ON THE ROAD TO BETTER VALUE: STATE ROLES IN PROMOTING ACCOUNTABLE CARE ORGANIZATIONS

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ABSTRACT: Lack of coordination, fragmentation, and disparities in the cost and quality of care are pervasive in the U.S. health system. As purchasers of health care, states are keenly aware of the need to create more coherent and value-driven systems of care through improved payment and delivery systems. The accountable care organization (ACO) model is a mechanism that can promote better value in health care spending. This report examines the development of the ACO model, focusing on Colorado, Massachusetts, Minnesota, North Carolina, Oregon, Vermont, and Washington. The report highlights five key areas in which states have played a role in supporting the development of the ACO model (data, designing and promoting new payment methods, accountability measures, identifying and promoting systems of care, and supporting a continuum of care, including the patient-centered medical home) and is intended to provide state and national policymakers with information that can stimulate further innovation.

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EXECUTIVE SUMMARY

Lack of care coordination and wide disparities in the cost and quality of care are pervasive problems in the U.S. health care system, perpetuated by the prevailing fee-for-service payment method. With the passage of the Affordable Care Act in 2010 and the enormous opportunities available to states to transform the health care delivery system, the accountable care organization (ACO) model is receiving increased attention for its potential to promote better value in health care spending without some of the perceived problems of past approaches. ACOs provide incentives to manage utilization, improve quality, and harness cost growth using a shared-savings model.

ACOs can take a variety of forms. Chief principles and prerequisites of the model include:

- payment reform that promotes value, including a shared-savings model based on targeted savings using a global, prospective budget;
- performance measurement using timely and accurate data that allows organizations to be accountable for quality and cost for a defined population; and
- delivery system changes that promote integrated, organized processes for improving quality and controlling costs.

In this report, the National Academy for State Health Policy (NASHP) conducted structured interviews with national experts, including providers and state leaders, to provide a variety of perspectives on state roles in developing ACOs. Seven states—Colorado, Massachusetts, Minnesota, North Carolina, Oregon, Vermont, and Washington—are profiled. The report is intended to provide state and national policymakers with information that can stimulate further exploration. States should consider using the ACO model within their own context and resources, while national policymakers should collaborate with states and delivery system leaders to coordinate initiatives to have a farther-reaching effect.

State Roles in Developing the Accountable Care Model

States have an important role to play in the development of the model. States are highly motivated to work on value, and at the same time, have significant infrastructure, unique levers, and extensive expertise to bring to the discussion. NASHP research indicates that state activity correlates roughly with five key components of the ACO model, as follows:

- data;
- designing and promoting new payment methods;
- accountability measures;
- identifying and promoting systems of care; and
- supporting a continuum of care and the medical home model.

Data. States are providing leadership and specific funding to develop new data capabilities. In particular, states are developing multipayer databases to assist in the collection and analysis of health care data across payers. With recent funding the American Recovery and Reinvestment Act of 2009 (ARRA), states are at the forefront of health information technology (health IT) and health information exchange (HIE) development. States are leaders in building new infrastructure to collect and exchange data. This data infrastructure can be leveraged to support accountability and payment reform.

Designing and promoting new payment methods. States have an essential and unique role in convening stakeholders to talk about ACO development. Critical discussions among providers and payers in forming an ACO may run afoul of antitrust law. States are uniquely positioned to bring groups of providers and payers together under the "State Actions" doctrine to facilitate these discussions. In addition, pilot testing and other funding initiatives by states promote ACO payment innovation. States have enacted legislation and provided some funding for pilots that explore a variety of ACO payment models. Others are designing pilots as part of a broader health reform strategy already under way.

States are leveraging their health care purchasing power, including coverage for Medicaid members and state employees, to support new ACO payment and contracting models. And importantly, states can bring Medicare to the table. Through existing waivers and new opportunities in the Affordable Care Act, states can join with Medicare in their ACO development efforts. One state, Vermont, has already covered the Medicare portion of funding in a medical home initiative and will be able to expand beyond a pilot phase with Medicare's participation.

Accountability measures. Through the adoption of statewide reporting requirements, states can lead in the design of accountability measures. States have provided leadership to enact systems for tracking and comparing cost and quality, a critical component of ACOs. Similarly, by using their significant health care purchasing power, states can promote accountability measures. By leveraging this purchasing power, states can

develop performance-based contracts for ACOs and include population-based health care goals in these agreements. States are also using their convening role to bring together stakeholders to develop consensus on statewide health care standards. Finally, by tying standards to funding, states can promote accountability. States are requiring certain competencies and national certifications (such as National Committee for Quality Assurance medical home standards) for providers that participate in ACO and related medical home pilots.

Identifying and promoting systems of care. Providers seeking to form an ACO must address a variety of issues, such as retaining the critical mass of covered lives to function successfully and designing an attribution model. States can be useful partners here, as well. States are taking various approaches in promoting systems, by shaping regional systems of care through contracts and also by convening and educating local groups of providers to facilitate ACO development.

Supporting a continuum of care and the role of medical homes. States agree that strong primary care is critical to the ACO model, but they may take different approaches in promoting the patient-centered medical home (PCMH) within the ACO model. Some are building explicitly from their medical home pilots, while others are looking to the provider community to propose new configurations. Importantly, accountable care seeks to create "systemness" beyond the medical home. ACOs can provide a unifying force to a community or defined region—providers across the continuum of care, including specialists and hospitals, can be integrated through aligned cost and quality measures. Furthermore, the ACO model provides a budgeting methodology that allows some savings to remain in the community for reinvestment or expansion of services.

PCMHs and ACOs are mutually beneficial, synergistic models, although ACOs can function without a PCMH and medical homes can exist without an accountable care model. States recognize that the benefits of the patient-centered medical home can be enhanced through an ACO model, which can incentivize the broader service system to coordinate and improve care. Likewise, the ACO model will be more successful in delivering value if built around an evidence-based, high-performing, patient-centered medical home.

Federal Health Reform and State Opportunities for Accountable Care Organization Development

There are several opportunities for ACO development in the Affordable Care Act. The Medicare Shared Savings Program in Section 3022 offers an opportunity for providers to

form ACOs and partake in shared savings with the Medicare program. Section 2706 provides Medicaid programs the opportunity to develop pediatric ACOs using the same incentive program described in Section 3022. Section 3021 establishes the Center for Medicare and Medicaid Innovation, to test innovative models for health care payment and delivery. In addition:

- **States can leverage the activities of interested providers.** States can support interested providers by identifying and convening these organizations and thinking about how state health reform and ACO efforts can support their goals.
- **Exchanges provide opportunities for states.** Leading states recognize that the large expansion of coverage afforded by the Affordable Care Act provides an imperative to reform delivery and payment to sustain coverage, and are designing quality and efficiency reforms as they plan for health insurance exchanges. As part of this planning, some states (such as those profiled in this report) are working on ACO pilots.
- **Health information technology and meaningful use can be tools for payment reform and quality.** State policymakers are well-positioned to think strategically about HIE resources and how they can be used to advance long-standing goals of cost and quality.

Key Themes: State Roles in Accountable Care Organization Development

- **Build on the foundation of other state health reform initiatives.** Rather than requiring a new direction or policy shift, states can build directly on their health reform efforts to promote ACOs.
- **Look for community-based and regional opportunities.** Experts agree it is unwise to start an ACO from the top down. ACOs should start with provider-driven, locally developed discussions and opportunities. States can assist in identifying, convening, and supporting such opportunities.
- **Establish pilots to test new models and build a core.** Pilot testing represents a key tool for states to use for introducing the model, gaining traction, and assessing provider readiness.
- **Legislation is an important tool.** Although significant progress can be made with voluntary efforts, several states that have enacted legislation to develop ACO pilots or elements of the model, such as data collection and reporting systems, report that the time frames and funding in the legislation "hold their feet to the fire" in ways that voluntary efforts cannot.

- **Build stakeholder support.** Because the ACO model touches on nearly all aspects of the health care system, states reiterated that bringing stakeholders into the process early and often—with a clear message—was crucial.
- **ACOs are not a "one-size-fits-all" model.** State policymakers and experts noted that the ACO model can be adapted to fit various settings. While the basic elements of the model— payment reform, accountability, and a coordinated continuum of care— must be addressed and incorporated, how these components are actually implemented can vary widely.

