A Study of Safety-Net Providers Functioning as Accountable Care Organizations (ACOs)

July 22, 2015

Exhibits

Executive Summary

Safety-net providers are increasingly forming Accountable Care Organizations (ACOs) to contract with Medicaid and other payers. We define a safety-net ACO as a safety-net provider-based organization that a) assumes clinical responsibility for an attributed Medicaid patient population, b) assumes financial responsibility for that population through a shared savings or shared risk contract, and c) does not operate as a health plan (i.e., does not assume full (insurance) risk).

There is limited information available about the origins, structure and function of these ACOs. We studied seven such organizations across five states to better understand them and to identify the federal and state policy questions associated with their emergence. The ACOs included hospital, federally qualified health center (FQHC) and county-based ACOs in rural and urban settings. Each ACO received a one-day site visit. Subsequent interviews were conducted with the state Medicaid program, a contracted health plan (if applicable) and a network provider.

Each of the safety-net ACOs was developed based on a belief that providing services under a value-based payment model that focused on accountability for the care of a population was a financial opportunity. While two had operated for considerable time, most had been in business for two or fewer years. In some cases, they formed because the sponsoring provider had a precarious financial situation, which served as a "burning bridge" for change and innovation. In others, the sponsoring provider either feared for its future financial stability based on the recent performance of their state and/or Medicaid managed care organizations (MMCOs), and had a strong desire to be in control of its own destiny.

The governance model and business strategies of the safety-net ACOs often reflected the identity and culture of the organization(s) that organized the entity. Yet all ACOs, regardless of origin or structure, utilized a network model, wherein contracted providers (especially primary care practices) augmented the provider(s) that initially formed the ACO. For most of the safety-net ACOs studied, this meant that some clinicians were employed, while others were contracted. Management efforts were typically heightened with the employed clinicians.

We observed that the ACOs typically had a limited planning period before becoming operational. As a result they were building their infrastructure while operating. Since most were not assuming downside financial risk for their Medicaid business, this was viewed as a viable approach.

Safety-net ACO business strategies focused on cost reduction, quality improvement and in some instances, revenue maximization. Cost management strategies centered foremost on care management for patients at risk of hospitalization and emergency department (ED) use. Care management differed in several ways, but most notably in whether it was a centralized ACO administrative function or one delegated to primary care sites. In addition, safety-net ACOs targeted improvement in areas identified as associated with high spending and reduction opportunities, e.g., avoidable ED use, or readmissions. Some ACOs also tried to address "leakage" by keeping care within their system or network.

Quality improvement work was generally focused on addressing gaps in care related to specific measures that were built into ACO contracts and for which there were financial consequences tied to performance. In two cases, ACOs embedded quality improvement advisors into practices to

assist with process re-engineering and with practice transformation support. At the time of our study, the ACOs had not fundamentally changed care delivery, but appeared to have the promise of doing so with greater maturity.

Some ACOs focused on revenue maximization and identified specific strategies to ensure appropriate coding of patient diagnoses to make certain that any per capita patient budget was reflective of the actual health risk of the population.

We observed a number of challenges faced by the safety-net ACOs studied:

1. **Lack of capitalization:** Lack of capital, especially for non-hospital based safety-net ACOs, appears to be a major problem. Staffing and health information infrastructure are two needed investments that undercapitalized ACOs are hard pressed to support.

2. **Access to management information:** Each ACO stressed the importance of timely, accurate and usable data to its ability to be successful. Yet most did not have easy access to both claims and clinical data for analysis, and most had few analytic resources. They often conveyed difficulty in getting timely claims from states or Medicaid managed care organizations (MMCOs).

3. **The hospital conundrum:** For those safety-net ACOs that are led by safety-net hospitals, there is a conundrum. The financial imperative of the hospital is to keep beds as full as possible, while the business interest of the ACO is to reduce hospital admissions and ED usage in order to contain costs.

4. **Serving low-income populations:** Medicaid enrollees are poor and often have disabling conditions. They also have high need for behavioral health services and social supports. There are unique challenges in managing care and improving health status for the population given these characteristics and evidence regarding best practices is lacking (or just emerging).

The organization of safety-net ACOs was sometimes driven by state initiatives, and sometimes occurred without any state influence or other involvement. Whether states and the federal government should actively support ACO development is a question worthy of consideration. While ACOs offer promise, it is unclear with limited evaluation data available if that opportunity will be realized. If a state or the federal government decides to offer support, safety-net provider-sponsored ACOs could potentially benefit from:

- start-up capital investment;

- clarification to current State Plan payment requirements and additional State Plan payment flexibility;

- flexibility to align state or MMCO contracting parameters, including alignment of measure sets and incentives, with those used by Medicare and/or a state's commercial payers;

- supporting the efforts of small safety-net providers to come together to form an ACO when size requirements dictate that they do so, and

- ensuring that there is a health information infrastructure in place to provide timely, accurate and complete claims and clinical data to the ACO.

1. Introduction

In the face of increasing pressure and opportunity for delivery system reform aimed at reducing costs and improving quality, state Medicaid programs are increasingly focused on implementing reform through Accountable Care Organizations (ACOs).[1] For the purposes of this report, we define ACOs as provider-based business entities that agree to accept clinical responsibility and some measure of financial responsibility for the health and health care of a defined patient population. Some providers currently operating as Medicare and/or commercial ACOs are interested in expanding their ACO arrangements to their Medicaid business; other providers are initially creating ACOs to serve the Medicaid program, sometimes directly through contracts with Medicaid managed care organizations (MMCOs) without any state-based initiative.

Safety-net providers - those who primarily serve uninsured, Medicaid and other low-income populations – are increasingly forming and joining ACOs. However, safety-net providers face special challenges in adopting an ACO service delivery and financial model. These challenges distinguish them from most of the early entrants to Medicare's ACO programs. Because Medicaid enrollees must meet state eligibility rules, individuals typically churn on and off of coverage, making it difficult to have continuous enrollment with a particular provider over a long enough period to allow and/or expect accountability for health outcomes. This lack of continuity of coverage makes it more difficult for providers to take on risk. In addition, federal Medicaid regulations meant to protect enrollee choice make it difficult to limit enrollees to obtaining services within a particular network, and there is limited ability to utilize cost sharing to create incentives for individuals to see providers within a limited network. Finally, the Medicaid population itself faces more challenges than other populations to attainment of good health and positive health outcomes due to the impact of social determinants such as housing, employment, nutrition and other social and environmental factors.

Most national attention to date has been on ACO implementation in the Medicare Pioneer and Shared Savings Programs. Both of these initiatives involve provider organizations taking accountability through shared savings and/or shared risks for management of a specific Medicare patient cohort under a fee-for-service payment system.[2] While there has been some attention to Medicaid ACOs and the providers who are organizing them,[3] that attention has been limited and focused on individual case studies, and on potential state strategies to promote safety-net ACO development.[4]

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[1] For purposes of this study, an ACO is a group of health care providers which enter into shared savings or shared risk arrangements with a health care purchaser, but that do not take on insurance risk or any traditional features of a managed care organization (e.g., claims payment, customer service and utilization review).

[2] Abt Associates and its partners, Truven Health Analytics and L&M Policy Research, evaluated on behalf of the Centers for Medicare and Medicaid Innovation (CMMI) the effectiveness of 32 Pioneer accountable care organizations (ACOs) on spending utilization and quality relative to traditional Medicare fee-for-service. The study was also designed to assess early markers of success as nascent ACOs began operation across the country.

[3] See, for example, Sandberg SF et al. "Hennepin Health: A Safety-Net Accountable Care Organization For The Expanded Medicaid Population" *Health Affairs* **November 2014** vol. 33 no. 11 **1975-1984**; Maxwell

This report examines how a diverse group of safety-net providers has made headway in forming and operating Medicaid ACOs. Specifically, we sought to understand: how safety-net ACOs are organized; what strategies they have adopted and implemented to meet the goals of reduced costs, improved access, better patient experience and better outcomes; how they are performing relative to achieving these goals; lessons learned; and the implications for the Medicaid program going forward. This study focused on seven safety-net ACOs located across several states that provide care to Medicaid enrollees, either through a direct contract with the state, or with state Medicaid Managed Care Organizations (MMCOs). It also compares the safety-net ACOs' organizational structures to those of ACOs participating in the Pioneer ACO program.[5]

There is no universal definition of a safety-net ACO. For the purpose of this study, we define a safety-net ACO as a safety-net provider-based organization that a) assumes clinical responsibility for an attributed Medicaid patient population, b) assumes financial responsibility for that population through a shared savings or shared risk contract, and c) does not operate as a health plan (i.e., does not assume full (insurance) risk). Using this definition, we did not include any participants in Oregon's Coordinated Care Organization (CCO) model or Utah's ACO program, because many of the CCOs and ACOs are led or co-led by health plans, or Colorado's Accountable Care Collaborative (ACC), because the Regional Care Coordination Organizations (RCCOs) do not provide direct care for beneficiaries. Because most safety-net provider-based ACOs are still quite new, this study is not a formal evaluation of the effectiveness safety-net ACOs. Rather, it serves as an early review of the still-evolving ACO model for Medicaid and its implication for safety-net providers, Medicaid enrollees and for policymakers. The safety-net ACOs we identified and visited are in varying stages of development. While this report includes both findings and considerations for continued ACO development, it should not be seen as an evaluation of the long-term impact and sustainability of ACOs on the Medicaid program. While CMS has provided states with some guidance on implementation of ACOs and shared savings arrangement and other payment methodologies in Medicaid programs through State Medicaid Director (SMD) letters,[6] there are limited data on Medicaid ACO performance. As safety-net ACOs become more mature, there will be more opportunity to evaluate the value they create and whether they are sustainable in the long term.

