of \$3.1 billion over five years through improved coordination of physical and mental health and greater provider accountability for the costs and quality of care.

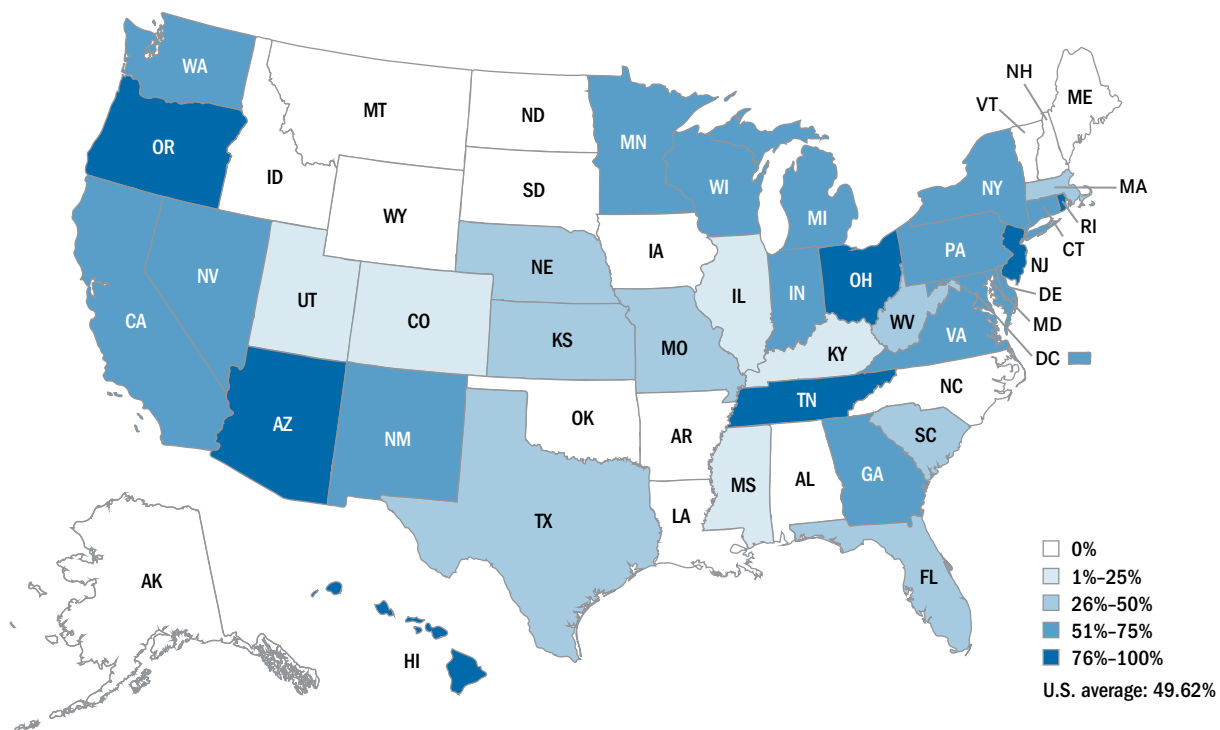
Similarly, Minnesota has created a three-year demonstration project to create ACO-like entities. Under the demonstration, nonintegrated providers and provider organizations can join together to coordinate care for patients, receiving shared savings payments but not bearing downside risk. Alternatively, integrated delivery systems that currently provide both inpatient and ambulatory care will be eligible for shared savings and responsible for shared losses. Participating entities will be responsible for the quality and costs of care for non-dually eligible adults and children who are

currently covered under Medicaid managed care or the fee-for-service program.

While some states have begun to experiment with accountable care strategies, the far more dominant trend is to embrace managed care as a means to control costs and improve quality in Medicaid. Nationwide, 49.4 percent of Medicaid beneficiaries are enrolled in a fully capitated managed care organization (MCO).²¹ By contrast, approximately 25 percent of Medicare beneficiaries are enrolled in managed care through Medicare Advantage plans.²² But there is great variation among states in terms of the numbers of Medicaid beneficiaries enrolled in MCOs (Exhibit 2). As of May 2012, no Medicaid beneficiaries were enrolled in MCOs in 15 states while more than three-quarters of Medicaid beneficiaries were enrolled in MCOs in seven states.

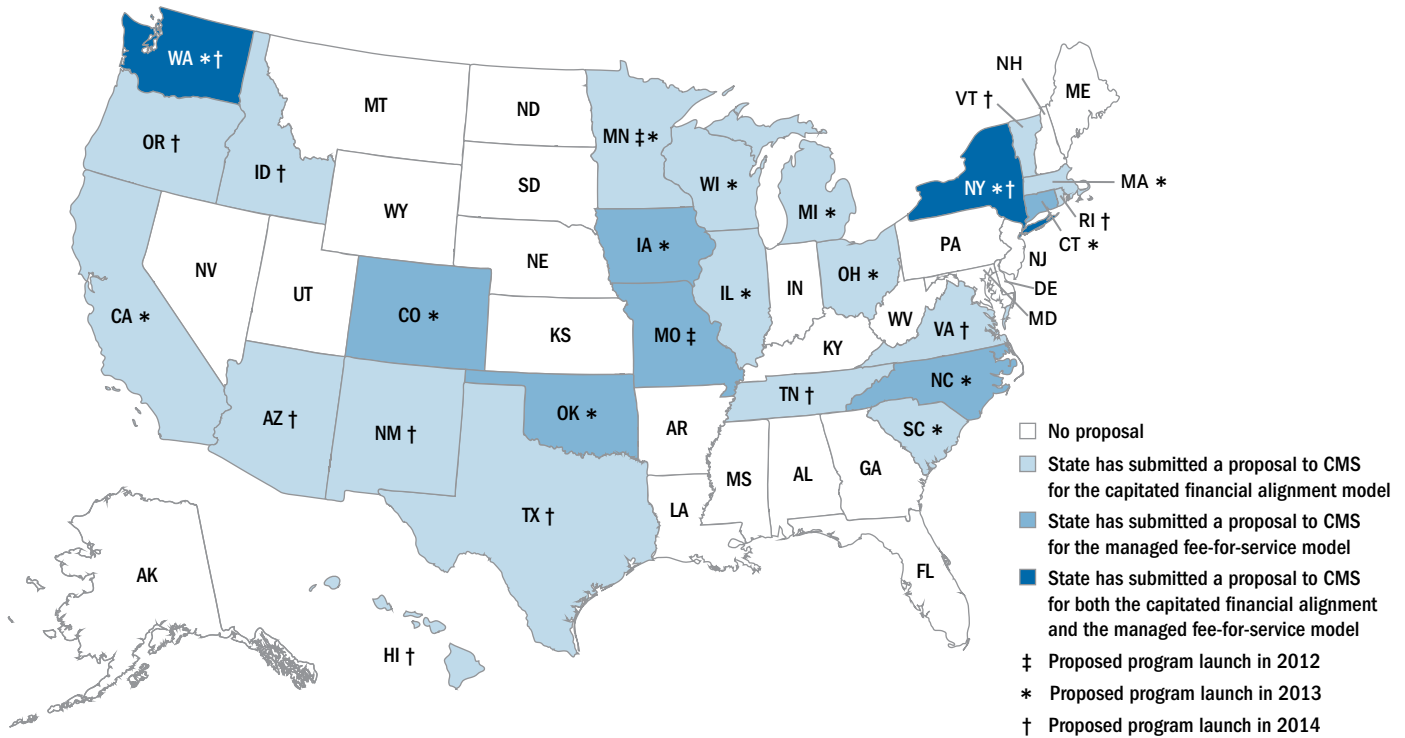
The growth in Medicaid managed care is expected to continue to accelerate. By one estimate that assumes all states will expand Medicaid eligibility levels to 133 percent of the federal poverty level, the number of beneficiaries enrolled in Medicaid managed

Exhibit 2. Percentage of Medicaid Beneficiaries Enrolled in Fully Capitated MCOs



Note: Oregon is reflected as having a high percentage of Medicaid beneficiaries enrolled in MCOs, but, as described above, the state began shifting Medicaid beneficiaries from MCOs to CCOs in September 2012. Source: Manatt Health Solutions, based on Kaiser Family Foundation data, May 2012.