Conclusion

The ACO model holds promise as a new and flexible structure for the promotion of value in health care systems. Supported by mature data systems and using a shared-savings model that recognizes the importance of health care outcomes, ACOs can incentivize what states want— controlled costs and better health outcomes—while addressing health care in a longitudinal and population-based way. States have an important role to play in the development of ACOs. They are using lessons from their own health reform efforts, including medical home initiatives and data capacity-building, as well as other projects, to promote the ACO model in innovative and timely ways.

Exhibit ES-1. Summary of State Activity to Foster Key Components of the Accountable Care Organization Model

Colorado
• Developing statewide data and analytics organization
• Developing regional community care organizations, an ACO model for Medicaid participants
• Contracts will be performance-based and will incorporate public health and community-wide health goals
• Established medical home initiative for all children enrolled in Medicaid and the Children's Health Insurance Program; also, pilot testing medical homes for adults with chronic illnesses
Massachusetts
• e-Health Institute to support statewide use of electronic health records and the creation of an interoperable health exchange
• Commission on Health Care Payment System recommended ACO development in health reform
• Reforms include risk-sharing arrangements between ACOs and payers
• Conducting multipayer patient-centered medical home (PCMH) effort involving all major commercial and Medicaid payers and a diverse group of primary care practices
Minnesota
• Collecting multipayer data on specific measures of cost and quality
• Passed legislation that supports quality measurement

- Convening providers for discussion and review of ACO model
- State Quality Improvement Institute engaging stakeholders in developing ACOs and cost-of-care payment methodologies

North Carolina

- Using Medicaid data as feedback to Community Care of North Carolina networks and providers, adding third-party payer claims data in 10 rural counties
- Passed legislation to explore shared-savings, risk-adjusted payment models in Medicaid
- Stakeholders looking to additional opportunities for ACO development out of existing state demonstrations and initiatives, including the Community Care of North Carolina program, Beacon Communities, and the Medicare 646 Demonstration

Oregon

- Developing all-payer health care claims data reporting program
- Recommending community-based accountable entities and focusing on support for "communities of care" in state health reform initiatives
- Sponsoring a variety of community collaboration initiatives to promote cost-savings and health improvement activities at the local level
- Consolidating state purchasing power under a single entity
- Conducting two medical home pilots to collect cost and quality metrics, will serve as future model for ACOs

Vermont

- Utilizing all-payer claims database administered by a health data management contractor
- Passed legislation that calls for the implementation of a "community-based payment reform" pilot to coincide with Medicare ACO pilots authorized by the Affordable Care Act
- Conducted ACO feasibility study that recommended a strong PCMH as prerequisite for implementing ACO model
- Using lessons learned from PCMH to determine standards for funding under ACO initiative
- Mandating that commercial payers participate in enhanced PCMH payment reform
- Envision more than one payment model, ranging from shared savings to partial capitation

Washington

- Planning for all-payer claims database
- Collaborating with the Puget Sound Health Alliance to coordinate reporting efforts
- Passed legislation authorizing ACO pilots, will establish and test different payment models
- Outlined the need for coordinated efforts with medical home pilots, work is currently under way to assess how to best integrate programs
- Convening and educating providers on ACO model

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INTRODUCTION

Fragmentation and lack of coordination are pervasive in the U.S. health care system. Coordination on critical issues across primary care, specialty care, and hospital settings is the exception, not the rule. This lack of coordinated, integrated care affects quality of care and overall patient experience, and contributes to rising costs and poor outcomes.[1,2] Wide cost variation is another prominent feature of the U.S. health care system: some areas of the country spend nearly twice as much as others for their health care, but do not necessarily receive better care.[3] Exacerbating these problems is the fact that most health care delivery relies on fee-for-service billing, a methodology which encourages volume with no incentives for better quality, and can perpetuate variations in cost across service areas, without regard to outcome. One strategy that holds potential for reducing fragmentation, lack of coordination, and cost variation is the accountable care organization (ACO). This model has received attention from state and national leaders alike for its potential to promote better value, in terms of quality and cost efficiency, in health care spending. With the passage of the Affordable Care Act and the enormous opportunities available to states to transform the health care delivery system, the ACO model is receiving increased attention for its potential to promote better value in health care spending without some of the perceived problems of past approaches.

The ACO model can take various forms. It is generally characterized by regional or community-based health care systems that include, at minimum, hospitals, primary care, and specialist services. To be designated as an ACO, these systems are accountable for the quality and cost of all of the health care services for a specified population. The ACO model employs a shared-savings mechanism that is driven by a global budgeting process: the total projected costs for the target population are calculated and a prospective budget is developed. By meeting both quality measures and budget expectations, providers can share in the savings that result. The model therefore can provide incentives for providers to use resources prudently, while at the same time creating shared incentives for quality and coordination across systems of care.

In the context of federal health reform and passage of the Affordable Care Act, states are exploring the multiple opportunities and options available to transform state health care systems to reduce cost and promote better care and are exploring the ACO model as a mechanism to achieve these goals. The act articulates specific opportunities for the development of the ACO model in both Medicaid and Medicare, providing

incentives for both providers and payers to consider these configurations in delivery and payment design.

States have an important role to play in the development of the ACO model, bringing significant infrastructure, unique levers, and extensive expertise to the discussion. All states are engaged in difficult policy discussions in their efforts to address the uninsured or underinsured; to rein in increasing costs of health care for individuals, employers, Medicaid programs, and employees; and to reduce fragmentation in care. In their roles as major payers, regulators, and purchasers of health care, with a population-focused, longitudinal perspective, states view the ACO model as an option to promote value in public and private delivery systems.

To understand what states are doing to promote the development of ACOs and to examine the model in practice, NASHP conducted 14 structured interviews with key informants (Appendix A). Informants are from Colorado, Massachusetts, Minnesota, North Carolina, Oregon, Vermont, and Washington, and include a number of experts and leaders in the field who provided a variety of perspectives. We sought information about planned activities and those in progress, as well as expert opinion about the roles states may play in promoting this model. Primary source materials, state legislation, and public documents were also reviewed to complete the analysis.

This report is intended to provide state and national policymakers with information that can stimulate further exploration. State policymakers should consider the potential for the ACO model within their states. For national policymakers, we seek to spur collaboration with states and delivery system leaders to coordinate initiatives

THE ACCOUNTABLE CARE ORGANIZATION MODEL

The accountable care organization (ACO) model is designed to provide incentives for delivery system reform to promote coordination of care and quality, while managing cost and reducing cost disparities. Definitions vary on precisely what is and is not an ACO, but chief principles and prerequisites include:

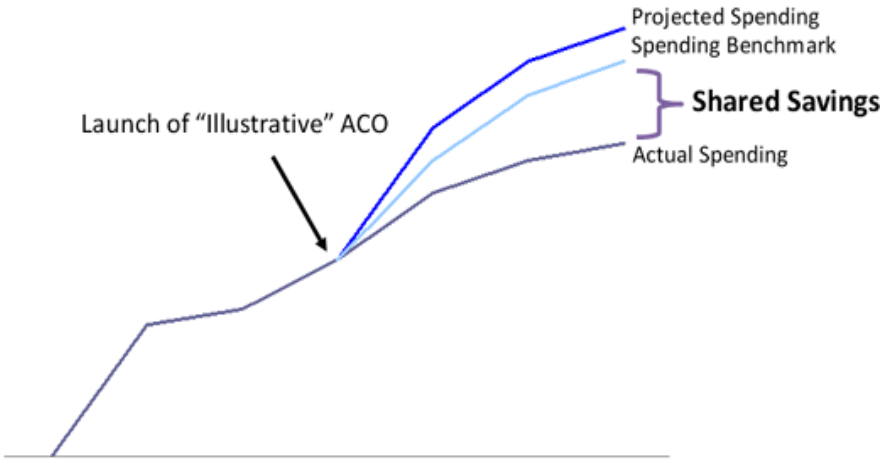
- payment reform that promotes value, including a shared-savings model based on targeted savings using a global, prospective budget;
- performance measurement using timely and accurate data that allows organizations to be accountable for quality and cost for a defined population; and
- delivery system changes that promote integrated, organized processes for improving quality and controlling costs.[4]

Payment Reform to Promote Value

Payment reform is central to improving the delivery system. Mindful of the damage that abrupt (or failed) payment reform can wreak upon systems of care (in particular, safety-net service systems), proponents of the ACO model do not necessarily advocate for full capitation. Instead, ACOs are charged with meeting specific quality benchmarks and managing a prospective budget to produce savings.