J, Bailit M, Tobey R and Barron C. "Early Observations Show Safety Net ACOs Hold Promise to Achieve the Triple Aim and Promote Health Equity" *Health Affairs* blog, September 15, 2014; Hacker K, Santos P, Thompson D, et al. Early Experience of a Safety-Net Provider Reorganizing into an Accountable Care Organization. *Journal of Health Politics, Policy. and Law,* August 2014; *39*(4):901-17; Dolan E. "Building ACOs in the Safety Net: Lessons from HealthCare First South Los Angeles" Integrated Healthcare Association Issue Brief #5, December 2011.

[4] Houston R and Kozick DB. "Five Strategies to Boost Safety Net Participation in Medicaid ACOs" Center for Health Care Strategies Blog, January 21, 2015; **Witgert K and Hess C. "Including Safety-Net Providers in Integrated Delivery Systems: Issues and Options for Policymakers" The Commonwealth Fund, August 2012.**

[5] The study compared safety-net ACOs to Pioneer ACOs because we were able to leverage previous work completed by Abt Associates in the evaluation of Pioneer ACOs. It is important to know that some of the safety-net ACOs were actually modeled after the Medicare Shared Savings Program (MSSP).

[6] See for example, SMDL#12-002 accessible at: www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf

2. Study Methodology

In identifying safety-net ACOs to participate in this study, we began by looking for a diverse mix of organizations with the following characteristics:

- have federally qualified health center (FQHC)-based and/or safety-net hospital-based ownership;

- assume responsibility for care delivery through employed and/or contracted providers;

- assume some level of upside and/or downside financial risk;

- contract with a state or health plan(s) for a Medicaid population;

- represent a combination of rural and urban services areas; and

- have been operational for a minimum of 12 months at the time of interview, whenever possible.

As noted above, our definition excluded managed care organizations or other insurers. There is no official list of safety-net ACOs. In reviewing and selecting safety-net ACOs for inclusion in this study, we relied on our knowledge of safety-net ACOs based on our prior and current work nationally, as well as on referrals. The exhibit below includes the safety-net ACOs included in this study, organized by state. There was not a wide array of safety-net ACOs from which to choose. Few met the above requirements as there were not many safety-net ACOs that had been fully operational for 12 or more months as of the fall of 2014.

Exhibit 1: Safety-net ACOs Included in Study

State	Safety-net ACO	Lead Organization	Geography	Medicaid Lives in ACO	ACO in Medicare or Commercial
ME	Penobscot Community Health Care	FQHC	Rural	36,000	Yes
MA	Cambridge Health Alliance	Hospital system	Urban	20,000	Yes
	Signature Health Care	Hospital system	Urban	5,000	Yes
MN	FQHC Urban Health Network (FUHN)	FQHC	Urban	24,000	No
	Southern Prairie Community Care	County coalition	Rural	20,000	No
NY	Montefiore Medical Center	Hospital system	Urban	111,000	Yes
OH	Nationwide Children's Hospital/ Partners for Kids (PFK)	Hospital system	Urban/Rural	325,000	No

In advance of our site visits, we developed an interview questionnaire to use with each ACO in order to provide structure to each visit. Attached as Appendix One, the ACO interview questionnaire includes discussion questions regarding each ACO's:

- history and development;

- governance, leadership and organizational structure;

- primary business strategies;

- market context;

- state, policy and regulatory context;

- impact on access to care;

- approach to care management, care coordination, and population health management;

- approach to quality;

- approach to patient engagement and behavior change support;

- approach to social determinants of health and partnerships with community and social services;

- payment arrangements and financial management;

- approach to health information technology and data analytics; and,

- overarching challenges and lessons learned.

In addition to conducting site visits at each of the selected safety-net ACOs, we also met, either in person or via telephone, with state Medicaid program leadership in four of the five states[7] to understand how these safety-net ACOs fit within the state's strategy. State strategy included any payment and delivery system reform initiatives, how involved the state had been to-date in the development of these ACOs, and the state's plans for ACO development, monitoring and evaluation going forward. To ensure that we obtained similar information from each state Medicaid program, we utilized a State Medicaid Program Questionnaire (Appendix Two). Similarly, for those states where the ACOs participated in the Medicaid program through a MMCO contract, we sought to interview the largest MMCO with which the ACO contracted using a MMCO Questionnaire (Appendix Three).

We supplemented information obtained through our interviews with a) reviews of documents provided by the ACOs before, during and after the site visits, b) review of any identified peer-reviewed and gray literature regarding the ACO, and c) observations from complementary studies of safety-net ACOs we recently completed.[8]

Finally, we considered these safety-net ACOs in comparison to Pioneer ACOs to understand the similarities and differences between the two types of organizations, if any.

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[7]   The Maine Medicaid agency declined our request for an interview.

[8]   These included studies for the Robert Wood Johnson Foundation and the Blue Cross Blue Shield of Massachusetts Foundation. Publications resulting from this research include the following: Bailit M, Tobey R, Maxwell J and Bateman C. "The ACO Conundrum for Hospitals: Safety-Net Hospitals in the Era of Accountable Care" Robert Wood Johnson Foundation, Princeton, NJ, May 2015, and Burns M and Bailit M. "Alternative Payment Models and the Case of Safety-Net Providers in Massachusetts" Blue Cross Blue Shield of Massachusetts Foundation, Boston, MA, March 2015.

3. Overview of ACOs Visited

The seven ACOs we visited as part of this study had both commonalities and differences. In this section, we will provide an overview of key elements that define who the ACOs are, how they operate, what strategies they have focused on, and where they have faced the largest barriers. Specifically, we provide a brief summary of the ACOs in terms of their:

- history and development;
- state context;
- governance, leadership and organizational structure;
- care management and social determinant strategies;
- clinical and non-clinical performance improvement strategies;
- payment arrangements; and
- informatics.

3.1   History and Development

Unlike the Pioneer ACOs that all formed specifically to participate in the model, the safety-net ACOs varied in how and when they were formed. Each of the safety-net ACOs was developed based on a belief that providing services under a value-based payment model that focused on accountability for the care of a population was a financial opportunity. For many, ACO formation was an act of necessity in the context of a perceived "burning bridge" of declining revenue. The financial opportunity to share in savings for improving health across the health care system was also a consideration for all four organizations with experience in taking on risk; aligning payment incentives across payers was attractive. Finally, the opportunity to "control one's own destiny" was attractive for safety-net providers feeling threatened by growing competition. All but one ACO was developed and led by health care providers – either integrated health systems (Cambridge Health Alliance, Montefiore, Nationwide/PFK, and Signature Health) or FQHCs (FUHN and Penobscot). Southern Prairie was developed by action of county commissioners in southwestern Minnesota who saw the ACO model as a way to improve the health of their population by better coordinating health care services with the behavioral health and social supports provided by the county.

3.2   Governance, Leadership and Organizational Structure

Each ACO is governed by a board. In some cases, the ACO operates in complete alignment with its lead entity and its board is identical to the lead entity's board. The board make-up varies depending on the organizational structure. For example, the hospital-based ACOs utilize hospital executives as board members and include some representation from other providers in the network (Nationwide/PFK, Signature Health). The FQHC-based ACOs are governed by the sponsoring FQHC(s) and are represented by the Executive Director of each individual FQHC (FUHN, Penobscot). County Commissioners serve as the board of Southern Prairie, but since they have little expertise in health care delivery, they have also created an advisory committee of health care providers, community-based organizations and other stakeholders to help provide strategic direction for the ACO. Regardless of the specific governance structure, strong leadership appeared to be a

factor in providing the momentum to develop and implement an ACO model. This is consistent with the findings of the Pioneer ACO evaluation which saw "actively engaged leadership" and saw correlations between the strongest leaders and the greatest level of savings.

For hospitals, the provider networks consist of the hospital's employed physicians, supplemented by contracted physician practices. While hospitals have been buying physician practices and continue to do so, they often need to contract with primary care practices, in particular to increase their attributed population. The FQHC-based ACOs have developed a network of FQHCs to join together to create a larger panel of patients that can be attributed to the ACO (FUHN, Penobscot[9]). Southern Prairie has developed a network of providers across its region to participate in the ACO, and to share in any savings that result from the initiative.