Exhibit 3. States Issuing Demonstration Plans for Dually Eligible Individuals



Note: Washington has proposed a 2013 start date for the capitated and managed fee-for-service models and a 2014 start date for a hybrid model. Minnesota has proposed a 2012 start date for seniors and a 2014 start date for those with disabilities. Source: Manatt Health Solutions, updated Aug. 22, 2012.

care will jump to 62.4 percent by 2019, while Medicaid enrollment is expected to grow only 33.9 percent during the same period.²³ States also are developing plans to improve quality and reduce costs for their dually eligible populations, with some working on managed care models and others focusing on ACO-like strategies. Nationwide, dually eligible individuals represent 15 percent of the Medicaid population but account for 39 percent of Medicaid expenditures.²⁴ Currently, less than 15 percent of dually eligible individuals are enrolled in managed care plans, and most dually eligible individuals receive Medicaid benefits through fee-for-service arrangements that do not promote coordination among providers. As a result, some studies estimate that Medicare and Medicaid could save \$125 billion over 10 years by improving coordination of care for dually eligible individuals.

To achieve these savings, the Center for Medicare and Medicaid Innovation has announced two models for reforming payment for care provided to dually eligible individuals: fully integrated capitation and managed fee-for-service payments. Under the first, MCOs would receive a blended capitation payment from CMS and the state Medicaid agency to cover the costs of both Medicare and Medicaid benefits. By contrast, under the managed fee-for-service model, providers would continue to receive fee-for-service payments from Medicare and Medicaid but would be eligible to receive a portion of any savings achieved through improved care coordination, much like an ACO that participates in the MSSP. As Exhibit 3 illustrates, states have taken varied approaches to managing care for their dually eligible populations, with 18 states proposing to adopt the fully integrated capitated model, six proposing to adopt a managed fee-for-service approach, and two states proposing to adopt both models.

THE ROLES OF ACOs AND MCOs IN MEDICARE AND MEDICAID

To date, policymakers have largely viewed MCOs and ACOs as distinct approaches. At the federal level, the MSSP applies exclusively to fee-for-service beneficiaries. Similarly, the capitated enrollment program for dual eligibles allows only licensed MCOs to participate and does not provide any guidance as to how enrollees in this program might relate to ACOs. The managed fee-for-service model for dual eligibles is an entirely distinct approach with providers, rather than MCOs, at the core. The bifurcation of managed care and fee-for-service initiatives presents a challenge for providers and policymakers alike.²⁵ Ultimately, the goal should be to define and harmonize the models, so that both support integrated delivery systems that provide cost-effective, quality care for patients and communities.

We propose that MCOs and ACOs can be viewed as two poles on a continuum. At one end, MCOs receive monthly capitation payments and are responsible for arranging comprehensive health care to enrolled individuals and families through a contracted network of participating providers. Providers are generally paid on a fee-for-service basis by the MCO. Patients select or are assigned to the MCO. Additionally, patients are generally required to receive all of their care, except emergency care, through providers in the MCO's network. The MCO provides care management at the plan level, and care managers, who are generally employed by the plan or its vendor, manage care for enrollees. Finally, MCOs are required to obtain a state license to bear risk and must establish adequate reserves.

At the other end of the continuum is a non-capitated ACO, an entity formed by providers that contracts with payers (whether public or private) to receive fee-for-service payments with shared savings (or shared losses). Shared savings (or losses) are determined by measuring the total cost of care for the ACO's patients against a benchmark. ACOs are owned and led by participating providers, at times with nonproviders holding a minority stake. Patients are generally assigned to an ACO based on where they receive care, and may see

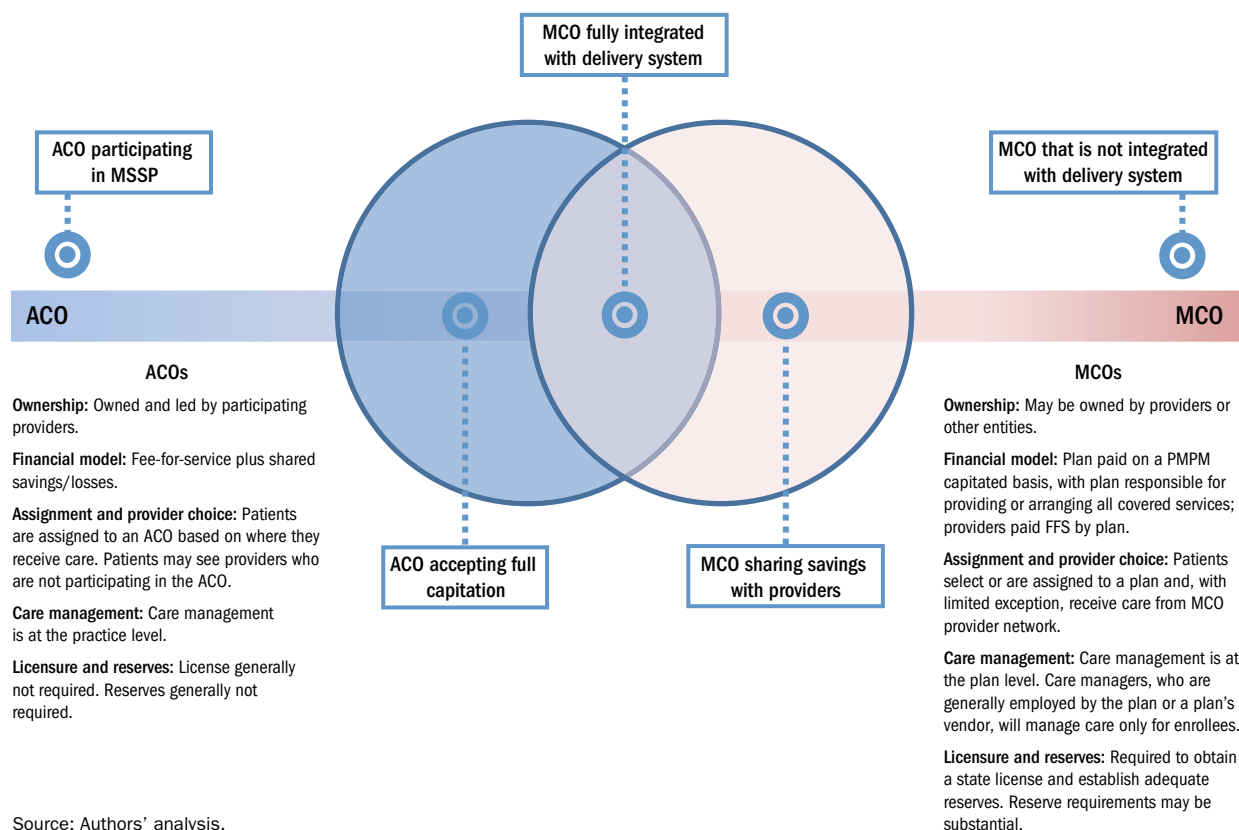
providers who are not participating in the ACO. Unlike MCOs, care management is at the practice level, and care managers will likely be embedded in hospitals or providers' offices to manage care for all patients, regardless of payer. State licenses are generally not required for a financial model incorporating fee-for-service payments plus shared savings or shared losses.

In between these two extremes is a range of models, including provider-sponsored MCOs, staff-model HMOs, and fully capitated ACOs. Likewise, an MCO with a contracted network can share risk and savings and offer quality incentives to its providers. The issue is less about the legal or corporate structure and more about whether the delivery model and the payment model support integrated, cost-effective, quality care. Exhibit 4 on page 18 depicts the ACO–MCO continuum.