The specific provider reimbursement model within the ACO may vary, but the overall budgeting methodology includes a shared-savings structure that can provide incentives for lower costs. Shared savings involves identifying spending targets in the form of a prospective budget. This prospective budget is set using claims data utilization that describes all costs for the target population. With accurate data on spending and claims, the ACO can identify a spending benchmark that serves as a target for all spending for the population. If the ACO meets the target, the resulting savings can be shared with ACO participating provider organizations, or in a nonprofit setting, used for other community health care needs. Exhibit 1 illustrates this prospective budgeting approach.[5]

Exhibit 1. Shared Savings in an Accountable Care Organization



Source: Brookings-Dartmouth ACO Learning Network. (2009). *Reforming Provider Payment: Moving Toward Accountability for Quality and Value.* Retrieved from: http://www.brookings.edu/~/media/Files/events/2009/0311_aco/issuebriefacofinal.pdf.

This budgeting methodology can create incentives for better systemwide planning and cost reductions. In a single specialty practice, for instance, the purchase of expensive new technology—a new MRI machine, for example—that duplicates existing community resources may be seen as a market-share imperative. In an ACO model, all providers are engaged in managing the global health care resources and budget of a population or region. The impact of such a duplicative purchase may adversely affect that budget while

providing negligible health care value to the community. Instead, providers are incentivized to share existing resources and make practice changes that reduce the use of expensive technology while maintaining good health care outcomes.

Exactly how risk is shared between the ACO and the payer can vary. While a full risk-sharing model may result in more savings for the payer, narrowing risk (eliminating the potential downside) may encourage more providers to participate in the ACO model.[6]

Performance Measurement and Data

The ACO qualifies for incentive payments by effectively managing costs and meeting specific quality expectations. This dual accountability creates an incentive for all members of the provider community to coordinate care, use data to understand utilization patterns and referrals, identify areas of overlap or duplication, and recognize system failure and unnecessary cost. Dual accountability, supported by good data and measurement, is one of the important features of the ACO model. However, these performance measures need not be uniform across the nation: experts noted the importance of developing the ACO model based on local conditions to address local problems. Several experts also noted the importance of measuring actual health outcomes, in addition to care processes.[7]

Accurate performance measurement—including cost and quality—is impossible without access to comprehensive and timely data. Accordingly, state policymakers and other experts agree that a robust data system is a prerequisite in the development of the ACO model.

Delivery System

Supporting high-performing systems of care is essential to realizing the potential of the ACO model. Systems of care, according to the Institute of Medicine, can improve care by improving use of information technology, management of clinical knowledge and skills, development of teams, coordination of care across conditions and settings, and measurement of outcomes.[8] In the ACO model, because accountability for the cost and quality of care for an identified population of patients is shared across a continuum of providers, the focus on quality moves beyond the individual practitioner. In working toward the joint goal of better outcomes, providers in an ACO model need to work together, across settings, to develop those components of a system of care noted above

In structuring the delivery system, experts agree that the ACO should provide access to a continuum of care in order to be able to manage a global health care budget for a given population. Hospitals, as a central feature of many health care systems and a

significant cost driver, are generally considered to be an important, although not essential, component of the ACO model. There is also agreement that any high-performing delivery system needs to include a strong primary care component, preferably a patient-centered medical home.[9] Several leading states appear to be embracing this viewpoint, and are using the groundwork and many of the lessons learned from their medical home initiatives to inform ACO development.

As ACOs develop, they will differ in structure and number of people covered. According to the Medicare Payment Advisory Commission, an ACO entity would include, at minimum: primary care physicians, specialists, and at least one hospital.[10] Other models could include home health, behavioral health, and other services. An ACO could be developed from a multispecialty group practice; for instance, from a hospital medical staff organization or physician–hospital organization.[11,12] Smaller practices could form independent physician associations (IPAs) that provide the requisite size, capital, and infrastructure to accept accountability.

STATE ROLES IN THE DEVELOPMENT OF ACCOUNTABLE CARE ORGANIZATIONS

States have an important role to play in the development and implementation of the accountable care organization model. States are using varied approaches to this work, often weaving the ACO model into the broader fabric of state health reform initiatives. In structured interviews, state policy leaders discussed their efforts to develop, facilitate, and promote the ACO model. Areas of activity correlated roughly with the five key components of the model (Exhibit 2).

Exhibit 2. Key Components of Accountable Care Organizations

Data	Timely utilization and cost data to inform decision-making, promote quality, and monitor use of resources
Payment Incentives	Shared-savings structure to promote lower costs and coordination
Accountability Measures	Used to ensure value, not only cost containment
Identified Population and System of Care	An identified target population (by region, community, or group) whose care can be tracked and managed and a system of care to serve that population
Continuum of Care	Minimal ACO components include strong primary care practices, at least one hospital, and specialists

Data

ACOs need timely, accurate, and comprehensive data to make the decisions necessary to realize value in their health care community or region. Data are necessary to track all

health care utilization of an assigned population, including use of primary, specialty, and hospital care, as well as social services, behavioral health, and public health.

Harnessing health care data from multiple providers, through claims data and the data resources of multiple payers, is a complex task. Through leadership and funding, states can develop new capacities to support the data needs of the ACO, particularly in accessing data from multiple payers. In addition, with the recent funding from the American Recovery and Reinvestment Act (ARRA), states are at the forefront of health information technology (health IT) and health information exchange (HIE) development.

State examples:

State leadership and funding. States have a unique relationship with health care data. Because most other payers shield data to protect market share or other industry advantages, states can often be the only entity in a position to gather, analyze, and share large amounts of data, especially data that cut across providers and payers. States can mandate the disclosure of data and also shield data from competitors. In addition, states may be in the best position to promote transparency in ACO cost reporting.

Key informants from five of the seven states interviewed noted that their states are using their roles as data broker to develop, through legislative action and funding, multipayer databases. A sixth state is strongly interested in developing such capabilities and has some legislative support (although no funding) to do so. Although developing a multipayer database can be very challenging, this kind of comprehensive claims information will ultimately allow states to identify opportunities to promote better clinical outcomes, align payment incentives more effectively, identify and address region-specific problems, and meet other health care objectives (Exhibit 3).

Vermont has developed a multipayer database to support a wide range of health policy initiatives, including its patient-centered medical home program. The state has funded and developed a Web-based registry that provides clinical tracking and supports population-based analysis. The tool is supported through the state HIE system (known as Vermont Information Technology Leaders) and will be part of the health IT infrastructure for ACOs.[13] Colorado, which will fund regional care coordination organizations (RCCOs) through its Medicaid system, plans to contract with a private entity to provide the data and analytics services that will support the RCCOs. The contract will include the creation of a Web-based provider health information system and collection and analysis of data from the RCCOs across the state to identify opportunities to improve care quality.[14]

Exhibit 3. Multipayer Database Development in Selected States

Colorado	Colorado has established an Advisory Committee to make recommendations to the Governor and General Assembly on the establishment and operation of an all-payer claims database. Recommendations are due on March 1, 2011.[15]
Massachusetts	Massachusetts has passed legislation and is in the process of developing an all-payer claims database derived from medical claims, dental claims, pharmacy claims, and information from member eligibility files, provider files, and product files. The database will include information on patients covered by a variety of payers, including fully insured and self-insured plans, Medicare, and Medicaid.
Minnesota	Minnesota, as part of its health reform initiative, passed legislation in 2008 that requires health plans and third-party administrators to submit claims data to the Minnesota Department of Health beginning July 1, 2009.[16] The data form the basis for the provider peer grouping program, a system designed to allow for public comparison of health care provider value.
North Carolina	North Carolina has recently partnered with Blue Cross Blue Shield, the state's largest private insurer, to collect and combine claims data. Collection efforts are already taking place in the Medicaid program for the Community Care of North Carolina health networks. The state will target data collection efforts in rural communities with the upcoming launch of a multipayer data collection pilot to be rolled out in 10 counties.
Oregon	A companion bill to Oregon's 2009 health care reforms authorized the Oregon Health Policy Board to develop the all-payer health care claims data reporting program. The board has emphasized that collection and monitoring of cost, quality, and utilization will supplement other data for policy decisions. Oregon ended a public comment period in January 2010, released a request for proposals for vendors in July 2010, and selected a data vendor in the fall of 2010.[17]
Vermont	Vermont has an all-payers claims database administered by OnPoint, a nonprofit health data management firm. The organization provides claims, cost, and utilization data on all Vermont residents, including patients participating in medical home practices.
Washington	Washington works with the Puget Sound Health Alliance to coordinate reporting efforts in the region that is served by the Alliance. The state has begun to discuss an all-payer claims database with legislators.