It was clear from our interviews that while contracting to supplement owned practices is necessary to increase attributed population size to reach minimum participation status and/or have the ability to increase potential savings, there are significant challenges in influencing behavior change across a network of independent entities. For this reason, safety-net hospital ACOs with owned practices tended to apply their most intensive management efforts on the owned practices.

3.3   State Context

The organization and approach of safety-net ACOs are influenced by the state markets in which they operate, regardless of whether the state is specifically involved in the ACO arrangement. In Ohio and New York,[10] large hospital systems formed ACOs without specific state action through relationships with MMCOs. They were able to do this because of their market dominance, and in the case of Montefiore, because it is a part owner of a Medicaid health plan.

In Maine, Massachusetts and Minnesota, the safety-net providers each participated as an ACO at least in part due to state activity. These state Medicaid programs issued specific procurements to enter into shared savings arrangements with provider organizations. Minnesota has required its MCOs to participate in its Integrated Health Partnership model by contracting with the participating ACOs and passing on savings. Both Massachusetts and Maine have developed and implemented models by contracting directly with providers. Some Massachusetts MCOs also have entered into shared savings and/or shared risk contracts with providers, with the encouragement, but not the contractual directive, of the state.

3.4   Care Management and Social Determinant Strategies

Every ACO we visited had implemented, or was in the process of implementing, a care management strategy that focused on providing support to the highest risk Medicaid enrollees. They differed in whether they utilized a centralized care management strategy (Montefiore, Nationwide/PFK,

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9   At the time of our site visit, Penobscot's ACO did not include other FQHCs. As part of its planned expansion, Penobscot was planning to include additional health centers, as well as three community hospitals, as part of its ACO network.

10   Although Montefiore formed its Medicaid ACO without specific involvement from the state of New York, its ACO activities have grown in part as a result of recent state activity, including implementation of health homes and the Delivery System Reform Initiative Payment (DSRIP) funded initiatives.

Southern Prairie) or a practice-based model where care managers are embedded within the practice (Cambridge Health Alliance, Penobscot). In comparison, most Pioneer ACOs, including Montefiore, utilized a centralized care management strategy. Those ACOs that utilized the practice-based model typically leveraged and built upon preceding patient-centered medical home (PCMH) initiatives. The extent to which the care management programs had been standardized in terms of population risk stratification and care management protocols varied, as did the type of staff employed for care management, and whether different staff were used for different types of patients or whether staff worked in teams. Montefiore's care management function was the most defined of those studied, reflective of the ACO's high strategic priority placed on the function and the maturity of the ACO.

All of the ACOs we visited recognized the need to address social determinants of health to the extent possible through both care management and population health strategies. While most were just beginning to implement such strategies, both Cambridge Health Alliance and FUHN explicitly integrated consideration of, and approaches to, addressing social determinants of a particular individual's health into their care plans. Southern Prairie's model was focused on providing better integration across health care and social supports through increased communication and better referral practices.

3.5   Clinical Care Improvement Strategies

In addition to implementing care management strategies, some of the ACOs also worked to improve care in particular clinical areas and moderate use of expensive avoidable services, such as reducing premature births and thereby reducing expensive neonatal intensive care unit (NICU) stays (Nation-wide/PFK); reducing inappropriate emergency department visits and unnecessary hospital admissions and readmissions (Cambridge Health Alliance), and reducing readmissions and avoidable ED visits (FUHN). Three ACOs (Cambridge Health Alliance, Montefiore, Penobscot) were focusing on behavioral health integration as a key clinical strategy.

All ACOs had some level of quality improvement plan and strategy. One ACO executive observed "20 percent of the population determine the costs, 100 percent determine the quality of care." For ACOs that were part of integrated health systems, the quality improvement plan was aligned with the strategies of the system as a whole, although focused on ambulatory care quality more than inpatient quality in keeping with the performance measures built into their Medicaid ACO contracts. The extent to which ACOs focused on specific clinical quality improvement activities was often related to whether their payer contracts created strong financial incentive to do so. Those that did focused on gaps in care for selected measures. Montefiore observed: "Pioneer helped us to focus on quality because so much was at risk."

Two ACOs embedded quality improvement coaches in their large practices. Their focus was not on generating improvement on specific contractual performance measures, but on supporting more far-reaching change. These staff helped with practice transformation support, including process re-engineering, and teaching and applying Continuous Quality Improvement practices, including assistance with using data to inform performance improvement.

For hospital-based ACOs, the implementation of clinical-based strategies raised the "hospital conundrum." That is, to be successful as an ACO, strategies must include initiatives to reduce use of the emergency department and inpatient hospital services, even though the hospital requires a certain level of capacity in its inpatient units in order to remain viable. This conundrum is discussed

more below.   For FQHCs, there is a different conundrum – because they have a more limited network of providers, they have a more limited range of clinical strategies that they can directly control.

3.6   Non-Clinical Strategies

In addition to implementing clinical strategies to improve care and reduce costs, the safety-net ACOs also focused on improving operations in ways not intended to impact quality. For example, several ACOs made concerted efforts to reduce leakage; that is, to ensure that individuals receive as much care as possible within the integrated health system (Cambridge Health Alliance, Montefiore, Signature Health). This is important because the ACO has more ability to control care that occurs within its system relative to care provided outside of it. ACOs also aimed to align contract terms across payers to ease associated administrative burden and to help align incentives to implement specific evidence-based clinical care strategies.

Some ACOs focused not only on cost reduction, but on revenue enhancement. These ACOs identified specific strategies to ensure appropriate coding of patient diagnoses to ensure that any per capita patient budget is reflective of the actual population health risk.

3.7   Payment Arrangements

The ACOs varied in the services for which they were responsible, how they were paid for their services, and under what circumstances they would be eligible to share in savings. Typically, the ACOs were responsible only for medical services, however, some of the ACOs had taken on responsibility for behavioral health as well.

Three of the ACOs we visited (Montefiore, Nationwide and Cambridge Health Alliance) were assuming downside risk for the Medicaid population.[11] Some of these risk arrangements involved ACO receipt of a prospective budget or an actual comprehensive payment for a specific set of services for a population of attributed Medicaid enrollees. In many cases, the providers continue to receive payment for services on a fee-for-service basis and then reconcile those payments to an agreed upon prospective budget for all included services over the time frame.

The other ACOs participated in models where they were eligible to share in savings that would otherwise accumulate to the state Medicaid agency and/or the MCO based on reduced spending on a specific set of services for a population of attributed Medicaid enrollees. The division of any shared savings varied within each ACO based on their own negotiated contract. As in most of the shared-risk arrangements, the providers typically continued to be paid on a fee-for-service basis for services rendered, and were eligible to share in savings once they reached a target level of savings, and achieved threshold performance on quality measures.

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[11]   Signature Health expressed willingness to take on risk for the Medicaid population, but fell just short of the number of lives needed to participate in the risk sharing model under the Massachusetts Primary Care Payment Reform Initiative (PCPRI). Signature does participate in risk-sharing models in the commercial and Medicare markets.

Often, it takes several months to reconcile payments following the end of the designated fiscal period. This delay in payment can be problematic for safety-net ACOs that have limited resources. Delay in receiving a reconciliation payment may make it difficult for an ACO to continue its ongoing investment in care management and in other resources, such as data analytics, that support the successful functioning of the ACO.

3.8   Informatics

Each ACO we visited stressed the importance of having: access to the right data in a timely way; the appropriate tools with which to manage those data; and the right resources to analyze those data. A number of the ACOs noted that they had difficulty receiving timely and accurate data on their enrollees from state Medicaid programs. These sentiments are consistent with the importance that Pioneer ACOs placed on informatics.

ACOs varied in whether they used primarily internal resources (Nationwide/PFK, Signature Health); contracted with external resources (FUHN); or used a combination of internal or external resources (Cambridge Health Alliance) to obtain and analyze data, and on their level of sophistication in working with data to develop strategies to improve the health outcomes and reduce the costs associated with caring for a cohort of Medicaid enrollees. One ACO noted that understanding cost and quality drivers and being able to prioritize what is most important to do first were keys to its success. Data analytics allow the ACO to understand what clinical issues drive outcomes, what common characteristics exist in its patient population that clinicians need to address, and which providers can do the best job. The ACO must then use this information to manage its performance and that of its network. As a next step, another ACO noted that it is necessary to work with providers to embrace the use of data to manage patients, see gaps in care, and inform their workflow.

All of the ACOs we visited with owned practices and hospitals had implemented an electronic health record (EHR) system(s), but ACOs with networks had different EHRs in place within the provider network. This limited the ability to share information on patients and potentially results in a missed opportunity to manage care across the provider network. Pioneer ACOs faced the same problem. State health information exchanges could not be used to overcome this barrier, although Maine's health information exchange was providing significant value to Penobscot.