Moving from left to right on the continuum illustrated in Exhibit 4, the ACO entity accepts more financial risk for the total cost of care—triggering state licensing and reserve requirements at some point. Moving from right to left, by contrast, the MCO entity becomes more integrated with the health care delivery system by developing financial and clinical initiatives that foster greater coordination and accountability across the delivery system. The overlapping area represents a “sweet spot” where the entity bearing financial risk is clinically integrated with the delivery system. This can be achieved whether the starting point is an ACO or an MCO model; in each case, the key challenge for states is to ensure that providers are supported, given incentives, and held accountable for providing integrated, efficient, and effective care.

In developing Medicaid policy, states should assess their market characteristics to determine the best building blocks for advancing shared clinical care processes, a common information technology infrastructure, and common quality metrics and payment structures, including incentives, across payers. In markets with strong and well-functioning Medicaid managed care systems, the key issue will be how to harmonize the policies of multiple plans to support accountability at the provider level, including supporting development of

Exhibit 4. The ACO-MCO Continuum



ACO initiatives. In markets where the Medicaid managed care penetration is more limited or the managed care program is not functioning as desired, states may want to consider direct provider contracting vehicles similar to those in the MSSP program. Some states may want to consider a mix of managed care and direct contracting vehicles; in such instances there will be a higher burden to ensure that the proliferation of models does not cause administrative complexity and undermine accountability.

BUILDING AN ACO FRAMEWORK IN MEDICAID

This section advances policy recommendations for states to consider in constructing a framework in Medicaid to support the development and operation of accountable care organizations that: 1) aligns with the Medicare Shared Savings Program; 2) addresses the needs of Medicaid beneficiaries, and 3) advances

statewide payment and delivery reform. To the extent states build on Medicare policies, they may achieve some efficiencies in terms of data collection and monitoring of ACOs.²⁶ States should begin by building on the MSSP program requirements and adapting them to accommodate the unique characteristics of their Medicaid population or market conditions. States will want to strike a careful balance in addressing the needs of the Medicaid population without losing the benefits of consistent standards across ACO initiatives.

Getting the Strategy Right

States will need to decide whether supporting the formation and ongoing operations of accountable care organizations is central to achieving their goals of containing cost and improving quality in the Medicaid program.

ACOs have the potential to improve the quality of care and reduce the overall cost of care for Medicaid beneficiaries for several reasons. First, ACOs make

providers directly accountable for patient costs and outcomes, fostering accountability at the level at which care is delivered.²⁷ Additionally, by holding large groups of providers jointly accountable for quality and costs, the ACO model promotes systemwide change, rather than discrete changes limited to individual providers or practices. And since most ACOs will involve partnerships between individual physicians or group practices and hospitals, hospitals will have both the incentives and ability to invest in the infrastructure to enable providers to reduce costs and improve quality.²⁸

Finally, ACOs are well positioned to improve care for patients with complex health care needs. In particular, they are well suited to integrate community-based resources into beneficiaries' care, which could benefit those who experience poor health outcomes driven by poverty and related social issues, including unstable housing and employment, problems getting transportation, and insufficient access to a nutritious diet.²⁹ By bringing together primary care physicians, specialists, and acute care hospitals with community-based mental health and social services agencies, ACOs can ensure coordination of care across the spectrum of providers, potentially eliminating the gaps in care that have the most negative effects on those with complex health care needs.³⁰

Translating Strategy into Action

In markets that are dominated by traditional fee-for-service payment structures, states may want to model their ACO programs on the MSSP. But, as discussed above, for the large number of states with significant Medicaid managed care programs, limiting ACOs to the fee-for-service population may hamper the development of ACOs in Medicaid and among safety-net hospitals serving the largest numbers of Medicaid patients.

To promote the development of ACOs in high-density Medicaid managed care markets, states will want to consider adopting contracting guidelines governing the relationship between MCOs and ACOs, thereby supporting integrated care delivery. Such guidelines might address issues such as the assignment of patients to an ACO, services performed by MCOs and

ACOs, payment methodologies, and risk allocation. Most important, to realize the benefits of high-performing delivery systems, states will want to minimize the use of fee-for-service payment methodologies that can promote disjointed or duplicative care. Whether through direct contracting or downstream contracting requirements between Medicaid managed care plans and ACOs, Medicaid programs should seek to advance the development and implementation of new payment models that combine quality metrics (such as those in the MSSP) with capitation or shared savings payment methodologies that reward providers for performance. In short, states will want to ensure that their Medicaid fee-for-service and managed care policy priorities align with each other and to the maximum extent possible and appropriate with Medicare as well.

Some states have begun to recognize the importance of contracting requirements. In New York, for example, MCOs are required under their contract with the state to provide enhanced payments to medical homes certified by the National Committee for Quality Assurance (NCQA) and to contract with health homes to coordinate care for individuals with certain chronic conditions.³¹ Additionally under the Affordable Care Act, MCOs are also required to pay providers the Medicare rate for primary care services provided in 2013 and 2014.³² Finally, Pennsylvania requires that its Medicaid managed care plans share with providers \$1 per member per month from the performance-based payment that the plan receives from the state to promote patient-centered medical homes.³³

ACO Certification

States should adopt a streamlined certification procedure that takes advantage of the extensive MSSP certification process already in place. Currently, the MSSP requires that applicants set out their governance model, plan for use of shared savings payments, data-sharing protections, and intended use of beneficiary data. Applicants also must outline their clinical processes for promoting patient-centered care, delivering evidence-based medicine, engaging beneficiaries, and coordinating care. Certification of ACOs is the pathway through

which ACOs become legally recognized and entitled to significant benefits, both in terms of the ability to receive shared savings and to structure commercial arrangements with payers and network participants that entail reduced legal liability.

States might deem ACOs participating in the MSSP to be certified for purposes of a Medicaid ACO, thus streamlining the application process for these ACOs as well as for the state. There is ample precedent for states relying on external certification processes for state law purposes. Beginning in 1965, the federal government stated that all hospitals accredited by the Joint Commission on Accreditation of Health Care Organizations were “deemed” to be in compliance with the conditions for participation in Medicare. States have followed suit. Currently, at least 38 states grant deeming authority to various NCQA and URAC accreditation programs.³⁴ For example, NCQA-certified medical homes are deemed medical homes in Iowa’s Medicaid incentive program.³⁵

While reliance on the Medicare certification process is an appropriate starting point, states may want to add their own requirements or support an alternative certification route for ACOs with small numbers of Medicare patients. For example, Medicaid ACOs will likely need to demonstrate network adequacy and care management capabilities that extend to pediatric patients, have greater capabilities to address substance abuse and mental health problems, and have the ability to address beneficiaries’ community-based and institutional long-term care needs. To address these unique characteristics of the Medicaid program, states need not set up a separate ACO certification process. Instead, the state could simply accept Medicare’s certification and require a streamlined supplemental state certification to address the unique issues of the Medicaid program.

Providers serving predominantly Medicaid patients, such as pediatric providers and safety-net hospitals, may not be able to or wish to apply for and receive certification as an MSSP ACO. For these providers, the state may want to create a parallel state certification process. If a state takes this course, it would make sense to mirror wherever possible the MSSP

federal requirement so as to promote consistency in organization and program design.

States also may want to consider working with an outside accreditation body to develop certification criteria for ACOs that bridge the requirements of both the Medicare and Medicaid programs. In fact, NCQA announced three levels of accreditation for ACOs in November 2011, and other accreditation bodies are likely to follow suit.³⁶

ACO Governance and Ownership

States will want to align any Medicaid ACO-specific governance and ownership requirements with those set forth in the MSSP in order to avoid imposing conflicting standards on ACOs participating in both programs. The MSSP requires that clinical providers lead the ACO and own a majority stake in it.³⁷ According to the preamble to the final rule establishing the MSSP, this requirement is intended to ensure that the organizations are driven by providers, not investors.³⁸ Other MSSP governance requirements include the following: 1) all providers forming the ACO must be able to participate meaningfully in the composition and control of its governing body; 2) the governing body must include a Medicare beneficiary who is served by the ACO; 3) providers participating in the ACO must control at least 75 percent of the governing body; and 4) the governing body must adopt a conflict-of-interest policy.