State health IT/HIE development. With the passage of ARRA, states have access to substantial resources, both to assist providers in adopting and meaningfully using electronic medical records and to build out their technical infrastructure to support interoperable exchange of data. With current ARRA-funded planning efforts under way, states are looking to align these federally funded, state-driven programs with their own health reform and accountable care efforts. The Regional Extension Centers funded by ARRA are a particularly important resource for assisting practices in implementing health IT tools and using them effectively.

Designing and Promoting New Payment Methods

Aligning payment methods and budgeting processes with health and quality goals is one of the critical components of the ACO model. Global budgeting—that is, budgeting for

an entire population's health care needs or for those of an identified geographic region or community—across providers and payers is an enormous undertaking and no single payment or budgeting mechanism will be appropriate for every community's needs or for every ACO. Communities may be interested in incorporating a wider variety of providers, including safety-net service providers, public health clinics, and behavioral care services—all of which may require an understanding of and sensitivity to the scarce resources available to these providers and their limited ability to bear risk. Different payers and the populations they serve—in particular, Medicaid, Medicare, and the dual-eligible population—may also require different payment mechanisms to address more intense health care needs. Different organizations also have access to different types and amounts of resources. Some are more prepared than others to make the investments necessary to implement the clinical and process changes to function as an ACO; in those cases, a payment model that increases risk and reward as organizational capacity increases may be appropriate. While some states are exploring legislative initiatives to promote payment reform, experts and states alike recognize that working with existing organizations and health care systems to develop appropriate models for prospective budgeting, risk-sharing, and shared savings, takes time, data, stakeholder discussion, and a localized approach.

States can play multiple roles in the design and promotion of these new payment mechanisms. Importantly, states are uniquely positioned to convene stakeholders to talk about ACO development and new payment strategies under the "state actions" doctrine found in antitrust law. This doctrine permits some kinds of "anticompetitive" activities—such as meeting to discuss standardized rates across payers or providers. To be permitted, the activity must be 1) in furtherance of a clearly articulated state policy, and 2) actively supervised by the state.[18] While a full discussion of the antitrust implications of the ACO model is outside the scope of this paper, a recent workshop facilitated by the Federal Trade Commission with the Centers for Medicare and Medicaid Services found that many of the legal issues in the area need clarification and states will have a continuing role to play.[19]

State examples:

Convening stakeholders under the "state actions" doctrine to promote new payment methods. Without state involvement, providers and payers who gather together to talk about payment issues, global budgeting, and other potential components of an ACO reimbursement model may run a significant risk of violating antitrust rules. Vermont expressly included language in the legislation creating its ACO pilot to shield payers and providers from antitrust violations.[20] Similarly, Washington has a strongly articulated

antitrust provision in its state law, noting that "collaboration among public payers, private health carriers, third-party purchasers, health care delivery systems, and providers to identify appropriate reimbursement methods to align incentives in support of accountable care organizations is in the best interest of the public."[21]

Piloting, testing, and funding of payment reform. States are also moving the payment discussion forward by pilot testing different forms of ACO models in a variety of settings, using flexibility to manage local conditions and capacities. Washington, for instance, recently passed legislation authorizing its Health Care Authority to pilot the ACO model.[22] The role of Washington's Health Care Authority is still being defined, but policymakers feel it is likely the ACO will benefit from the lessons learned from its multipayer medical homes pilot. In that pilot, the state-convened, multipayer collaborative has developed two payment methodologies. One requires upfront investment from the medical home practice, with shared savings after a specified period. The other, which may be more attractive to smaller practices, provides for upfront support for medical home activities in the form of a per-member per-month payment and also allows for some shared savings. Both models require practices to meet quality outcome targets.

Vermont is exploring multiple ACO payment models, which may range from "simple shared savings . . . to partial capitation for a physician–hospital organization that has had a decade of experience in managing health maintenance organization risk contracts."[23] Legislation passed in 2010 calls for the implementation of the first pilot in community-based payment reform by January 2012, to coincide with the Medicare ACO pilots authorized by the Affordable Care Act. It creates a new senior position in the executive branch to lead the effort and mandates commercial payer participation.[24]

Using state purchasing power. States are using their significant purchasing power, through Medicaid, state employees, and other programs, to create the market for ACOs and to shape new payment strategies that promote ACO development. Colorado plans to provide services to all its Medicaid-covered individuals through ACOs (also referred to in Colorado as accountable care communities or regional care coordination organizations).[25]

Oregon, as a part of its recent health care reform activities, has consolidated its purchasing power under a single entity in the form of the Oregon Health Authority. Both Medicaid and state employee health care purchasing will now be conducted through the same authority. While there are no concrete plans yet to contract with ACOs, Oregon's

health reform initiative calls for community-based accountable entities and the Oregon Health Authority has been charged with implementing these reforms.

State legislative authority. States can use the legislative process to move the payment reform discussion. In North Carolina, the state legislature has recently enacted language that promotes an "enhanced primary care case management system" to be built from the foundation of the state-established Community Care of North Carolina (CCNC) program, which groups various provider types with local hospitals and health departments and is overseen by the nonprofit North Carolina Community Care Network, Inc. (NCCCN). The state will contract with NCCCN and its local community networks to include "comprehensive statewide quantitative performance goals and deliverables which shall include all of the following areas: service utilization management, budget analytics, budget forecasting methodologies, quality of care analytics, participant access measures, and predictable cost containment methodologies."[26] The legislation is designed to move the Community Care system toward more ACO-like accountability and payment incentives. Exhibit 4 describes Minnesota's experience in using legislation to promote these kinds of reforms.

Exhibit 4. Minnesota's "Level 3" Payment Reform Plan

Minnesota's 2008 legislation contained a number of elements with significant potential to achieve overall health care cost savings. One important payment reform provision was discussed, though ultimately not included in the final bill. "Level 3" or "total cost of care" payments envisioned a process through which provider groups and care systems would submit bids for the total cost of care for a given population. Under this design, providers and care systems would submit bids to health plans and other purchasers to provide care under a standardized benefit. As written into proposed legislation, the total cost of care accounted for in these bids would include anything within a standard benefit package, although nothing outside it. Furthermore, bids would be required to decrease costs from current levels. Payments to providers would be varying, based on the health and special needs of the population managed. Consumers would then select systems based on cost and quality.

The provision was not included in the final bill, largely because of concerns from the provider community. Since then, however, many providers have indicated an interest in revisiting the discussion. Given drastic cuts in Medicaid rates to providers and a deteriorating state budget, providers are seeing benefits in moving past the fee-for-service environment. Minnesota's Quality Improvement Institute team is now engaging the public health community, leaders in the payer and provider communities, and those other parties interested in developing Level 3-type payment methodologies.[27] In addition, language passed during the 2010 legislative session calls for the state's Department of Human Services to develop a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations, which could provide services to a specified patient population for an agreed-upon total cost of care or risk–gain-sharing payment arrangement.