The capacity to aggregate and analyze claims and/or clinical data from EHRs represented a major investment for each safety net ACO we studied. Better capitalized ACOs were more easily able to develop this capacity than those with weaker financial footing. In some cases, the safety-net ACOs that we visited were reliant on external parties for financing analytic support, either through grant funding or the promise of a share of future savings. It was rare to find an ACO that had integrated claims and clinical data for analytic purposes.

4.   Key Findings

While each safety-net ACO that we visited was unique, themes emerged in their motivation to become an ACO, their mission and implementation strategies and the challenges they face.

1. **Providers pursued Medicaid ACOs because of financial constraints and a belief that adopting new payment models was necessary for long-term sustainability.**

Each of the safety-net ACOs we visited faced a similar, but unique, motivation to becoming an ACO. The providers often had precarious financial situations, which served as a "burning bridge" for change and innovation. Those providers that were not in a precarious financial situation themselves, feared for their financial stability based on the performance of their state and/or MMCOs, and/or had a strong desire to be in control of their own destiny. In each case, the ACOs took advantage of opportunities presented to them either based on their market position or state, federal or commercial market initiatives. Many of the ACOs didn't see the opportunities as optional, but as a step they needed to take in order to remain an essential part of the safety-net landscape going forward, either because the state health insurance market was moving that way and they wanted to be included, or because key competitors were beginning to develop ACO structures and they didn't want to be marginalized.

2. **Many factors go into the final design of a given ACO – including underlying provider identity, market factors, and available start-up resources.**

The mission and strategy of each ACO was very much dependent on its founding/leading provider. While all ACOs claim to be focused on meeting the Triple Aim of improved health, improved patient experience of care and reduced per capita costs, their specific missions and strategies were tied to their founding organizations. Those led by public hospitals and FQHCs tended to have less experience assuming financial risk and were very focused on patient-centered care, cultural competency and engaging diverse populations in their health. Those led by private safety-net hospitals or entities with prior risk contract experience had significant focus on managing both revenue and cost in order to be financially successful. The strategies adopted by the ACOs may be as much about the people who are in leadership roles in the organization, and what they champion, as they are about the organization itself.

Similarly, ACO development is also impacted by the market context within which the ACOs operate. ACOs that are led by providers with market dominance (large hospital systems) expressed greater confidence in their financial stability and cited resources to invest in ACO development, maintenance and expansion of ACO operations. Those ACOs with fewer financial resources (FQHCs, smaller safety-net hospitals, counties) had limited financial flexibility and, therefore, were dependent on external investments from the state and/or federal government, or other interested investors.

We visited some ACOs that clearly lacked adequate staffing for core ACO functions such as data analysis and care management. This paucity of resources poses a major challenge to safety-net provider ACO development.

All of the safety-net ACOs we visited had adopted, or were working to become, network models. By this, we mean that the ACO included a contracted group of independent provider organizations.

In most cases, the ACO had a lead provider. The lead provider added other providers (particularly primary care practices) because the lead provider a) could not alone have enough attributed lives to generate statistically reliable savings, b) wanted to add primary care providers in order to expand market share and/or geographic spread[12], or c) was pursuing a community partnership model.

Yet in expanding to independent providers, ACOs are greatly challenged to implement consistent change to care delivery across the network entities. Both hospital-based and FQHC-based ACOs face this challenge, but it is greater for FQHCs since even their largest FQHC member will typically employ fewer physicians than most hospital systems.

Integrated health system-based ACOs with a large percentage of providers employed have greater ability to develop aligned strategies and tighter requirements among their providers than do ACOs that rely more heavily on a contracted network of providers.

3. Safety-net ACOs face significant challenges.

The following are some other common and significant challenges among the safety-net ACOs that we visited.

4.1 Limited Financial Resources

Many safety-net ACOs face financial challenges based on their limited cash reserves. Without them, the ACOs are unable to make needed investments in staffing and health information tools absent external funding. Even where the ACO can make up-front investments, it may have trouble continuing such investments while it awaits reconciliation and distribution of any savings. In addition, lack of capital impacts the ACO's ability to take on downside risk.

4.2 Access to management information

As noted above, each ACO stressed the importance of timely, accurate and usable data to its ability to be successful. Safety-net ACOs need to have the internal capacity to conduct data analytics and then use their findings to implement evidence-based approaches to improving patient care. If they cannot do this internally, ACOs need to develop strong partnerships with competent analytics vendors that can help them do this work and provide information in a timely way.

ACOs need to regularly obtain timely and digestible data from states, Medicaid managed care entities and their providers (including through health information exchanges) to help identify opportunities for performance improvement. Such data include both clinical record-based data and claims data. We visited ACOs that had access to both, one and neither. Access to comprehensive clinical data was hardest to come by, since state health information exchange functionality remains poor nationally, and, with the exception of Arkansas and Maine, does not consolidate data in a repository.[13] ACOs

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[12] Hospitals often contract with community primary care practices because they employ more specialist than they do primary care physicians – if they employ any of the latter at all.

[13] Hunt Blair, formerly of the Office of the National Coordinator, personal communication, April 22, 2015. Arkansas also consolidates data within a repository.

with access to clinical data typically had electronic health record-based data for their owned practices only, and perhaps laboratory data.

4.3   The hospital conundrum

As noted above, for those safety-net ACOs that are led by safety-net hospitals, there is a conundrum. That is, the financial imperative of the hospital (i.e., keep beds as full as possible in order to allow the hospital to continue to operate) is in direct conflict with the mission of the ACO (i.e., reduce hospital admissions and ED usage in order to contain costs).[14] For some ACOs, they may be able to deal with the strategy by reducing hospital utilization outside of the system, rather than internally or there may be enough need for the beds so that reduction in use by ACO patients does not cause a financial strain. However, for other ACOs, this is a larger issue. Some may consider changing their focus to significantly reduce hospital beds, but this can be difficult where hospitals are reliant, for example, on revenue they earn in their role as a teaching hospital for graduate medical education. In addition, typically safety-net hospital support from states and/or the federal government is specifically tied to the hospital structure, in terms of funding for graduate medical education and other revenue sources, and the number of operating beds. Finally, Medicaid hospital utilization is often a key factor in the allocation of Medicaid DSH payments and other supplemental payments to support safety-net providers.

4.4   Serving low-income populations

Perhaps the biggest challenge for ACOs serving the safety-net is the burden of poverty and illness that faces the Medicaid population. By definition, Medicaid beneficiaries are of low income and/or have disabling conditions. Within the Medicaid population there is a higher need for behavioral health services and social supports. These challenges that Medicaid patients face each day become both the challenge and the opportunity of the ACO that is focused on improving the health and health outcomes of its population, while reducing costs. The level and intensity of services required to engage Medicaid patients in their health and in self-care management are quite high and the strategies to engage them may be different than those used to engage Medicare and commercial populations where the populations are more likely to come to the provider, rather than in Medicaid where significant outreach to the population often is needed.

4.   Safety-net ACOs pursue a small group of common cost-saving strategies.

Regardless of their composition, safety-net ACOs have focused their strategies on a short list of cost reduction opportunities. Most ACOs attempted to improve care delivery through primary care practice-embedded or centralized care management. Care managers varied by ACO in number and composition, often including nurses, social workers and/or behavioral health providers. Care management typically focused on patients deemed to be at high risk of future acute care service utilization based on their health status and sometimes social determinants.

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[14]   For more information on this topic, see Bailit M, Tobey R, Maxwell J and Bateman C. "The Hospital Conundrum; Safety Net Hospitals in the Era of Accountable Care" Robert Wood Johnson Foundation, May 2015

In addition, for almost all ACOs, a top priority was acquiring needed data and improving predictive modeling and other data analytic strategies to help identify patients appropriate to target.

More experienced ACOs prioritized improving their claim coding to ensure the greatest global payment (or population budget) based on clinical risk. They also gave attention to reducing referral care "leakage" from the ACO's network (and especially owned practices) to non-ACO providers.

5. Safety-net ACOs develop and implement key strategies once they become operational.

Particularly for ACOs that are being formed to take advantage of a state opportunity, the ACOs typically had little time to organize and design and implement their strategies. Initially, they were likely to be "building while flying" – that is, they were operating under shared savings or shared risk contracts while building basic infrastructure. As a result, they focused on what they believed was absolutely necessary for start-up given tight time frames, and did not conduct significant strategic planning prior to their go-live date. This approach limited real opportunity for improved quality and cost containment in the near term, although some reported gains. Over time, organizations may develop the ability to think more strategically about how best to organize, and where to focus their limited resources in order to allow for longer term sustainability. We found that even mature safety-net ACOs continued to have to innovate and change their strategies to respond to new challenges and opportunities.