Encouraging partnerships, especially among providers serving large numbers of Medicaid beneficiaries, is an important way in which states can support the formation of ACOs. Early evidence suggests that there is a wide range of private companies with experience in information technology, risk management, and care coordination interested in supporting ACO development and operations.³⁹ In addition to expertise, capital is required to launch an ACO. Federal estimates suggest that putting an ACO infrastructure in place will take \$1.5 million to \$2 million.⁴⁰ But the size of the investment needed to launch a successful ACO may be considerably higher, depending on the required investment in information technology, care management staff,

network development staff, and quality reporting and financial analytics capabilities.

States should consider how to support safety-net providers in their efforts to form ACOs. The participation of safety-net providers is critical to the success of any Medicaid ACO. As The Commonwealth Fund's Commission on a High Performance Health System noted in a recent report, safety-net providers have historically provided "otherwise unavailable or unaffordable care to vulnerable populations" and "are often better able to meet the complex social, cultural, and linguistic needs that are more prevalent within vulnerable populations."⁴¹

Assignment to an ACO

An accurate assignment methodology is key to the success of an ACO, since it must be held accountable only for the cost and quality of care rendered to patients accessing its providers. The MSSP assigns beneficiaries to an ACO retroactively, based on where they received the majority of their primary care in a given year.⁴² As described in the final MSSP rule, it is critically important that the assignment process "accurately reflect the population that an ACO is actually caring for, in order to ensure that the evaluation of quality measures is fair and that the calculation of shared savings, if any, accurately reflects the ACO's success in improving the quality and efficiency of the care provided to the beneficiaries for which it was actually accountable."⁴³

In the case of Medicaid fee-for-service patients, following the MSSP lead and assigning patients on a retrospective basis, though not without problems, may be the most sensible approach. Medicaid beneficiaries, especially those in fee-for-service Medicaid who are not required to receive care from a fixed network of providers, may not receive primary care from a regular provider, but instead receive primary care services in emergency departments or from multiple providers in health clinics.⁴⁴ Additionally, Medicaid beneficiaries, unlike Medicare beneficiaries, may move on and off coverage during a year as their income fluctuates. Research indicates that as many as 43 percent of adults

newly enrolled in Medicaid experience a disruption of coverage within 12 months.⁴⁵

One of the limitations of retrospective assignment is that it may prove ineffective for individuals with the most complex conditions, particularly those with behavioral health conditions. Outreach and close management of these individuals is required upfront, and after-the-fact assignment may not address their needs. States may want to consider prospectively assigning individuals with complex needs to ACOs and providing those ACOs with additional payments for outreach and engagement of those beneficiaries. Minnesota's ACO-like Health Care Delivery Systems Demonstration uses retrospective assignment methodology but then takes into account whether the individual had been assigned to a health home affiliated with the ACO-like entity and where that individual receives primary care.⁴⁶

By contrast, for Medicaid beneficiaries enrolled in Medicaid managed care plans, states may want to require a prospective assignment system based on the enrollee's selected (or assigned) primary care provider. In the preamble to the MSSP final rule, CMS noted that managed care members tended to have lower year-to-year variability in treating physicians than fee-for-service Medicare beneficiaries.⁴⁷ Assuming the same is true for Medicaid beneficiaries, a prospective assignment methodology would ensure that ACOs are assigned responsibility for beneficiaries for whom its participating providers are responsible. A prospective assignment methodology also would enable ACOs to focus their care coordination efforts on the patients for whom they and the managed care plan will be held financially responsible.⁴⁸

Opt Out

Permitting patients to opt out of an ACO is not a significant issue because participation does not impose gatekeeper restrictions or risk loss of benefits based on where patients choose to receive care. Consequently, states will not want to permit Medicaid beneficiaries to opt out of an ACO, just as Medicare beneficiaries may not opt out of assignment to a MSSP ACO. States should follow MSSP's lead and allow beneficiaries to

opt out of having their data shared with an ACO.⁴⁹ By aligning with the MSSP with respect to opt out, states will avoid imposing conflicting standards for beneficiary notification and consent on ACOs participating in both the MSSP and Medicaid ACOs.

Exclusivity of Primary Care Providers

States will likely want to follow CMS's lead and limit primary care providers to only one ACO for each tax identification number (TIN) under which they bill Medicaid. In the MSSP, primary care providers may participate in only one ACO for each TIN under which they bill Medicare, since the beneficiary assignment methodology relies on the TINs of primary care providers.⁵⁰ In other words, a primary care physician who bills under one TIN as part of a physician group and another TIN when providing care at a health center could participate in different ACOs for each TIN. By contrast, specialty providers may participate in multiple ACOs with a single TIN.⁵¹ While exclusivity seems highly desirable, states will want to be certain that this requirement does not erode or impede access to care for Medicaid beneficiaries.

Financial Model

States should follow the MSSP approach in developing a financial model to support ACOs that allows them to choose to avoid downside risk during their first three-year contract with the state.⁵² Permitting ACOs to be eligible for shared savings, but not shared losses, will make participation more appealing to providers, especially groups that are still developing the capabilities to work under performance-based contracting arrangements. Minnesota's Health Care Delivery System Demonstration takes this approach by allowing providers who are not part of an integrated delivery system to participate in gainsharing only.⁵³ New Jersey, too, permits gainsharing only in its Medicaid ACO demonstration.⁵⁴

State financial models also will need to consider a number of other issues addressed in the final MSSP

rule, including: 1) the minimum savings/losses threshold that ACOs must achieve to trigger savings; 2) what portion of the savings are eligible for sharing; and 3) the sharing rate. For each of these aspects, states should weigh the extent to which the program is appealing to providers with the potential for it to garner significant savings for the state.

Specifically, states should consider the extent to which they share savings with providers and, if applicable, MCOs. In the MSSP, the ACO is eligible to share in the first dollar of savings or losses, and the ACO's share of the savings is adjusted to reflect their quality scores.⁵⁵ Because they can share in the first dollar of savings, ACOs are better able to recoup their investments in ACO infrastructure. To make the Medicaid ACO program appealing to providers, especially to safety-net providers that may find it challenging to invest in the ACO infrastructure, states should permit ACOs to share in the first dollar of savings. In the managed care context, states also should require that MCOs share a portion of their savings with the state, so that the state Medicaid program benefits from greater care efficiency.

In Minnesota's Health Care Delivery Systems Demonstration, MCOs are not required to contract with ACO-like entities, but the MCO must contribute a portion of the shared savings payment owed to ACO-like entities serving the MCO's enrollees.⁵⁶ For example, if an ACO-like entity is entitled to a shared savings payment of \$100,000, and 30 percent of that ACO-like entity's assigned patients are also enrolled in a particular managed care plan and 70 percent are covered through fee-for-service Medicaid, then the MCO would be responsible for \$30,000 (30%) of the shared savings payment to the ACO-like entity and the state would be responsible for \$70,000 (70%) of the shared savings payment. While the MCO is not required to contract directly with the ACO-like entity, it benefits from decreased utilization because of the ACO-like entity's efforts and is responsible for a portion of the shared savings payment to the ACO-like entity, just as if it had contracted directly with that entity.⁵⁷

Benchmark Calculation and Trending

To evaluate whether an ACO has achieved savings (or incurred losses), the state will want to compare actual spending to a benchmark—an estimate of what would have been spent on the ACO’s assigned beneficiaries. There are three core features in CMS’s methodology for calculating the benchmark expenditures for the MSSP program that state policymakers can import into their Medicaid ACO programs: 1) using claims data from beneficiaries who are not necessarily assigned to the ACO; 2) risk-adjusting benchmarks based on beneficiary health status; and 3) using trend factors based on growth in health care expenditures across a broad region.

States that opt to expand their Medicaid populations to include childless adults with incomes of less than 133 percent of the federal poverty level beginning in 2014 will face additional challenges in creating spending benchmarks for this newly eligible population.⁵⁸ Since these populations will be new to the Medicaid program, there will not be similar individuals with claims experience from years prior to the start of the Medicaid ACO program. To avoid inaccurate benchmarks, states may want to exclude the newly eligible populations for the first year of the Medicaid ACO program and then include them in subsequent years.