Engaging Medicare as a payer. States also have the ability to develop partnerships with Medicare, an important payer. Vermont, for example, had been paying for Medicare recipients' costs within its medical home initiative to better integrate systems and reward

providers. Vermont submitted a successful application to expand Medicare's involvement in this initiative through the Advanced Primary Care Demonstration, a CMS initiative that will enable participation of Medicare in state-based advanced primary care initiatives. It is also exploring how to use the new authority under Section 3022 of the Accountable Care Act to create Medicare pilots in shared-savings models.

North Carolina was recently selected by CMS to take part in a five-year demonstration program under Section 646 of the Medicare Modernization Act of 2003.[28] The North Carolina Community Care Network (NCCCN), which includes 14 regionally based provider networks, plans to expand its patient-centered medical home and networks of physicians, hospitals, health departments, and other community organizations to the Medicare population.[29] The demonstration will allow NCCCN to manage approximately 30,000 dually eligible beneficiaries in the first wave of the project, which started in 2010. An additional 150,000 Medicare-only members will be will be added to the demonstration in 2013.[30]

Accountability Measures

In order to realize value in health care delivery, the ACO model requires accountability through measurement of health care quality. The ACO model may therefore provide states and other payers a framework in which to measure value not only within an individual practice, but across systems and for identified populations. States must work through multiple challenges in the development and implementation of measures, including lack of standardization across payers, adding additional reporting and tracking burdens to providers, and establishing the validity of data.

State policymakers have been deeply involved in the accountability discussion and bring significant expertise to the development of this key ACO component. States have made accountability a clear priority through legislative initiatives that mandate quality standards and reporting, for instance. States have also used their significant purchasing power to promote accountability, and have tied specific pilot-funding opportunities to quality standards.

State examples:

Promoting accountability through statewide reporting requirements. Minnesota has taken a strong leadership role through legislation that supports quality measurement. Provider peer grouping, included in a statute passed in 2008, provides a system for the state to track and compare the cost and quality of patient care delivered by providers across the state.[31] Multipayer data is collected on specific measures and is used in annual

reporting and to provide public information on cost and quality. The program is supported by the Minnesota Statewide Quality and Reporting System, a set of standards and measures developed through the rulemaking process and finalized in December 2009.[32] Since January 1, 2010, health plans may not require providers to submit data on any measure outside this standardized set.

Using state purchasing power to formalize accountability standards and measures. Colorado Medicaid will be contracting with regional ACO entities for its Medicaid population and sees this initiative as a key opportunity to promote broader health care outcomes. Colorado policymakers expect to develop performance-based contracts with the regional entities and incorporate more public health and community-wide improvement goals into these contracts. State policymakers are considering public health goals such as reducing smoking rates, improving depression treatment, and reducing other income-related health disparities. Moreover, Colorado policymakers hope to promote system and community-wide goals, such as reducing school sick days.

Using pilot funding to tie standards and core competencies to provider funding. Vermont is looking at lessons learned under its medical home efforts to determine standards for sites that will receive funding under its ACO initiative. State policymakers feel that the National Committee for Quality Assurance standards used for the patient-centered medical home initiative are a good starting point and may use them for its ACO pilot program.

Convening stakeholders. States are moving toward accountability measures by convening and facilitating stakeholder discussion. Oregon's Health Incentives and Outcomes Committee was chartered to "continually refine uniform, statewide health care quality standards for use by all purchasers of health care, third-party payers, health care providers and consumers."[33] The committee includes a broad scope of stakeholders, including providers, payers, employers, and advocates, and has been tasked with a variety of deliverables that include recommendations on both cost and quality measures.

Identifying and Promoting Systems of Care

The ACO has been conceptualized primarily as a provider-driven model (often, specifically as hospital-driven) that allows providers to join together voluntarily, establish the necessary systemic infrastructure, and work with payers to align quality and cost goals with global budgeting methods to achieve value for their community. Although provider-driven, states are using a variety of strategies to support the identification and fostering of ACO systems of care. This work can be seen on a continuum: some states are

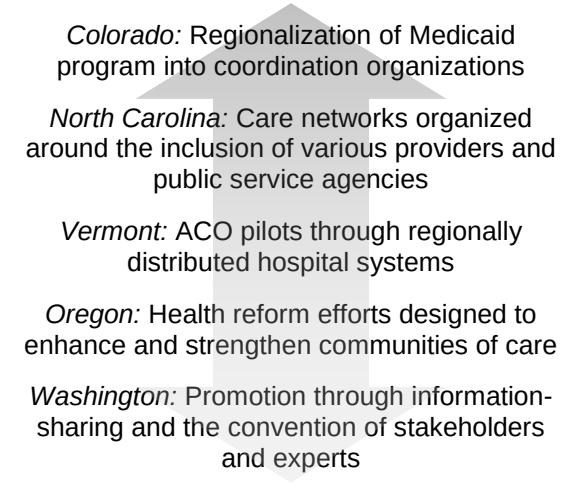
taking a very direct approach to identifying systems of care that can accommodate the ACO model, while other states are facilitating activity at the provider or community level to promote interest and capacity. In fostering systems of care, states and ACOs must address the following issues:

Critical mass. ACO delivery systems require a certain minimum number of covered lives to function successfully; with too few, using data to draw conclusions about cost and quality outcomes becomes difficult. Ensuring that leadership and managerial attention is focused on meeting quality and cost benchmarks also requires that a minimum number of patients participate in the ACO in order to create real financial and organizational incentives. Experts (notably the Brookings–Dartmouth Collaborative) have estimated these minimum covered lives at approximately 5,000 Medicare patients, 10,000 Medicaid patients, or 15,000 third-party insured patients.[34] States are piloting initiatives with fewer patients, which could potentially be problematic, given that quality measures need more data points for statistical validity.

Attribution. Under the ACO model, patients may formally enroll or they may be attributed to an ACO based on their utilization patterns and characteristics. As ACOs become a more common feature of the health care landscape, payers may want more standardized attribution models across regions and payers. Attribution models will need to address who gets counted; for example, how many visits and to whom, over what period of time, and other issues. Other challenges include how to attribute individuals who have no utilization or how to attribute individuals who primarily use specialists. Mechanisms to assure that ACOs do not avoid high-cost patients must also be considered. States have a role in guiding this development (in particular, for safety-net services and Medicaid-covered individuals) and piloting can be a useful process through which states and other payers can tease out various permutations.

State activity in identifying and promoting systems of care. Colorado plans to regionalize its Medicaid system into seven regional care coordination organizations. These RCCOs are based on a previous regionalization effort headed by the state Medicaid agency that focused on the development of behavioral health systems (Exhibit 5).

Exhibit 5. Spectrum of State Activity to Create Systems of Care



North Carolina began developing its Community Care networks in the 1990s to serve its Medicaid population through a state-initiated, public–private partnership. The state was instrumental in the development and funding of local, nonprofit community networks of care that feature an enhanced medical home and also involve hospitals, social service agencies, and county public health offices. Since the program's inception, 14 regional care networks have evolved to provide supportive services to the primary care practices. The state is currently seeking to formalize relationships with specialty care providers through contracting agreements.

Other states, such as Vermont**,** are using pilot-testing opportunities to promote the ACO model, and expect that provider communities will use the opportunity to align accordingly. Vermont has a unique advantage in that its hospital systems are distributed regionally with little overlap, presenting an existing system-of-care map.

Oregon sees community-based health care systems and accountability as integral to its health reform effort. Accordingly, the state has structured various components of these efforts to support and enforce communities of care throughout the state. These include community collaboration initiatives to promote cost-savings and health improvement activities at the local level, as well as the inclusion of behavioral health and social services. One proposed example would be increased funding to foster partnerships among the state, public and private stakeholders, employers, schools, and community organizations that support evidence-based community efforts to detect and treat risk

factors for chronic disease.[35] The state also plans to make community-specific data available to "assist communities in designing health programs that maximize impact on population health."[36]

Health policymakers in Washington are also interested in promoting regional systems of care. They are convening health care providers within various regions of the state, providing information and access to national expertise to promote the ACO model.