6. The role of states has been highly variable in safety-net ACO formation.

In addition to being shaped by their leadership, the organizations we visited were also profoundly shaped by the state policy environment in which they operated. In some cases, ACOs developed without direction or support from state government, but rather in reaction to perceived external threats and due to the providers' desires to manage their own destiny (and their ability to do so). In other cases, safety-net ACOs developed based on specific opportunities presented by the state Medicaid agency, MMCOs, Medicare and/or commercial insurers. State involvement and resource commitment impacts the models and strategies that are developed. For example, the IHP in Minnesota had specific requirements for its virtual model that both FUHN and Southern Prairie needed to meet in order to participate, and specific quality and financial performance requirements that dictate the ACOs' focus. States have provided very limited resources to support ACO development, although considerable investments have been made in safety-net ACOs in selected states through State Innovation Model (SIM) Testing Grants (e.g., Vermont) and through funding for infrastructure and transformation available through 1115 Demonstration Waiver programs (e.g., New York).

7. Safety-net ACO development is redefining the roles of MMCOs and states.

As safety-net ACOs continue to develop, it is important to appropriately differentiate the role of the ACO from the role of the MMCO, other administrative entities that operate PCCMs on behalf of states or the state itself. While ACOs are appropriate vehicles for managing their own networks of providers, providing care management and care coordination, and clinical oversight and quality for the ACO, Medicaid managed care entities and other administrative entities may sometimes be best positioned to perform claims processing, utilization review, member services and other administrative functions, especially for small and relatively new ACOs. While allocation of responsibilities varies

across ACOs, it is important to recognize that ACOs are assuming some traditional MMCO functions. In fact, some safety- net ACOs may wish to assume all managed care functions.[15]

For states without contracted Medicaid managed care plans, the state typically provides (or outsources) the administrative functions that are performed by health plans, such as claims payment. ACOs need more than traditional administrative support as well, however. For example, safety-net ACOs are typically hungry for claims files and for reports that identify opportunities for improvement, sources of utilization, cost and quality variation among the providers serving their ACO population, and comparative benchmarks. In addition, ACOs may seek administrative support for implementing new payment models with their ACO network providers, such as primary care capitation payments.

8.   Safety-net ACOs are not yet fundamentally changing care delivery, but hold promise to do so.

Most of the ACOs we visited had done relatively little beyond implementing patient-centered medical homes and care management programs, and identifying gaps in care, to change and improve clinical care delivery and to address social determinants of health. Clinical change strategies, such as implementation of clinical pathways to standardize clinical care delivery, were seldom in evidence, and when they were, such strategies were small in number and scope. Safety-net ACOs that had applied clinical change strategies typically had done so with owned practices but not with contracted provider entities.

While safety-net providers are often knowledgeable about the social determinants that impact their patients' health status, we encountered surprisingly few examples of systematic strategies to address these determinants outside of limited numbers of special focused projects.

Finally, with some notable exceptions, we observed very limited, if any, activity at the safety-net ACOs to integrate behavioral health services, although there was a widespread recognition by the safety-net ACOs of their need to do so as a next step in ACO development.

Because making fundamental changes to care delivery is exceedingly challenging, particularly with a network including independent provider entities, and because most of the ACOs we visited had been functioning as a Medicaid safety-net ACO for a relatively brief duration, it is understandable that more difficult strategies such as these had not yet been fully realized.

However, ACOs do hold important promise for transforming care in a manner that focuses on value – that is improving quality and outcomes while containing costs. In addition, there is likely benefit in the Medicaid program working in alignment with the Medicare and commercial marketplaces. While there is limited evidence of long-term sustainability given the age of the most ACOs, there are a number of examples of safety-net ACOs that have demonstrated elements of success, including the long-established ACOs that we visited. Montefiore's ACO has proven financially viable for its Medicaid line of business over many years. Its Medicare Pioneer ACO has been the most financially

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[15]   McClusky PD. "Amendment incites Medicaid fight" *The Boston Globe*, May 26, 2015.

successful in the country per CMS.[16] Nationwide's Partners for Kids has demonstrated cost savings over time serving Medicaid patients without diminishing quality of care.[17]

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[16] Punke H. "What Makes an ACO in the Bronx One of the Top-Performing Pioneers?" *Becker's Hospital Review* February 12, 2014

[16] Kelleher KJ et al. "Cost Saving and Quality of Care in a Pediatric Accountable Care Organization" *Pediatrics* Volume 135, Number 3, March 2015

5.   Policy Areas to Consider

There are a number of important policy areas to consider relative to Medicaid's involvement in the development and monitoring of ACOs.

The role of policymakers in encouraging the development of ACOs among providers serving high numbers of Medicaid enrollees

While state involvement is not necessary for providers to develop an ACO in states where there is Medicaid managed care, state involvement may help to empower providers and may offer support for providers that move in this direction, both through technical assistance and financial support.

Whether Medicaid ACOs will produce value in most applications is unclear. The weak financial footing of many safety net providers, the impact of ACO development on provider market consolidation, and the potential for any payment model to be gamed are all legitimate reasons for uncertainty.

If state Medicaid programs decide to encourage ACO development, they may be able to provide safety-net ACOs with needed support to overcome barriers, including additional investment dollars to support infrastructure development, developing program options attentive to their characteristics, and making data and making shared data utilities available. States can also provide technical support to ACO development and implementation, and coordinate learning communities.

Possible program changes at the federal level to assist in ACO development

CMS has taken steps, through its 2012 State Medicaid Director Letter, to allow flexibility to states in implementing alternative payment methodologies through a state plan option, including with ACOs.[18] For example, while Medicaid programs have traditionally been required to tie payments to a specific service, for a specific Medicaid beneficiary, and by a specific provider, CMS indicated that through 1905(t) of the Social Security Act, states may provide a PMPM payment for care coordination, and allow for shared savings and other outcomes-based payments.

Where states are required to pay FQHCs under the Prospective Payment System on a cost-based fee-for-service basis that reflects the volume of the services that FQHCs deliver, FQHC participation in ACO arrangements such as those observed in this study suggests an opportunity for more value-based approaches for FQHC payment.

States can help align market rules for ACOs to better align payment models with delivery system reform. Providers are looking for consistency across requirements, so the more closely ACO requirements can be aligned across Medicare and Medicaid programs, the more helpful that will be for providers. Alignment of measure sets is an often-identified example that some states have already identified and acted upon, including Maine, Washington and Vermont.[19] In addition to alignment,

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[18]   See: www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf

[19]   In aligning measures it is important to recognize that not all Medicare measures may be relevant for Medicaid populations, and that there may need to be some additional measures that focus specifically on aspects of quality that are most relevant to the Medicaid population.

providers are also looking for consistency in rule application and stability in the requirements and programs.

Finally, states may in some cases want to facilitate safety net providers coming together to form ACOs since many providers have too few attributed Medicaid lives on their own to be viable as an ACO. Such facilitative activity may not always be needed. When it is warranted, however, it could take many forms, as evidenced by Minnesota's creation of a "virtual" ACO model, New York's DSRIP waiver heavily incentivizing Performing Provider Systems (PPSs) formation by coalitions of safety net providers and Massachusetts inviting safety net providers to partner with one another for the purpose of sharing risk.

5.1   Relationship of Medicaid ACOs to MCOs

States need adequate administrative infrastructure to support safety-net ACOs. The ability of states to share usable and timely data with the ACOs is incredibly important. To the extent that CMS can support states in improving their own data analytics capacity, such action could be helpful to safety-net ACO development. For example, the creation of shared claims data utilities such as that created by North Carolina[20] could be of great value, as could parallel tools built on top of health information exchange repositories to the extent they exist. In addition, CMS and states could consider how to differentiate the role of ACOs vs. MCOs and recognize the limitations of what ACOs can do, and what states can do on their own to support ACOs, while recognizing the continued functions that make sense to remain with MCOs. If states decide to move away from MCOs, it will be essential for states to develop in-house capacity, or purchase through another vendor, those functions that are available through MCOs today.

5.2   Enrollee Choice

The Medicaid program, since its inception, has long supported enrollee choice and protections. As more safety-net ACOs develop, it will be incumbent on states to continue to focus on enrollee protections and ensure that there is appropriate provider choice for members in the context of ACOs.

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[20] For more information on North Carolina's Community Care Network and its informatics center, see: www.communitycarenc.com/informatics-center/

6.   Conclusion

Medicaid ACOs are emerging quickly using many names and multiple forms. We restricted our study to safety-net provider-organized ACOs that take clinical and financial responsibility for the care of a population of patients and are not operating as health insurers. Intentionally selecting a diverse group of organizations, we found that with the rare exception of providers which had begun assuming financial risk in the 1990's, most safety net ACOs were relatively new and still in the process of building the basic building blocks of their business strategies and gaining enough experience and membership in order to take on downside risk. Generally speaking, start-up financing was a hurdle, especially for ACOs that were not hospital-based. As a result, creative short-term financing strategies were sometimes required to get started and staffing and system investments often inadequate.