States also should risk adjust the benchmark expenditures to account for the health status of the individuals enrolled, to the extent that this is technically feasible. As discussed above, the MSSP borrows its risk-adjustment methodology from the Medicare Advantage program.⁵⁹ Only a small number of states, however, risk adjust Medicaid managed care capitation rates based on health status; most use a combination of demographic factors and regional adjustments to create capitation rates.⁶⁰ States that do not currently risk adjust Medicaid managed care capitation rates may consider developing a risk adjustment methodology for the Medicaid ACO program. If this is not possible, states could adjust the benchmark using only demographic and geographic factors.

Finally, states should use statewide trend factors to account for growth in health care spending.

The MSSP increases the benchmark each year by the absolute dollar amount of growth in national health care spending for Medicare beneficiaries.⁶¹ By using a national growth factor to adjust the benchmark, CMS will hold ACOs in regions with high growth in health care spending to a lower growth rate. Likewise, states can apply statewide trends in Medicaid spending to a benchmark.

Compensation of ACO Participating Providers

States should give ACOs wide latitude to determine how they distribute shared savings (or, if applicable, shared losses) among providers. The MSSP affords ACOs considerable flexibility in determining how to distribute shared savings payments among participating providers, but it does require that applicants to the program describe how they plan to do so.⁶² States should provide flexibility in distributing savings to encourage innovation and collaboration. States also may want to require that ACOs distribute a fixed percentage of savings to safety-net providers, such as federally qualified health centers and disproportionate share hospitals, to further Medicaid’s mission of ensuring access to care for low-income individuals.

Quality Metrics

States may choose to base their ACO quality measures on the MSSP’s quality metrics while incorporating additional metrics tailored to the Medicaid population. In the MSSP, ACOs must report their performance on 33 quality measures.⁶³ An ACO’s total quality score directly affects its sharing rate, so maintaining high scores is essential for collecting significant shared savings payments. Aligning the Medicaid ACO and MSSP quality metrics would ensure consistency across initiatives and better enable ACOs to create systemwide quality improvement initiatives. The MSSP’s quality metrics, though applicable to most patients, were designed for the Medicare population. As a result, they do not include metrics for some services provided to Medicaid beneficiaries, such as pediatric care, obstetric care, or behavioral health care.

Health Information Technology and Exchanges

The effective exchange of health information is critical for an ACO's success. In the preamble to the MSSP final rule, CMS stated that "health information exchanges are of the utmost importance for both effective coordination of care activities and the success of the [MSSP]."⁶⁴ CMS allows ACOs to craft their own health information exchange strategies. States have a unique opportunity to promote interoperability of electronic medical records by building into the Medicaid ACO certification process requirements related to data sharing and use of public health information exchanges to support care coordination.

Safety-net providers may, however, lack the capital needed to invest in a robust health information technology infrastructure. The Health Information Technology for Economic and Clinical Health Act provided a down payment for Medicaid providers seeking to adopt electronic health records.⁶⁵ States should consider whether additional support is needed to ensure that safety-net providers can meet the certification requirements related to data sharing and use of health information exchanges.

Without multiple payers implementing programs to promote high-performance delivery systems, there will not be enough patients, and thus enough potential shared savings, to justify the upfront costs of investments in ACO infrastructure, health information technology, and care processes necessary to support its operations. The alternative—adopting separate health IT systems and care processes depending on the patient's source of coverage—will hinder the success of the ACO. As CMS recognized, the more patients an ACO sees for which it is subject to a coordinated set of performance-based payments, the more likely it will achieve the desired cost and quality outcomes.

Federal Fraud and Abuse Provisions

States could request that CMS and the Office of the Inspector General extend the MSSP's existing fraud and abuse waivers to Medicaid ACOs to reduce barriers for groups not also participating in the MSSP.

The waivers remove several key barriers to creating an ACO, and they apply to all arrangements between the ACOs participating in the MSSP and other payers. As some ACOs may form to coordinate care for Medicaid patients, but not Medicare patients, it seems reasonable to request that the same waiver program be made available to such groups.

Antitrust Guidance and the State Action Doctrine

As part of the MSSP, the Department of Justice and the Federal Trade Commission also issued antitrust guidance that will likely protect ACOs from some antitrust scrutiny for actions taken to further their collaborations. States could request that the Department of Justice and the Federal Trade Commission extend such antitrust guidance to ACOs participating in a state's Medicaid ACO program. Alternatively, states could use the "state action doctrine" to insulate ACOs from federal antitrust provisions. Under the state action doctrine, the federal antitrust laws do not prohibit activities that arise out of a state regulatory scheme, so long as public actors supervise the otherwise unlawful activities.⁶⁶ Therefore, if a state, when acting in its regulatory capacity, creates an ACO program, ACOs that organize under such program are not subject to federal antitrust scrutiny, provided that the state maintains an active role in overseeing the ACOs. Significantly, in assuming this more active role, states would be positioned to take steps or impose requirements to ensure that the arrangements that providers and payers develop benefit the public interest or even drive the arrangements so as to advance public priorities.

State Laws and Levers

Just as some federal laws posed roadblocks to the establishment of ACOs, some state laws may pose barriers to ACO formation. States starting ACO programs targeting Medicaid beneficiaries should assess which state laws will have an impact on the success of the program and, where necessary, follow the federal lead and issue waivers or establish guidance that supports ACO development and growth. A number of state laws

can be considered in this assessment, including fraud and abuse laws, antitrust laws, corporate practice of medicine laws, laws relating to the privacy and security of health information, and laws relating to risk-bearing entities.⁶⁷ Additionally, states should consider whether their Medicaid supplemental payment policies or certificate-of-need programs need to be restructured to align with the goals of Medicare and Medicare payment and delivery system reform. A final state policy lever that should not be overlooked is the role of newly formed state-based Health Insurance Exchanges in supporting multipayer ACO initiatives.

CONCLUSION

The Affordable Care Act and state Medicaid reform efforts present an enormous opportunity to reengineer health care payment and delivery to promote a high-performing health care system. But this opportunity will be squandered unless Medicare and Medicaid work collaboratively to develop a common framework in which providers can develop and sustain an integrated care model for their patients. Aligning the requirements for ACOs in both Medicare and Medicaid, to the extent practical, will support more streamlined and efficient health care delivery systems. Even more important, coordinating ACO efforts will create coherent economic incentives for providers that encourage the best results in terms of quality improvement and cost control for all patients and communities.

APPENDIX. OVERVIEW OF MEDICARE ACO PROGRAMS

The Affordable Care Act promotes payment and delivery system reform by creating programs designed to encourage providers to form ACOs. An ACO is a “group of providers who are willing and able to take responsibility for improving the overall health status, care efficiency, and healthcare experience for a defined population.”⁶⁸ The group of providers linking together to form an ACO may have existing relationships, such as a hospital forming an ACO with its employed physicians, or the providers may not have existing relationships, such as a patchwork of physician practices and hospitals in a service area forming an ACO. Generally, an ACO is held accountable for the total per capita spending for its patients. Depending on an ACO’s arrangement with a payer, the ACO may receive a portion of any savings relative to a benchmark for the ACO’s population (“shared savings”); the ACO also may be responsible for paying for a portion of any losses (“shared losses”). ACOs also may accept partial or complete capitation to cover the costs of care for their patients.

Through the Affordable Care Act, Medicare adopted the ACO concept as a strategy for improving the quality and increasing the efficiency of care provided to its beneficiaries. Two separate ACO programs have been established: the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Program.⁶⁹ Through the MSSP, CMS has estimated that 50 to 270 ACOs will form in the first four years, affecting 1 million to 5 million Medicare beneficiaries.⁷⁰ As of the most recent announcement, in July 2012, there are 116 ACOs in the MSSP. The Pioneer ACO program, established in December 2011, is designed for providers with experience coordinating care for patients across multiple care settings. The program enables these groups of providers to move quickly from a shared savings ACO model to a population-based payment model. There are 32 Pioneer ACOs that are estimated to care for 860,000 Medicare beneficiaries.⁷¹ The Pioneer program is generally viewed as a laboratory for the further development of the more far-reaching MSSP initiative.