Supporting a Continuum of Care and the Role of the Medical Home

ACOs must be able to manage and affect delivery of care at the high-cost end of the spectrum (i.e., hospital and specialty care) as well as in preventive and primary care. Reducing cost and utilization at the high-cost end of care is a primary goal and one of the chief methods for attaining that goal is strengthening preventive and primary services. States are therefore using their experience in developing patient-centered medical homes (PCMHs) as a starting point for ACO planning and development. A NASHP survey of Medicaid and Children's Health Insurance Program (CHIP) programs found that 31 states were engaged in PCMH initiatives.

Key elements of the PCMH include:

1. having a personal physician or provider who provides first-contact care or a point-of-entry for new problems;
2. ongoing care over time;
3. comprehensive care; and
4. coordination of care across conditions, providers, and settings.[37]

Much of the work that states have engaged in as part of their medical home initiatives is applicable to ACO model development. States are engaging multiple payers and are gathering timely, multipayer claims data; identifying and implementing key quality measures; and engaging in payment reform discussion and development.

There is substantial alignment between the goals of the PCMH and the ACO (Exhibit 6). However, at least one state policymaker reported significant resistance from the provider community to the ACO model, because of long-standing efforts to develop the medical home model and a sense that the ACO would supplant it. Several key themes emerged at the crossroads of the PCMH and ACO discussion.

Exhibit 6. State Medical Home and Accountable Care Organization Development

State	Patient-Centered Medical Home Initiative	ACO Development
Colorado	Medical home initiative for all children enrolled in Medicaid and CHIP; piloting medical homes for adults with chronic illness.	• Colorado policymakers see PCMH initiative as one piece of health reform framework, with ACOs as the next step. • Transforming primary care practices and convening providers set the stage for ACO development.
Massachusetts	In the spring of 2010, Massachusetts launched a multipayer PCMH effort involving all the major commercial and Medicaid payers and a diverse group of primary care practices. The initiative seeks to: target fragmented, discontinuous care that damages patients' health and increases cost; increase prevalence and improve management of chronic disease; and address a growing shortage of primary care providers.[38]	• The state's Special Commission on Health Care Payment and Health Care Quality and Cost Council, each comprising key public and private stakeholders, unanimously recommended moving to a global payment system for all payers and using ACOs to take responsibility for the care of their patients. • Multiple private payers are currently developing ACOs in the state, with a model contract offered by the largest payer. • The state's data collection and reporting efforts are a key building block for ACOs.
Minnesota	The statewide Health Care Homes (HCH) program emphasizes outcome measures with coordination fees that vary based on the complexity of cases. The HCH certification process involves measuring quality, affordability, and accountability, with consumer representation in both the certification and quality improvement process.	• State policymakers see the HCH as a bridge between clinical practice and the design of ACOs. • Attributes of the HCH, while not mandated in the ACO pilot, are expected to be incorporated into ACO development. • The data-gathering needed for the HCH certification process can be used by ACOs.
North Carolina	North Carolina Community Care Network (NCCCN) operates 14 private, nonprofit health networks with the intent of enhancing primary care goals through the connection of providers, hospitals, health departments, and social services. The program's inception was initially facilitated by the state and the networks now contract with the state to cover two-thirds of Medicaid recipients.	• Recent legislation will facilitate the development of NCCCN's care networks into ACOs. Provisions of this legislation include the establishment of new measures for quality, utilization, and access, as well as the development of performance incentive models, accountable budget models, and shared-savings budget models.[39]
Oregon	Oregon is currently running two medical home pilots. The first is in development and seeks to engage all patients without regard to specific health conditions or status. The second is led by a consortium of private purchasers and focuses efforts on the top 10 percent of sickest patients. It will include five to six commercial plans and Medicaid.	• The PCMH pilot is complementary to the ACO in terms of quality and cost metrics.

State	Patient-Centered Medical Home Initiative	ACO Development
Vermont	The PCMH involves the state's three major private payers and Medicaid. The state pays for Medicare patients' participation. Physicians receive up to $2.50 per-member, per-month, based on how well they meet National Committee for Quality Assurance PCMH guidelines. Five salaried, full-time–equivalent staff are assigned to each PCMH to assist with care coordination and support.	• The ACO will build on PCMH model and include specialists and hospitals. • The ACO model will allow for reinvestment of savings gained from the PCMH back into the community, instead of only going to insurers. • The state's long history with the PCMH model has laid a foundation of relationships between payers and coordinated care models, facilitating the future growth of ACOs.
Washington	Current work on the medical home pilot is focused on finalizing payment models and recruiting practices to participate. To participate, a practice must meet 13 core medical home competencies. The program is slated to roll out in January 2011.	• Legislation passed in 2010 addressing the establishment of ACOs and HIE work has explicitly outlined the need for coordinated efforts with the medical home pilots. Work is under way to assess how to best integrate the programs.

Key themes:

Primary care is at the heart of accountable care. State leaders and health care experts agree that a strong, patient-centered primary care model is at the heart of any successful accountable care organization that seeks to provide value to its community, patients, and payers. However, states differed on how to provide incentives for this component of accountable care. Colorado, as part of its Medicaid Regional Community Care Organization effort, envisions the medical home model as the cornerstone of care. Vermont's ACO feasibility study concluded that a strong PCMH was a key prerequisite for implementing an ACO. Other states, such as Minnesota, are not mandating that ACO pilots include certified medical homes, but are looking to the provider community to propose configurations.

Accountable care seeks to create "systemness" beyond the medical home. Under the medical home model, there are no explicit incentives for specialists and hospitals to coordinate care with the medical home. While effective care coordination can bridge these gaps, the larger system can remain fragmented. Moreover, the medical home has little leverage to offset the cost of a community's duplicative and expensive medical infrastructure; for example, multiple MRI sites that depend on volume billing or a focus on expensive specialty care. ACOs can provide a unifying force to a community or defined region: providers across the continuum of care can be integrated through aligned and shared cost and quality incentives.

ACO savings can be reinvested in the community. Payers typically invest in the patient-centered medical home through a per-member per-month fee structure or other

payment strategy that moves primary care away from fee-for-service billing and toward incentivized quality outcomes. The savings realized through the delivery of higher-quality care accrue to the payer, although some state Medicaid agencies have chosen to reinvest these savings into the community health care system. The ACO model likewise can provide a budgeting methodology that allows some savings to remain in the community for reinvestment or expansion of services.

PCMH and ACO models are synergistic. ACOs can function without the patient-centered medical home and the medical home can exist without an accountable care model. However, states recognize that the benefits of the PCMH can be enhanced through an ACO model, which can encourage the broader system to coordinate and improve care. Likewise, the ACO model will be more successful in delivering value if built around an evidence-based, high-performing, patient-centered medical home model.

FEDERAL HEALTH REFORM AND STATE OPPORTUNITIES FOR ACCOUNTABLE CARE ORGANIZATION DEVELOPMENT

Explicit inclusion of the accountable care organization model in the Affordable Care Act is generating significant interest, while other avenues for health reform in that legislation—such as state health insurance exchanges—may provide additional opportunities for states to encourage or promote the ACO model. Federal funding for health information exchanges in ARRA provides additional tools to shape the state health care landscape in support of the ACO model.

The Accountable Care Model and the Affordable Care Act

In its June 2009 report to Congress, the Medicare Payment Advisory Commission (MedPAC) highlighted the potential benefits of the ACO. The MedPAC report noted that "the defining characteristic of ACOs is that a set of physicians and hospitals accept joint responsibility for the quality of care and the cost of care received by the ACO's panel of patients."[40] The report concluded, with some caveats, that "ACOs could prove to be an important catalyst for delivery system reform by creating incentives for increased organization and joint decision-making."[41]

The recommendation garnered attention and when Congress passed the legislation, it contained incentives for the development of ACOs in Medicare and Medicaid. These two programs—Medicare, in particular, because of its potential scope—provide vehicles for states to promote the adoption of the ACO model. Section 3022 of the Act, the Medicare Shared Savings Program, offers an opportunity for those providers "willing to be accountable for quality, cost, and overall care" to partake in shared savings

with the Medicare program.[42] Rules on this provision have not yet been released, but are expected in early 2011. The program may be overseen by the newly created Centers for Medicare and Medicaid Innovation, which aims to "test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care furnished to individuals."[43] Section 2706 of the Act also provides state Medicaid programs an opportunity to develop Pediatric Accountable Care Organizations using the same incentive program described in Section 3022.