As provider markets continue to consolidate nationally and states increasingly look towards ACO strategies, safety-net providers will be hard-pressed to succeed without developing new partnerships and obtaining adequate financing. Those that are unable to do so may lose their independence, risk failure or need to stay outside of the ACO movement altogether. If safety net providers cannot participate in safety net ACOs, states may need to utilize another strategy for value-based payment and delivery with this significant class of Medicaid providers.

Appendix 1 - MACPAC Safety Net ACO Study: ACO Site Visit Interview Tool

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Introduction: We are visiting with you today to learn about the structure and operation of ACOs that have been organized by safety net providers and which serve the Medicaid population.

I. **History & Development of the** ACO [Interviewee: ACO Director and others as noted below]

1. When, why and how was the ACO created? [ACO Director]

   a. Regardless of whether it was called an ACO at the time or not, when was the ACO created? e.g., when did the current organization begin to assume clinical and financial responsibility for the care of a defined population of patients relative to a set of quality performance targets and total-cost-of-care spending targets, with shared savings or shared risk?

   b. What was the primary impetus for creating the ACO? (e.g. competition, negotiating power, patient service, delivery system transformation)

   c. Who initiated the development of the ACO?

   d. Who championed ACO development within the organization(s)?

   e. What challenges had to be overcome to get necessary buy-in, and how was that support gained?

2. What is the mission of the ACO? [ACO Director]

3. How does creation of an ACO comport with your sponsoring providers' mission and that of your participating providers? [ACO Director and providers]

   a. Are there any mission conflicts that you identify with operating an ACO?

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4. What was the financial business case for your organization to become an ACO? [ACO Director and CFO, separately and providers]

    a. Did your organization create a formal business plan for the proposed ACO?

    b. How many dollars were invested to start up the ACO, and how many are being invested annually? (e.g., staff, new IT systems, meetings, contracts, legal, etc.)

    c. Who made the investments?

    d. What financial barriers did you face, if any, at start-up?

    e. What is the expected financial return and the timeline for achieving it?

    f. What are the top three financial indicators that you are monitoring closely?

    g. Where did you get the data and information to perform this analysis? Would you consider this information as the pre-ACO state? Would you be willing to share this information with us?

5. What is your service area?

    a. Where is your population most concentrated, and why?

6. [For health systems only] What is the projected loss in inpatient and other services revenues that will be caused by the ACO? [ACO Director and CFO, separately and providers]

    a. To what extent will ACO financial contributions cover anticipated losses in net service revenue?

    b. Which service areas have you seen increasing as a result of operating as an ACO? Which service areas are decreasing?

7. What populations does the ACO target? (e.g. Medicaid, Medicare, Medicare Advantage, commercial, other) [ACO Director]

    a. How many attributed lives fall into each category?

    b. How were these populations chosen?

    c. Are there plans to change the target population in any way? (e.g., add dual eligible)

II. **Governance, Leadership, and Organizational Structure** [ACO Director]

1. What is the governance structure of the ACO?

   a. Was the ACO created as a new legal entity?

      i. If a new legal entity, does it have a board?

         1. If so, what is the composition of the board? Who maintains majority control?

         2. To what extent are consumers and non-consumer community representatives included in the board of the ACO?

      ii. If not, is the ACO an operating unit of an existing organization?

2. Who has responsibility for directing and managing the ACO?

   a. What is the background of the ACO leader (organizationally and professionally)?

   b. How are operational and investment decisions made for the ACO?

3. To what extent are core ACO functions performed by ACO personnel, a related corporate entity or by an independent contractor(s)?

   a. How many staff are employed by and dedicated to the ACO?

4. What is the make-up of the ACO provider network?

   a. Which providers (and of what type and specialty) are members of the ACO vs. are contracted or are non-contracted referral providers?

      i. Probe: mental health?

      ii. Probe: substance abuse?

   b. For providers that are part of the ACO, are there different classes of membership reflected in governance and/or financial stake?

5. How has the ACO developed estimates of workforce needs for delivering care under an ACO?

   a. Adequate supply of primary care providers

   b. Adequate supply of support staff, case managers, community health workers

    c.   Adequate supply of child and adult mental health and substance abuse treatment providers within the ACO or referral networks

    d.   Adequate supply of specialty care providers within the ACO or referral networks

6.   Given that ACO beneficiaries can exercise their freedom of choice to obtain health services from whatever providers they choose, how do your ACO providers manage referral options for specialty care, hospitals, and other services? In other words, how do you prevent leakage?

7.   Can you describe other aspects of the decision making process of the ACO as it relates to:

    a.   Clinical standards for the ACO?

    b.   Resource allocation *[e.g. what initiatives are funded, what infrastructure investments are selected]* within the ACO?

    c.   Gain sharing/distribution of shared savings?

    d.   Development of care coordination services?

    e.   Evaluation of the organization's quality performance measures?

8.   Describe any challenges or barriers the governing body has faced since the inception of the ACO.

    a.   Have any of these challenges resulted in changes to the structure? To management of the ACO?

III. **Strategy** [ACO Director]

1. What do you think are the keys to the success of an ACO serving a patient population comprised of a significant number of Medicaid beneficiaries?

    a. How are these success factors reflected in your current list of strategic priorities?

    b. How do you think these success factors differ from those for a population of commercially-insured patients or Medicare beneficiaries?

    c. Relative to these success factors, where do you have the greatest concern regarding prospects for ACO success?

    d. Do you think that there may be any unintended consequences to ACO development? What they might be, and what state policy actions might follow in response?

2. [If the ACO serves non-Medicaid populations]: How are the keys to success in caring for the Medicaid population different from ACO keys to success when caring for other populations?

3. How does your short-term strategic focus differ from your longer-term strategic focus, if at all?

4. If you fail as an ACO, what do you think will be the likely causes?

IV. **Market Context** [ACO Director]

    1.   Do you have competitors forming ACOs targeting the Medicaid population within your service area?

        a.   If so, who are these competitors? Are they also developing ACOs for Medicare and commercial populations?

        b.   What relative share of the Medicaid market in your service area does your ACO and each of the competitor entities have?

V.   **State Policy and Regulatory Context** [ACO Director]

  1.   What was the role of the state, if any, in the development of your ACO?

    a.   What incentives and constraints to development did the state provide, if any?

    b.   Did any legislation or executive order in your state directly support the components of a safety-net ACO or ACO formation itself? (e.g. payment reform initiatives, PCMH, health information exchange, state data warehouse)

  2.   What, if any, regulatory barriers to ACO development exist in your state? (e.g., data sharing between medical, behavioral health, social services; licensing and scope of practice; Medicaid or insurance regulations re: risk assumption)

  3.   What, if any, financial facilitators are in place to support ACO formation? (e.g., state grants, foundation grants, preferential enrollment/attribution)

  4.   Are you participating in any other state-sponsored initiatives (e.g., DSRIP, multi-stakeholder performance measurement initiatives, etc.)?

  5.   What kinds of data reporting and quality reporting requirements did the state establish, if any?

VI. **Access to Care** [ACO Director; ACO Medical Director]

1. Is the current ACO provider network sufficient to meet the needs of your ACO beneficiaries?

2. Can you provide us the general parameters describing how many ACO beneficiaries are aligned/assigned to each participating provider?

3. Can you describe the ACO providers' accessibility to beneficiaries?

   a. How long does it take for the ACO beneficiaries to obtain an appointment?

   b. How long does it take for a patient to speak to a primary care provider regarding an urgent issue?

4. What safeguards – besides those we may have already discussed - are in place to encourage appropriate access to care for the ACO beneficiaries?

   a. With the ACO?

   b. Across the spectrum of care?

5. Can you describe the methods and tools the ACO employs to monitor access to care?

   a. What mechanisms are in place to access wait time, services needed, staffing patterns, operational hours that may affect patient access?

   b. Do you have any future plans to adjust how you monitor access to care?

VII. Care Management, Care Coordination and Population Health Management
[ACO Medical Director or specific frontline staff for each topic area, if applicable]

1. How are patients attributed to the ACO?

    a. What are the challenges in attribution, if any?

2. Does the ACO provide care coordination and care management services? ["care management" is defined for purposes of this interview to include care management of complex patients with one or more chronic conditions and high risk of future intensive service use (e.g., SPMI and heart disease) and care management of patients experiencing a period of significant acute illness and with high risk of future intensive service use (e.g., accident with trauma)]

3. What is the division of responsibilities for care coordination and care management between the ACOs and its contracted health plans (or the state PCCM program)?

    a. Did this division of responsibility change when you became an ACO?

    b. Are you directly compensated for performing these functions?

    c. How do you anticipate relative ACO and plan (state PCCM program) care coordination and care management roles evolving in the future?

4. In what manner does the ACO provide care coordination services to patients – as distinct from care management services?

    a. To which patients are they provided? How are these patients identified as needing care coordination?

    b. Who provides care coordination services and what are their qualifications to do so?

5. How is your ACO promoting communication and teamwork across the continuum of care, including primary and specialty providers, community-based non-physician providers, hospitals and other facilities?