Taken together, the MSSP and Pioneer programs represent a path-breaking attempt by the federal government to empower high-performing delivery systems. These programs provide a regulatory structure and economic incentives to promote providers’ efforts to improve the quality and efficiency of health care services. When announcing the release of the MSSP final rule, Kathleen Sebelius, secretary of the U.S. Department of Health and Human Services, stated that the MSSP represented an opportunity to “give doctors, hospitals, and other providers the flexibility and support they need to work together and focus on making sure patients get the care they need.”⁷²

The MSSP final rule, published on November 2, 2011, sets out the framework for most ACOs caring for Medicare beneficiaries. It is thus the starting point for any assessment relating to how Medicare and Medicaid can work together to create a common framework for advancing the development and operation of high-performing delivery systems.⁷³ Under the final rule, an ACO is defined as a legal entity recognized under state law that consists of Medicare providers that manage and coordinate care for Medicare fee-for-service beneficiaries.⁷⁴ Some of the key features of the MSSP that state Medicaid agencies should consider are described below.

Entities Eligible to Form ACOs

Several types of providers can join together to form a Medicare ACO, including physicians in group practice, networks of individual providers, partnerships or joint ventures between hospitals and providers, hospitals employing providers, federally qualified health centers, critical access hospitals that bill under Method II, and rural health centers.⁷⁵ The ACO entity must be capable of the following: 1) receiving and distributing shared savings; 2) repaying shared losses; 3) establishing, reporting, and ensuring provider compliance with health care quality criteria, including quality performance standards; and 4) fulfilling other ACO functions.⁷⁶ If two or more otherwise independent participants form an ACO, it must be a legal entity separate from any of its participants.⁷⁷

ACO Governance Structure

An ACO participating in the MSSP must have a governing body with the authority to perform the functions of an ACO, including, among other things: 1) defining processes to promote evidence-based medicine and patient engagement; 2) reporting on quality and cost measures; and 3) coordinating care.⁷⁸ ACO participants must control at least 75 percent of the ACO's governing body, limiting the control of nonprovider investors.⁷⁹ Each ACO also must include a Medicare beneficiary representative on the governing body.⁸⁰ ACOs may apply to CMS for waivers of these governance requirements.

Beneficiary Assignment

CMS will assign beneficiaries to ACOs participating in the MSSP on a retrospective basis at the end of each year.⁸¹ Assignment will be completed through a two-step process. In the first step, CMS will assign a beneficiary to an ACO if the beneficiary received a majority of his or her primary care services from primary care providers within the ACO.⁸² In the second step, CMS will assign beneficiaries who received no primary care services from a primary care provider to the ACO if the individual received most of his or her primary care services from a specialty physician or certain non-physician practitioners (namely, nurse practitioners, clinical nurse specialists, and physician assistants) who participate in the ACO.⁸³

Care Management and Health Information Technology Initiatives

CMS does not require that ACOs adopt specific care management criteria. Instead, it requires that an ACO document its plans to define, establish, implement, and update its care management processes.⁸⁴ Additionally, CMS does not require that a certain number of primary care providers in the ACO engage in “meaningful use” of health information technology. Rather, CMS includes meaningful use by primary care providers as one of 33 quality metrics that will affect an ACO's total shared savings payment.⁸⁵

Financial Model

CMS establishes two tracks for participating in the MSSP. Track One features shared savings only for the first three years of participation; Track Two includes shared savings and shared losses for all three years of participation.⁸⁶ To calculate shared savings or losses, CMS will first calculate the benchmark to establish what CMS would have paid for the care of beneficiaries attributed to the ACO.⁸⁷ The benchmark is calculated by identifying the beneficiaries who would have been assigned to the ACO in the three years prior to it participating in the MSSP and tallying the costs of care for those patients.⁸⁸ CMS then risk adjusts the benchmark and inflates it to account for growth in health care expenditures.⁸⁹

For each performance year of the contract, CMS will compare the actual expenditures to the benchmark. If the savings meet a specified savings or loss threshold—specifically, 2.0 percent to 3.9 percent for ACOs in Track One, depending on the number of beneficiaries assigned to the ACO, and 2.0 percent for ACOs in Track Two, regardless of size—then the ACO will share in a portion of the savings or losses.⁹⁰ An ACO's share of savings or losses will vary based on its quality score.

Quality Metrics

The MSSP measures 33 separate quality metrics to assess an ACO's performance.⁹¹ These metrics fall into the following four domains: 1) patient/caregiver experience; 2) care coordination and patient safety; 3) preventive health; and 4) at-risk populations. In year one, all 33 measures are pay-for-reporting, meaning that an ACO receives a

perfect quality score for reporting the quality measures, regardless of their actual performance.⁹² In year two, 25 measures are pay-for-performance; in year three, 32 measures are pay-for-performance.⁹³

Fraud and Abuse and Antitrust Provisions

Along with the final rule creating the MSSP, CMS and the Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services announced waivers of three key federal fraud and abuse laws for entities participating in the program.⁹⁴ The Federal Trade Commission (FTC) and Department of Justice (DOJ) also announced antitrust protections for ACOs participating in the MSSP.⁹⁵ Specifically, CMS and OIG announced that they would waive the Physician Self-Referral Law (referred to as the “Stark Law”), the federal Anti-Kickback Statute, and the Civil Monetary Penalties law provisions prohibiting certain gainsharing arrangements between hospitals and physicians (the “Gainsharing CMP”) for certain arrangements among providers in ACOs participating in the MSSP.⁹⁶

In the antitrust policy statement, DOJ and FTC stated that ACOs participating in the MSSP will be deemed clinically integrated, an important designation enabling them to conduct joint rate and other negotiations with commercial payers, without incurring the substantial financial risk (usually 20 percent of fees) that is otherwise required to justify providers jointly negotiating rates and key terms.⁹⁷ DOJ and FTC also established a “safety zone” for ACOs with a market share of less than 30 percent for each service, effectively insulating these providers from antitrust review.⁹⁸ For ACOs formed after March 23, 2010, with market shares above 30 percent, ACOs may submit their proposed arrangements to DOJ and FTC for expedited review, but review is not required.⁹⁹