Leveraging Interested Organizations and Providers

The Medicare Shared Savings Program is scheduled to be implemented in January 2012. Providers who are interested in joining together to become an ACO to partake in the shared-savings program will need to start engaging in discussions and organizing. States that are interested in promoting these organizations can begin by identifying and convening interested organizations and providers, identifying their needs, and thinking about how other state efforts (health IT, for example) may be able to support these organizations and entities.

States Can Provide Input into the Regulatory Process

The CMS legislative office is developing rules on the ACO model under the Affordable Care Act, and has held an "open-door" forum to provide information and solicit input from interested parties on the development of these rules. States that are interested in or are already pursuing the ACO model as a part of their health reform efforts may be able to offer a unique perspective and report on lessons learned from their experiences in shaping quality measures, working through payment challenges, provider qualifications, antitrust strategies, and other issues. Similarly, states can support the development of ACOs by aligning state-based accountability measures with evolving federal requirements. Shaping this key piece of regulation in a way that complements existing state efforts can be an important role for states. States will also want to engage with the Center for Medicare and Medicaid Innovation on payment reform, including the ACO model.

Health Insurance Exchanges Provide Opportunities for States

While the Affordable Care Act anticipates federal rule-making to establish the broad parameters of the insurance exchanges, they will be state-run and state-driven organizations for the states that choose to implement them. States may seek to align exchange requirements with existing health care goals and initiatives, such as ACOs. Section 1311(g), for instance, provides opportunities to promote quality through "market-based incentives" within the exchanges, including:

- improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication, and care compliance initiatives, including the use of the medical home model, for treatment or services under the plan or coverage;
- the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional;
- the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage; and
- the implementation of wellness and health promotion activities.[44]

While not explicitly supporting an ACO model, this section may provide states with a new "lever" and set of tools to promote it. A number of states recognize that the massive expansion of coverage afforded by the Affordable Care Act presents an imperative to reform delivery and payment to sustain coverage, and are designing quality and efficiency reforms as they plan for exchanges.[45]

Health Information Technology and Meaningful Use

The American Recovery and Reinvestment Act (ARRA) offers unprecedented opportunities for states to establish and support the development and meaningful use of health IT. ARRA provisions invest over $564,000,000 into state infrastructure through the State Health Information Exchange Cooperative Agreement Program.[46] States are also responsible for managing the Medicaid Electronic Health Record Incentives Program, which pays incentives to health care providers who can demonstrate meaningful use of electronic health records. States will also benefit from the creation of Regional Extension Centers, designed to provide technical assistance and further facilitate adoption. This package of programs—envisioned as a state-based, public–private partnership—has driven health information exchanges (HIEs) and health IT to the forefront of state health policy.

The ACO model, being intrinsically data-driven, is gaining traction with states at a challenging yet fortuitous moment. Through ARRA funding, states are able to invest significant resources into infrastructure that can connect health care providers, support

interoperable electronic health record use, and improve the quality and timeliness of available health care data. These data can then be used to inform and drive decisions about health care value.

Because of the scope of resources and activities around HIE, virtually all state Medicaid and health policy leadership are involved to some degree in HIE discussions. Some states have developed public–private entities to drive HIE development, while others have retained all planning and funding responsibility within state government, often within Medicaid. Regardless of the governance model, state policymakers are well-positioned to think strategically about HIE resources and how they can be used to advance long-standing state goals about cost and quality.

KEY THEMES: STATE ROLES IN ACCOUNTABLE CARE ORGANIZATION DEVELOPMENT

Build on the Foundation of Other State Health Reform Initiatives

Accountable care organization development is not typically viewed by leading states as a new, stand-alone initiative. Rather, implementation of the ACO model is seen as another step in the evolution of state health reform efforts. States are finding that many of the key pieces of their health reform efforts—multipayer databases, payment reform, quality measurement, medical home infrastructure, electronic medical records and health IT—can be tied together using the ACO vehicle. Rather than requiring a new direction or policy shift, states can build on existing health reform efforts to promote ACOs. These include developing coordinated, collaborative primary care models and collecting and reporting timely data across payers, including quality and cost measures (Exhibit 7).

Exhibit 7. Summary of State Activity to Foster Key Components of the Accountable Care Organization Model

Colorado
• Developing statewide data and analytics organization
• Developing regional community care organizations, an ACO model for Medicaid participants
• Contracts will be performance-based and will incorporate public health and community-wide health goals
• Established medical home initiative for all children enrolled in Medicaid and the Children's Health Insurance Program; also, pilot testing medical homes for adults with chronic illnesses
Massachusetts
• e-Health Institute to support statewide use of electronic health records and the creation of an interoperable health exchange
• Commission on Health Care Payment System recommended ACO development in health reform

- Reforms include risk-sharing arrangements between ACOs and payers
- Conducting multipayer patient-centered medical home (PCMH) effort involving all major commercial and Medicaid payers and a diverse group of primary care practices

Minnesota

- Collecting multipayer data on specific measures of cost and quality
- Passed legislation that supports quality measurement
- Convening providers for discussion and review of ACO model
- State Quality Improvement Institute engaging stakeholders in developing ACOs and cost-of-care payment methodologies

North Carolina

- Using Medicaid data as feedback to Community Care of North Carolina networks and providers, adding third-party payer claims data in 10 rural counties
- Passed legislation to explore shared-savings, risk-adjusted payment models in Medicaid
- Stakeholders looking to additional opportunities for ACO development out of existing state demonstrations and initiatives, including the Community Care of North Carolina program, Beacon Communities, and the Medicare 646 Demonstration

Oregon

- Developing all-payer health care claims data reporting program
- Recommending community-based accountable entities and focusing on support for "communities of care" in state health reform initiatives
- Sponsoring a variety of community collaboration initiatives to promote cost-savings and health improvement activities at the local level
- Consolidating state purchasing power under a single entity
- Conducting two medical home pilots to collect cost and quality metrics, will serve as future model for ACOs

Vermont

- Utilizing all-payer claims database administered by a health data management contractor
- Passed legislation that calls for the implementation of a "community-based payment reform" pilot to coincide with Medicare ACO pilots authorized by the Affordable Care Act
- Conducted ACO feasibility study that recommended a strong PCMH as prerequisite for implementing ACO model
- Using lessons learned from PCMH to determine standards for funding under ACO initiative
- Mandating that commercial payers participate in enhanced PCMH payment reform
- Envision more than one payment model, ranging from shared savings to partial capitation

Washington

- Planning for all-payer claims database
- Collaborating with the Puget Sound Health Alliance to coordinate reporting efforts
- Passed legislation authorizing ACO pilots, will establish and test different payment models
- Outlined the need for coordinated efforts with medical home pilots, work is currently under way to assess how to best integrate programs
- Convening and educating providers on ACO model

Look for Community-Based and Regional Opportunities

State policymakers and national experts cautioned states against trying to create ACOs from the top down. Instead, they advised states to look for opportunities within their existing provider communities and structures. Data, communication, and stakeholder involvement are all critical. Are services clustered around a few high-performing physician practices in a given area? Is there an area of the state that might be ready to take its hospital and primary care practice partnership to the next level? Are there costs or poor outcomes in particular regions that can be addressed through better accountability and coordination of existing provider groups? States can find examples of regional activity that are similar to a system approach and then assist those stakeholders in ACO development. For example, they could convene major payers in the region to talk about ways to support "systemness," or assemble providers, including hospitals and specialists, to talk about systemwide outcome measures and then use data to move these conversations along. Through multipayer claims systems, states can develop the kind of comparison data that illustrate quality and cost in various regions. States can then assist communities in identifying the local, systemic problems that need to be tackled. ACOs germinate more successfully through provider-driven, locally grown discussions and opportunities.

Establish Pilots to Test Models and Build a Core

Pilot tests are a key tool for states to use for introducing the model, gaining traction, and assessing provider readiness. States recognize that pilot testing allows them to work through the necessary discussions, develop viable models, and identify motivated participants. The legislative initiatives that describe these pilots typically provide broad parameters, allowing state policymakers—together with payer, provider, and consumer communities—to work through the technical aspects of the model, such as the identification of regional entities, accountability and payment design, and delivery system development. Pilot testing allows states to convene key stakeholders, which provides a forum for technical assistance and stakeholder input. It also stimulates the provider community to use and develop community-responsive models, allowing states to leverage existing local networks and resources.