Care Management

6. Does the ACO provide care management to patients?

7. To which patients?

    a. How are high-risk patients identified? [e.g., retrospective (past utilization, clinical tracking, EHR triggers), real-time (admission referral, internal practice referral)]

      b.   Do you use any specialty predictive modeling software for patient identification?

      c.   What are the case identification criteria you employ?

      d.   Do physicians and other personnel have the ability to identify and enroll/suggest a patient gets care management services?

8.   What is the professional training of your care managers? (e.g., RNs, LPNs, LICSWs, CHWs, peer counselors)

      a.   Do you utilize different types of care managers with different types of patients? If so, how?

9.   What are your staffing ratios for care managers to attributed patients?

10.   Are care managers embedded within primary care practice sites, centralized, or both? Please explain the rationale for your approach.

11.   What are the core responsibilities of care managers? (e.g. empanelment, disease management, care plan establishment, management of care transitions, medication management, social service linkage and coordination)

12.   Does a comprehensive plan of care exist that is visible in the EHR to the patients' full care team, including the care manager, PCP and specialists?

13.   Is the patient involved in goal setting and care plan development?

14.   What strategies are used to engage and activate patients in case management services?

15.   What is the realized rate of return or expected ROI on these programs?

16.   Describe the ACO's strategy for population health improvement through improved health behaviors.

      a.   What are the key priorities for the ACO in this regard?

Medical Home

17.   What percentage of ACO primary care practices have been recognized by the ACO or by an external entity?

18.   What steps, if any, has the ACO taken to advance medical home transformation among its participating primary care practices.

19. To the extent you are aware, which of the following functionalities are prevalent within your ACO primary care practices?

   a. Multidisciplinary care team

   b. Empanelment

      i. Are non-clinical patient characteristics taken into account when empaneling patients? (e.g., homelessness, food assistance, etc.)

   c. Population-based tracking and reminders

   d. Planned visits

   e. Self-management support

   f. Enhanced access

   g. Practice-based clinical care managers

   h. Group visits

   i. Non-traditional types of visits (e.g. phone, email, "virtual," etc.)

Behavioral Health

20. How is care coordinated between primary care and behavioral health professionals?[21]

   a. Do you use primary care expansion models, e.g.,

      i. Off-site behavioral health consultants to primary care clinicians?

      ii. Co-location of behavioral health clinicians?

      iii. Embedded behavioral health providers in primary care teams?

   a. Do you use reverse co-location at behavioral health provider sites?

   b. Are same-day visit referrals from primary care to behavioral health available to patients?

   c. Are clinical records shared between medical and behavioral health providers?

   d. Is there an integrated care plan?

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[21] Some questions informed by Lewis VA et al. "Few ACOs Pursue Innovative Models That Integrate Care For Mental Illness And Substance Abuse With Primary Care" *Health Affairs* 33:10, 1808-1816 October 2014

21. How does care coordination for persons with substance abuse disorders differ from care coordination for patients with mental health service needs?

22. How has all of the above care coordination activity changed as a result of ACO formation, if at all?

Care Transitions

23. Does the ACO offer care transition services to patients?

   a. If yes, to which patients?

   b. What criteria are used to identify patients needing these services? How were the criteria developed? (e.g., by payer, diagnosis, social acuity, etc.)

24. What transitional care services are offered to patients by the ACO?

   a. Who provides transitional care? ACO care managers? Practice care managers? Hospital staff? Others?

   b. Are best practices for care transitions implemented for all patients (regardless of specific risk)? If so, please describe (e.g., adoption of teach-back as a standard, arranging appointments for all, same-day discharge summaries, etc.).

   c. Do you have more than one bundle of transitional care services, based on risk? (e.g., improved transitional care for all patients to being discharged to a skilled nursing facility but transitional services for CHF patients only when being discharged to home, etc.)

   d. What services are delivered to patients deemed at high risk of readmission?

25. Does the ACO have cross-setting information management systems to manage care transitions across settings? (e.g., not just EHR, but specific tools for all providers across all settings to use)

   a. Does the ACO have a cross-setting team/workgroup to improve transitions from one setting to another?

      i. If so, what settings are included? (e.g. long-term acute care facility, skilled nursing facility, nursing home, home health, social community services, PCP, patient reps)

      ii. How frequently does this group meet?

    iii.   Has the nature, composition or workplan of this team changed since becoming an ACO?

    iv.   Are there any potential members missing from this team that might be helpful in your efforts to reduce readmissions?

VIII. Quality

Quality Improvement Strategy

1. What are the principle strategies your ACO is currently employing to improve the health status of ACO-attributed populations?

    a. If serving multiple populations, what, if anything, are you doing differently for your Medicaid population?

2. What quality reports do you produce regularly?

3. How are these reports used to improve quality?

Clinical Change Strategy

4. Has the ACO adopted or developed new clinical pathways as a result of becoming an ACO?

    a. If yes, for what conditions and procedures?

    b. If not, how are care delivery changes being implemented?

5. How are changes to the clinical pathway implemented?

    a. How were providers trained to make these changes?

    b. How are providers held accountable for maintaining new care models?

6. In your opinion, what are the top three clinical changes in care delivery that the ACO needs to make to be successful?

IX. **Patient Engagement & Behavior Change Support** [ACO Director or Patient Education Director]

1. Are patients aware they are part of an ACO?

   a. What has been done, if anything, to inform and educate patients that they are being cared for within an ACO?

2. How are patients engaged in health behavior change?

   a. Motivational interviewing

   b. Goal setting

   c. Care plan development

   d. Patient self-management

   e. Patient portals

   f. Wellness activities

3. Does the ACO measure patient engagement or activation using evidence-based tools? (e.g., Patient Activation Measure, How's Your Health?)

4. Are patient engagement activities, patient communications and/or behavioral change supports tailored to meet the needs of (medically) high-risk populations? For populations with socioeconomic risk factors? For high-risk populations with behavioral health issues?

X.   **Social Determinants of Health and Partnerships with Community and Social Services** [ACO Director or Program Manager]

1. Does the ACO have an explicit strategy for addressing social determinants of health?

2. Is the ACO collecting data on social determinants? What types of data and how?

3. Which social determinants have you found most influence health status and intensive service utilization?

4. What partnerships does the ACO have with community organizations and social service agencies?

   a. Housing

   b. Food assistance (SNAP and WIC)

   c. Employment

   d. Transportation

   e. Welfare/TANF

   f. Pharmacies

   g. Disability services

   h. Corrections

5. Of the above groups, which do you feel are the most important groups for the ACO to work with (whether or not a partnership has been established) as a strategy for addressing socioeconomic risk factors that influence a person's health?

6. How did the ACO engage these partners?

7. What is the nature of the partnerships?

8. What services are the agencies providing?

9. Are they being compensated by the ACO for their services?

10. How have the relationships with social service and other partners changed as a result of ACO formation?

11. How are social services integrated into patient care operationally? (e.g., through case management services or social service navigator)

    a. What are the biggest barriers to financial integration of social and health services?

XI.   Payment Arrangements and Financial Management [CFO or other financial executive]

Health Plans to ACO

1.   With which payers and for what populations do you hold shared savings or shared risk contracts? Do you participate in the CMS MSSP or Pioneer programs?

2.   How is the ACO paid by each of the health plans (or the state PCCM plan) with which you contract for Medicaid, Medicare, and commercial payers? How consistent are these payment arrangements across payers?

   a.   Please describe base payments (e.g., FFS or capitation) for these arrangements.

   b.   Is there a shared savings provision? Shared risk? If so, after what years in the contract did those provisions become effective?

   c.   For what percentage of shared savings and shared risk is the ACO eligible/responsible?

   d.   At what percentage of expected spending are shared savings or risk capped?

   e.   Are outliers excluded from savings calculations? If so, how are they defined?

   f.   Are spending targets defined prospectively, or by a comparison of ACO performance relative to the market?

      i.   If defined prospectively, are they adjusted for inflation?

   g.   Are savings calculations adjusted for population clinical risk? Socioeconomic risk?

   h.   Are quality measures used to qualify or modify shared savings or risk distributions?

      i.   [For FQHCs only] If yes, to what extent do the measures align with HRSA-required quality measures of FQHCs?

      ii.   If not, are quality measures used for a separate performance bonus pool? If so, how much is the value of these payments relative to the total cost of care? To ACO provider revenue?

       i.   Against which benchmarks are your quality performance results compared?

             i.   Are the benchmarks risk-adjusted?

     j.   Can you share the quality measures contained within your ACO contracts?

     k.   Are there any supplemental (e.g., PMPM) payments to the ACO or to the medical homes within the ACO? If so, for what services?

     l.   If payment does not involve a prospective payment component, was this something that you requested and/or something that would be desirable to you? Why?

3.   Did the health plan (state PCCM program) define a minimum attribution count for ACOs to qualify for shared savings and/or shared risk? If so, what are those levels and how does your attributed patients count compare to those levels for your ACO's contracted payers?