NOTES

- ¹ Affordable Care Act, Pub. L. No. 111-148, § 3502; Affordable Care Act § 2703; Affordable Care Act § 2704; and Affordable Care Act § 2702. See also 76 *Federal Register* 32,816 (June 6, 2011).
- ² Centers for Medicare and Medicaid Services, National Health Expenditure Projections 2010–2020, 2011, p. 2, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2010.pdf>. Note that these figures assume that all states will expand Medicaid eligibility to all childless adults with incomes below 133 percent of the federal poverty level. In the wake of the recent Supreme Court decision in *National Federation of Independent Businesses v. Sebelius*, Slip Op. No. 11-393 (June 28, 2012), some states may opt to not expand Medicaid eligibility for this population.
- ³ *Ibid.*
- ⁴ See Center for Medicaid and CHIP Services, State Medicaid Director Letter #12-001, July 10, 2012.
- ⁵ See E. Emanuel, N. Tanden, S. Altman et al., “A Systematic Approach to Containing Health Care Spending,” *New England Journal of Medicine: Election 2012* (Aug. 1, 2012), recommending, inter alia, that the Federal Employees Health Benefits Program align with Medicare by requiring plans to phase in alternative payment methods. See also S. Guterman, S. C. Schoenbaum, K. Davis, C. Schoen, A.-M. J. Audet, K. Stremikis, and M. A. Zezza, *High Performance Accountable Care: Building on Success and Learning from Experience* (New York: The Commonwealth Fund, April 2011); K. Davis and S. C. Schoenbaum, “Toward High-Performance Accountable Care: Promise and Pitfalls,” *The Commonwealth Fund Blog*, Sept. 14, 2010; P. Boland, P. Polakoff, and T. Schwab, “Accountable Care Organizations Hold Promise, But Will They Achieve Cost and Quality Targets?” *Managed Care*, Oct. 2010; P. B. Ginsburg, “Reforming Provider Payment—The Price Side of the Equation,” *New England Journal of Medicine*, Oct. 6, 2011 365(14):1268–70.
- ⁶ See Centers for Medicare and Medicaid Services, Program News and Announcements, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html>.
- ⁷ Center for Medicare and Medicaid Innovation, Pioneer ACO Request for Application, § II.I.
- ⁸ See Guterman, Schoenbaum, Davis et al., *High Performance Accountable Care*, 2011; Davis and Schoenbaum, *Toward High-Performance Accountable Care*, 2010; Boland, Polakoff, and Schwab, “Accountable Care Organizations Hold Promise,” 2010; and P. B. Ginsburg, “Reforming Provider Payment,” 2011.
- ⁹ Kaiser Commission on Medicaid and the Uninsured, *Medicare’s Role for Dual Eligible Beneficiaries* (Washington, D.C.: Henry J. Kaiser Family Foundation, April 2012).
- ¹⁰ For a discussion of Medicaid payment and delivery system reform initiatives in several states, see National Association of Medicaid Directors, *State Medicaid Directors Driving Innovation: Payment Reform* (Washington, D.C.: NAMD, July 20, 2012).
- ¹¹ Affordable Care Act § 1202; see also 77 *Federal Register* 27, 671 (May 11, 2012) (proposed rules implementing primary care rate increase). States receive federal funds to cover the difference between the Medicaid and Medicare rates. For a discussion of the proposed rule, see T. McGinnis, “Raising Medicaid Primary Care Rates: Next Steps for States,” *The Commonwealth Fund Blog*, May 24, 2012.
- ¹² M. K. Abrams, R. Nuzum, S. Mika, and G. Lawlor, *Realizing Health Reform’s Potential: How the Affordable Care Act Will Strengthen Primary Care and Benefit Patients, Providers, and Payers* (New York: The Commonwealth Fund, Jan. 2011).
- ¹³ M. Takach, “Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results,” *Health Affairs*, July 2011 30(7):1325–34.
- ¹⁴ Center for Health Care Strategies, *State-by-State Health Home State Plan Amendment Matrix: Summary Overview* (Hamilton, N.J.: CHCS, June 2012), available at http://www.chcs.org/usr_doc/State_by_State_HH_SPA_matrix.pdf. See Missouri State Plan Amendment, approved Oct. 2011.
- ¹⁵ Affordable Care Act § 2703.
- ¹⁶ CHCS, *State-by-State Health Home*, 2012.

- ¹⁷ Multi-Payer Advanced Primary Care Practice Demonstration Fact Sheet, (Washington, D.C.: CMS, April 2012), available at http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/mapcpdemo_Factsheet.pdf.
- ¹⁸ Comprehensive Primary Care Initiative Fact Sheet (Washington, D.C.: CMMI, Aug. 2012), available at <http://www.innovations.cms.gov/Files/fact-sheet/Comprehensive-Primary-Care-Initiative-Fact-Sheet.pdf>.
- ¹⁹ See H.B. 1242 (Colorado); S.B. 1154 (Connecticut); H.B. 7107 (Florida); H.B. 450 (Utah); H.B. 202 (Vermont); S.B. 5596 (Washington); and S.F. 50 (Wyoming).
- ²⁰ See Application for Amendment and Renewal: Oregon Health Plan 1115 Demonstration Project, March 1, 2012, available at <https://cco.health.oregon.gov/DraftDocuments/Documents/narrative.pdf>.
- ²¹ Manatt Health Solutions analysis based on Henry J. Kaiser Family Foundation data. Note: this figure excludes individuals enrolled in primary care case management.
- ²² Henry J. Kaiser Family Foundation, Medicare Advantage Enrollment Market Update, Sept. 2011.
- ²³ Barclay's Capital, The Barclay's Capital Medicaid Guidebook, 7 (2012).
- ²⁴ Kaiser Commission on Medicaid and the Uninsured, *Medicare's Role for Dual Eligible Beneficiaries* (Washington, D.C.: Henry J. Kaiser Family Foundation, April 2012).
- ²⁵ See Guterman, Schoenbaum, Davis et al., *High Performance Accountable Care*, 2011; Davis and Schoenbaum, *Toward High-Performance Accountable Care*, 2010; Boland, Polakoff, and Schwab, "Accountable Care Organizations Hold Promise, 2010; and Ginsburg, "Reforming Provider Payment," 2011.
- ²⁶ See T. McGinnis and N. Highsmith, *Accountable Care Organizations: Creating a Workable Approach for Medicaid* (Hamilton, N.J.: Center for Health Care Strategies, June 2011).
- ²⁷ E. S. Fisher, D. Staiger, J. P. W. Bynum et al., "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," *Health Affairs*, Dec. 2006 26(1):w44–w57; S. DeVore and R. Wesley Champion, "Driving Population Health Through Accountable Care Organizations," *Health Affairs*, Jan. 2011 30(1):41–50; E. S. Fisher, M. B. McClellan, J. Bertko et al., "Fostering Accountable Health Care: Moving Forward in Medicare," *Health Affairs*, Jan. 27, 2009 28(2):219–31. See also K. Devers and R. Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?* (Princeton, N.J., and Washington, D.C.: Robert Wood Johnson Foundation and Urban Institute, 2009), which notes that ACOs differ from MCOs because the former promote accountability at the provider level.
- ²⁸ *Ibid.*
- ²⁹ T. McGinnis and D. M. Small, *Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design* (Hamilton, N.J.: Center for Health Care Strategies, Feb. 2012).
- ³⁰ See, e.g., A. R. Nissenson, F. W. Maddux, R. L. Velez et al., "Accountable Care Organizations and ESRD: The Time Has Come," *American Journal of Kidney Disease*, May 2012 59(5):724–33 (arguing that ACOs could greatly improve care provided to patients with end-stage renal disease).
- ³¹ New York State Medicaid Managed Care Model Contract.
- ³² Affordable Care Act § 1202; see also 77 *Federal Register* 27, 671 (May 11, 2012).
- ³³ Takach, "Reinventing Medicaid," 2011.
- ³⁴ W. Bernstein, L. DuPont, and A. Garcimonde, *Examining the Potential Role for RHIO Accreditation in New York's Health Information Technology Strategy* (New York: New York eHealth Collaborative, 2008).
- ³⁵ M. Takach, "Reinventing Medicaid," 2011.
- ³⁶ National Committee for Quality Assurance, Accountable Care Organizations (Washington, D.C.: NCQA), available at <http://www.ncqa.org/tabid/1312/default.aspx> (last visited May 22, 2012).
- ³⁷ 42 C.F.R. §§ 425.106, 108.
- ³⁸ 76 *Federal Register* 67,802, 67,819–20 (Nov. 2, 2011).