4.   What percentage of the revenue of the ACO's principle participating providers is derived from payer ACO contracts? Alternatively, what percentage of ACO provider patients are under payer ACO contracts?

5.   What has been your experience in terms of financial performance to date? Quality performance on payer quality measures?

ACO to Provider

6.   How are ACO-participating providers compensated? Please distinguish between primary care, specialty care and hospital providers.

     a.   What percentage of provider compensation (primary care & specialty care assessed separately) is based on performance on:

          i.   Efficiency?

          ii.   Quality?

         iii.   Productivity? (e.g., RVUs)

         iv.   Other (e.g., citizenship)

    b.   What percentage of non-clinician staff compensation (primary care & specialty care assessed separately) is based on performance on any of the same factors, if any?

    c.   Are there any adjustments made in payment based on socioeconomic risk factors?

7.   How has the ACO explicitly sought to align the payment incentives created by its contracts with payers with its compensation and payment arrangements with the providers that make up the ACO?

8.   What is your methodology for distribution of savings/losses?

9.   If the ACO is a network model, are individual providers or regional groupings of providers assessed on their own performance and receive differential distributions of savings (or assume differential responsibility for losses) based on their own performance?

10.   Do you expect future changes to payment arrangements between the ACO and providers within the ACO? If so, what do you anticipate they will be?

Investment and Cost Management [ACO Director or CFO]

11.   What are the ACO's priorities in terms of making high-value investments? What is the order of the ACO's priorities?

    a.   How are you identifying opportunities for investment?

12.   Is there transparency around costs contributing to total cost of care? (E.g. cost of specialty care providers, hospital rates, drug costs, etc.)

    a.   If so, how is cost information shared?

    b.   Was this transparency done by virtue of being an ACO?

13.   What is the ACO's main strategy for reducing total cost of care per capita?

    a.   Is the strategy working?

    b.   If you serve multiple populations, what, if anything, are you doing differently for your Medicaid population?

XII. **Informatics** [Quality Improvement Director, Director of Information Technology, Analytics Director and/or ACO Director]

Use of Health Information Technology

1. Please describe your health information strategy for clinical information exchange and for performance measurement and analysis.

2. What data does the ACO currently collect, from what sources and with what frequency?

    a. Claims

    b. Medical EHR-based data

    c. Patient survey-based data

    d. Social service agency data

    e. Long-term supports provider data

    f. Public health data (e.g., immunization registry)

3. How does the ACO analyze the data is receives?

    a. Internal analytics staff using purchased software

    b. External analytics vendor

4. If the ACO has access to EHR data

    a. Does the ACO have access to EHR data for all of its providers?

        i. If not all providers, for what percentage of providers?

        ii. Is the access to all EHR data, or just for selected measures?

5. Does the ACO receive reports from contracted payers? If so, what do they contain?

6. Are ACO providers able to electronically exchange clinical data with one another?

        i. What are the limitations to such information exchange, if any?

        ii. Does the ACO collect and report data on patients' race and ethnicity?

        iii. Does the ACO collect data on socioeconomic risk factors?

7. Would you be willing to share data with us to perform a review of the impact on costs, quality and access pre and post?

Use of Performance Information

8. How are you using data to track how you are performing relative to ACO goals and targets?

    a. Do you have a dashboard or other measurement tool for assessing performance?

9. Do you measure use of non-ACO providers, and if so, how?

10. How are you using data to track how providers are performing relative to other providers?

11. What specific measures is the ACO using to track performance and changes in performance over time?

    a. Access

    b. Quality

    c. Utilization and cost of care

    d. Patient experience

12. How are cost and quality data communicated to ACO providers, i.e., in what format and with what frequency?

    a. What support, if any, are ACO providers given to understand and apply the information they are given?

13. What opportunities for improvement have you identified as a result of your analysis of available data?

    a. Do you know how those opportunities have been addressed?

XIII. Overarching Challenges and Lessons Learned [ACO Director]

1.   What impact has your ACO had on…

    a.   Access

    b.   Quality

    c.   Service utilization

    d.   Patient experience

    e.   Cost

2.   What the key challenges or barriers to forming and implementing an ACO that you have experienced so far?

    a.   How have you addressed those challenges?

3.   Do you consider your ACO to be a success to date? Why or why not?

4.   Please identify three lessons learned to share with aspiring safety net provider ACOs.

Appendix 2 - MACPAC Safety Net ACO Study: State Medicaid Agency Interview Tool

1. What steps, if any, did you take or do you plan to take to support the development of safety-net ACOs in your state?

    Prompts:

    a. Legislation

    b. Regulation

    c. Procurement opportunity (RFP)

    d. Developmental funding

    e. Health information infrastructure support (e.g., access to claims database, HIE connection)

    f. Technical assistance (e.g., consultation services, learning collaborative)

    g. Is this activity directed specifically at the safety net or is it multi-payer in orientation?

2. Do you believe that ACOs will generate superior value relative to that historically produced using less integrated delivery system and payment designs? If yes…

    a. Where (i.e., in what aspects of performance) do you expect to see that value?

    b. When do you expect to see that value?

3. Which patient populations do you currently or plan to incorporate or encourage including in ACOs?

    Prompts

    a. Medicaid (all)

    b. Medicaid (parents and children)

    c. Dual eligibles

        i.   Seniors

        ii. Persons with disabilities

    d. Medicaid expansion population

4. What do you think are the keys to the success of an ACO serving a patient population comprised of a significant number of Medicaid beneficiaries?

    a. How do you think these success factors differ from those for a population of commercially-insured patients or Medicare beneficiaries?

    b. Relative to these success factors, where do you have the greatest concern regarding prospects for ACO success?

    c. Do you think that there may be any unintended consequences to ACO development? What they might be, and what state policy actions might follow in response?

5. How does ACO development figure into the state's overall Medicaid strategy?

    a. Do you view ACOs as a primary Medicaid payment and delivery system strategy or as an experiment?

        i.   Is it included within an 1115 waiver?

        ii. Is safety net ACO development part of the state's SIM model (for states with testing grants (MA, MN, VT) and those that might be awarded test model grants in the second round of awards (e.g., NY))?

    b. Has or will the state utilize the DSRIP initiative in order to access funds to assist in development of ACOs?

    c. Are there any other state programs that have been or will be used to provide funding or infrastructure support to safety net provider-based ACOs?

6. How have key stakeholders responded to the emergence of an ACO(s) to serve Medicaid beneficiaries? What has encouraged them, and what has concerned them?

    Prompts:

    a. Legislators

    b. Physicians

    c. Hospitals

    d. Consumers and consumer advocates

    e. Medicaid managed care plans

7. How has stakeholder input shaped the ACO's approach, if at all?

8. How does the state view the relationship between ACOs and Medicaid managed care plans?

    a. Are there requirements in the state's contract(s) with its Medicaid managed care plans on how to contract with an ACO? If yes, are there any requirements about how the ACO shares savings/risk with its provider network?

9. Has the state considered its data collection requirements for safety-net ACOs?

10. Has the state established a framework for evaluating cost, quality and access for safety-net ACOs?

11. Does the state plan to modify its data requirements for Medicaid managed care plans?

12. Does the state plan to conduct an evaluation of the safety-net ACOs?

13. Would the state be willing to share its data with us so that we can review the impact of the ACO on costs, quality and access?

Appendix 3 - Safety Net ACO Site Visit Health Plan Questions

1. What is your relationship with the ACO?

    a. Have you undertaken any initiatives to help support the ACO's management and operations?

    b. How does the existence of the ACO impact your plan?

    c. Has the launch of the ACO impacted access to care in the service area?

    d. Do you see improvements in quality across the participating health centers?

2. Do you believe that ACOs will generate superior value relative to that historically produced using less integrated delivery system and payment designs? If yes…

    a. where (i.e., in what aspects of performance) do you expect to see that value?

    b. when do you expect to see that value?

3. How have/will you alter the way you manage care for members attributed to the ACO, particularly in terms of Care Management?

4. Have you made, or are you planning to make, any changes to the way in which you pay providers that are participating in the ACO

5. Are you working with other provider organizations to encourage ACO development?

    a. Which patient populations do you currently or plan to incorporate or encourage including in ACOs?

    Prompts

    i. Medicaid (all)

    ii. Medicaid (parents and children)

    iii. Dual eligibles

        1. Seniors

        2. Persons with disabilities

    iv. Medicaid expansion population

6. What do you think are the keys to the success of an ACO serving a patient population comprised of a significant number of Medicaid beneficiaries?

    a. How do you think these might these success factors differ from those for a population of commercially-insured patients or Medicare beneficiaries?

    b. Relative to these success factors, where do you have the greatest concern regarding prospects for ACO success?

    c. Do you think that there may be any unintended consequences to ACO development? What they might be, and what state policy actions might follow in response?

7. How do you think the ACO model will be included in the state's pending MCO RFP?

8. Looking ahead, do you view ACOs as a primary Medicaid payment and delivery system strategy or as an experiment?