- ³⁹ For examples of companies developing strategies to assist providers in forming ACOs, see M. Blatt, E. Dishman, and B. Wilson, *Accountable Care Organizations and Beyond: IT Strategies for 21st Century Healthcare* (Santa Clara, Calif.: Intel, 2011), available at <http://www.intel.com/Assets/PDF/whitepaper/325069.pdf> (outlining Intel’s views on how it can assist accountable care organizations in designing and implementing their health information technology infrastructures); Press Release, “Aetna Enters Accountable Care Collaboration with Banner Health Network, Introduces Aetna Whole Health to Employers in Phoenix Area,” Nov. 11, 2011, available at <http://www.aetna.com/news/newsReleases/2011/1121-Aetna-Banner-Health-Network.html> (describing Aetna’s collaboration with Banner Health Network); Press Release, “WESTMED Medical Group Launches Accountable Care Organization (ACO) in Collaboration with UnitedHealthcare and Optum,” March 20, 2012, available at http://www.uhc.com/united_for_reform_resource_center/health_reform_provisions/accountable_care_organizations/value_based_contracting_and_acos/westmed_launches_aco.htm (describing the collaboration of United HealthCare and Optum with WESTMED Medical Group).
- ⁴⁰ McGinnis and Small, *Accountable Care Organizations in Medicaid*, 2012.
- ⁴¹ E. L. Schor, J. Berenson, A. Shih, S. R. Collins, C. Schoen, P. Riley, and C. Dermody, *Ensuring Equity: A Post-Reform Framework to Achieve High Performance Health Care for Vulnerable Populations* (New York: The Commonwealth Fund, Oct. 2011).
- ⁴² 42 C.F.R. § 425.402. Note, however, that ACOs receive a preliminary list of beneficiaries who are likely to be assigned to them through the year-end retrospective assignment process.
- ⁴³ MSSP Final Rule, 67,862.
- ⁴⁴ See generally G. Rust, J. Ye, P. Baltrus et al., “Practical Barriers to Timely Primary Care Access: Impact on Adult Use of Emergency Department Services,” *Archives of Internal Medicine*, Aug. 2008 168(15):1705–10.
- ⁴⁵ B. D. Sommers, “Loss of Health Insurance Among Non-Elderly Adults in Medicaid,” *Journal of General Internal Medicine*, Jan. 2009 24(1):1–7.
- ⁴⁶ Request for Proposals, Minnesota Health Care Delivery Systems Demonstration, 9, available at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441.
- ⁴⁷ MSSP Final Rule, 67,861.
- ⁴⁸ Sommers, “Loss of Health Insurance,” 2009.
- ⁴⁹ 42 C.F.R. § 425.708.
- ⁵⁰ 42 C.F.R. § 425.306.
- ⁵¹ *Ibid.*
- ⁵² 42 C.F.R. § 425.600.
- ⁵³ Request for Proposals, Minnesota Health Care Delivery Systems Demonstration, 9.
- ⁵⁴ McGinnis and Small, *Accountable Care Organizations in Medicaid*, 2012.
- ⁵⁵ 42 C.F.R. §§ 425.604 & .606.
- ⁵⁶ Request for Proposals, Minnesota Health Care Delivery Systems Demonstration, 9.
- ⁵⁷ *Ibid.*
- ⁵⁸ Affordable Care Act § 2001. Note that the Supreme Court’s decision in *National Federation of Independent Business v. Sebelius*, Slip. Op. No. 11-393 (June 28, 2012) effectively made the expansion of Medicaid eligibility to childless adults with incomes below 133 percent of the federal poverty level optional for states.
- ⁵⁹ 42 C.F.R. § 425.602.
- ⁶⁰ Barclay’s Capital, *The Barclay’s Capital Medicaid Guidebook*, 65 (2012).
- ⁶¹ Medicare Parts A & B only. 42 C.F.R. § 425.602.
- ⁶² 42 C.F.R. § 425.204.
- ⁶³ 42 C.F.R. § 425.602.
- ⁶⁴ 76 Fed. Reg. 67,830.
- ⁶⁵ 42 C.F.R. Part 495.
- ⁶⁶ See, e.g., S. Semeraro, “Demystifying the Antitrust State Action Doctrine,” *Harvard Journal of Law and Public Policy*, 2000 24(1):203; and Sommers, “Loss of Health Insurance,” 2009.

- ⁶⁷ For an overview of state law issues that may impede the development of ACOs, see D. Bachrach, R. Belfort, W. Berstein et al., *Considerations for the Development of Accountable Care Organizations in New York State* (New York: New York State Health Foundation, June 2011); W. S. Bernstein, J. P. B. Frohlich, F. J. LaPallo et al., “Accountable Care Organizations in California: Programmatic and Legal Considerations” (Sacramento, Calif.: California HealthCare Foundation, July 2011). Several states, for example, have fraud and abuse laws that mirror the federal fraud and abuse provisions. See, e.g., CAL. BUS. & PROF. CODE § 650(a) (California); LA. STAT. ANN. § 37:1745 (Louisiana); MICH. COMP. LAWS ANN. § 752.1004 (Michigan); MINN. STAT. ANN. § 62J23(2) (Minnesota); MO. REV. STAT. § 191.905(3) (Missouri). States may also have antitrust provisions that track the federal antitrust laws. See, e.g., MASS. GEN. LAWS ch. 93 § 6 (Massachusetts). Additionally, several states prohibit the corporate practice of medicine, which may affect how ACOs may be structured. See, e.g., *People v. Cole*, 135 P.3d 669, 671 (Cal. 2006) (California); COLO. REV. STAT. § 12-36-134(1)(g)(7) (Colorado); *Carter-Shields, M.D. v. Alton Health Inst.*, 777 N.E.2d 948, 958 (Ill. 2002) (Illinois); N.J. ADMIN. CODE tit. 13, § 35-6.16(f) (New Jersey); *People v. John H. Woodbury Dermatological Inst.*, 85 N.E. 697 (N.Y. 1908) (New York); OHIO REV. CODE ANN. § 1701 (Ohio); *Gupta v. E. Idaho Tumor Institute, Inc.*, 140 S.W.3d 747, 752 (Tex. App. 2004) (Texas).
- ⁶⁸ DeVore and Wesley Champion, “Driving Population Health,” 2011; see also Fisher, Staiger, Bynum et al., “Creating Accountable Care Organizations,” 2006.
- ⁶⁹ Affordable Care Act § 3022 (creating the Medicare Shared Savings Program); Center for Medicare and Medicaid Innovation, Pioneer ACO Request for Applications, available at <http://innovations.cms.gov/Files/x/Pioneer-ACO-Model-Request-For-Applications-document.pdf>.
- ⁷⁰ 76 *Federal Register* 67,802, 67,962 (Nov. 2, 2011).
- ⁷¹ U.S. Department of Health and Human Services, Press Release, “Affordable Care Act Helps 32 Health Systems Improve Care for Patients, Saving up to \$1.1 Billion” (Washington, D.C.: DHHS, Dec. 19, 2011), available at <http://www.hhs.gov/news/press/2011pres/12/20111219a.html>.
- ⁷² U.S. Department of Health and Human Services, Press Release, “HHS Announces New Incentives for Providers to Work Together Through Accountable Care Organizations When Caring for People with Medicare” (Washington, D.C.: DHHS, Oct. 20, 2011), available at <http://www.hhs.gov/news/press/2011pres/10/20111020a.html>.
- ⁷³ 76 *Federal Register* 67,802 (Nov. 2, 2011).
- ⁷⁴ 42 C.F.R. § 425.20.
- ⁷⁵ Under Method II, the critical access hospital bills for facility and professional services; 42 C.F.R. § 425.102.
- ⁷⁶ 42 C.F.R. § 425.104.
- ⁷⁷ *Ibid.*
- ⁷⁸ 42 C.F.R. § 425.106.
- ⁷⁹ *Ibid.*
- ⁸⁰ *Ibid.*
- ⁸¹ 42 C.F.R. § 425.400.
- ⁸² *Ibid.*
- ⁸³ *Ibid.*
- ⁸⁴ 42 C.F.R. § 425.112.
- ⁸⁵ 42 C.F.R. § 425.500.
- ⁸⁶ 42 C.F.R. § 425.600.
- ⁸⁷ 42 C.F.R. § 425.602.
- ⁸⁸ *Ibid.*
- ⁸⁹ *Ibid.*
- ⁹⁰ 42 C.F.R. §§ 425.604 & .606.
- ⁹¹ 42 C.F.R. § 425.500.
- ⁹² *Ibid.*
- ⁹³ *Ibid.*
- ⁹⁴ 76 *Federal Register* 67,992 (Nov. 2, 2011).
- ⁹⁵ 76 *Federal Register* 67,026 (Oct. 28, 2011).
- ⁹⁶ 76 *Federal Register* 67,992 (Nov. 2, 2011).
- ⁹⁷ 76 *Federal Register* 67,026 (Oct. 28, 2011).
- ⁹⁸ *Ibid.*
- ⁹⁹ *Ibid.*

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