Legislation Is an Important Tool

Although there can be significant progress with purely voluntary efforts, states that have enacted legislation to develop ACO pilots or elements of the model, such as data collection and reporting systems, report that the time frames and funding in the legislation "hold their feet to the fire" in ways that voluntary efforts do not. By specifying

that provider collaboration on new payment methods is in the public interest and by using the state as convener, provider trepidation over antitrust action is minimized.

Build Stakeholder Support

State policymakers, as well as national experts, advised states interested in the ACO model to include a broad spectrum of stakeholders in their discussions and planning. Because the model touches on virtually all aspects of the health care system—payers, hospitals, specialty care, primary care, and patients—states reiterated that bringing stakeholders in early and often was key.

Similarly, being clear on the message is important. One policymaker reported that an earlier lack of clarity about the model, combined with provider allegiance to the state's patient-centered medical home initiative made some providers initially resistant to policy changes to support the ACO model. States also recommended that crafting the message was important: hospital systems, payers, advocates, and other powerful elements of a state health care system must understand what they stand to gain and lose under the model.

States also felt that meaningful engagement with consumer groups and communities is critical to ACO development. Consumers can inform the development of the model in other ways, including determining how financial incentives for consumers will actually work in practice. Communities need to understand how they fit into the continuum of care and how other social service or public supports can enhance the model.

ACOs Are Not a "One-Size-Fits-All" Model

Several state policymakers and experts noted that the ACO model has applicability to a wide variety of settings and systems of care, can accommodate diverse payment structures, and can be accountable in ways that are tailored to meet local needs and conditions. While all the basic elements of the model—payment reform, accountability, and a coordinated continuum of care—must be addressed and incorporated, how these components are implemented can vary widely.

States recognize this level of variation in their planning processes. Most states look at local conditions and expertise when developing their models. Through pilot testing, for instance, states are hoping to spur community-based providers to configure their services to meet baseline requirements. In one area of the state, the ACO may be a well-defined physician–hospital organization; in another area, a voluntary group of health

care organizations that meets regularly to problem-solve around local health issues may be encouraged to incorporate and evolve to meet ACO requirements. Similarly, states may develop payment structures that require significant infrastructure from well-capitalized, mature systems of care, or states could institute payment incentives with little or no up-front cost to reflect the limited resources of a safety-net provider system.

CONCLUSION

States are being presented with a dizzying array of health care options and decisions, which stem from their own complex health reform efforts, as well as the enormous opportunities available at the federal level through the Affordable Care Act. Among these options, the accountable care organization model holds promise as a new and flexible structure for the promotion of system-driven health care value. Supported by mature data systems and using a shared-savings model that recognizes the importance of health care outcomes, ACOs can incentivize what states want— controlled costs and improved health outcomes—while addressing health care in a longitudinal and population-based way.

States have an important role to play in the development of ACOs. As illustrated throughout this report, states are using lessons from their own health reform efforts, including medical home initiatives and data capacity-building, to promote the ACO model in innovative and timely ways.

States are also looking to the Affordable Care Act for additional tools, resources, and programs that may support the ACO model. While certain sections of the law specifically foster ACO development, other pieces of federal health reform, such as state insurance exchanges, may provide opportunities as well. As federal officials seek to implement these provisions of the Affordable Care Act, both state and federal officials would benefit greatly from discussion and collaboration on ACO-related issues.

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APPENDIX B. STATE SNAPSHOTS

Colorado

When Colorado's rocky relationship with Medicaid managed care ended in 2003, managed care ceased to be viewed as a cost-saving vehicle. In 2006, the state legislature formed the Blue Ribbon Commission of Health Reform, empowering a committee to review options for transforming Colorado's health care system (including Medicaid) and addressing the problems it faced regarding cost, quality, and access. Among its recommendations, the Blue Ribbon 2008 report to the Colorado legislature included the promotion of the accountable care organization (ACO) model as a new way to deliver managed care to the state's Medicaid members. The state passed additional legislation in 2009 and established the Accountable Care Collaborative.

A request for information was released in July 2009 soliciting information from stakeholders on the ACO model, known as accountable care communities (ACCs). The state is using the ACC framework in conjunction with infrastructure development and other health care reforms including medical home efforts, health information technology, and payment reform. The ACC will include a statewide data and analytics organization as well as regional care coordination organizations. Colorado is moving forward on recently passed ACO legislation, and expects to select regional entities in early 2011.

Foundations for the ACO Model in Colorado

- State health reform commission recommendations to promote ACOs
- Experience in medical home initiative for children
- Multipayer initiative, including participation in a medical home pilot
- Experience with regional health care systems
- Managed care history

Massachusetts

After Massachusetts passed its comprehensive health reform legislation in 2006, concerns about the sustainability of coverage expansion drove a second set of reforms in 2008. Provisions known as Chapter 305 strengthened the role of the state's Health Care Quality and Cost Council, and established a 10-member Special Commission on the Health Care Payment System to study alternative payment and delivery methodologies, purchasing strategies, and alignment of reimbursement incentives to produce high-quality and high-value health care.[51] The legislation further directed the Commission to investigate blended capitation, episodes of care payments, medical home models, global budgets, and other payment strategies that promote care coordination, chronic disease management, and incentives for patient-centered care.

One of the Commission's key recommendations was the development of ACOs. It subsequently developed a definition for ACOs that permits a wide range of integrated provider organizations that will allow providers to organize in respect to cultural and philosophic differences, as well as the flexibility to operationalize differences in financial risks and shared savings. The Commission concluded that a statewide transition to global payment systems, including ACOs, can be accomplished within a five-year timeline. Providers who have limited experiences with these systems can gradually transition from fee-for-service to shared savings to global payment systems. Ultimately, the Commission envisions a system of care that will have participation of all private and public payers, risk-sharing between payers and ACOs, a focus on patient-centered primary care, and quality and cost transparency.

Foundations for the ACO Model in Massachusetts

- Uniform data reporting from public and private payers
- Massachusetts e-Health Institute established to support statewide use of electronic health records and creation of an interoperable health exchange network
- Established medical home demonstration projects to enhance the focus on primary care
- Special Commission on the Health Care Payment System recommendations, including:
    - pay-for-performance incentives
    - risk-sharing arrangements and the development of risk adjustment models, and
    - patient choice, with payments rerouted through ACOs

Minnesota

Minnesota's health care landscape is shaped by the presence of several major employers, coupled with large integrated hospital and care systems. The state is home to companies like Cargill, 3M, General Mills, and Best Buy, as well as health care leaders such as the Mayo Clinic and HealthPartners. Minnesota has a history of partnerships among employers, community-minded health plans, care systems, and the state, which have informed the health care reform process and which currently shape the conversations around ACOs.

The state still struggled with rising cost, increasing uninsured rates, and uneven quality of care. In response, Minnesota passed significant health reform legislation in 2008. This legislation, which was ambitious in scope, will transform many aspects of Minnesota's health care system, touching on public health, chronic care management, payment reform, quality improvement, administrative efficiency, and cost containment. Many of these far-reaching reforms set the stage for the introduction and development of the ACO model. In particular, the state's emphasis on strong patient-centered primary care, data infrastructure, and payment and quality reforms have lead naturally to the current discussions and explorations with an engaged provider community.

Foundations for the ACO Model in Minnesota

- A standardized statewide set of quality-of-care measures
- Collection and use of all-payer encounter data and contracted prices
- Provider ranking based on a combination of risk-adjusted cost and quality
- Uniform definitions for at least seven "baskets of care" and standard quality measurements for those baskets
- A single, statewide system of quality-based incentive payments to providers to be used by public and private payers
- Standards of certification for "health care homes"
- Legislative mandate to incentivize electronic medical record adoption

North Carolina

North Carolina's roots in developing coordinated networks of care began in 1991 with the establishment of a Medicaid primary care case management program called the Carolina Access Program. The program was successful in moving the majority of Medicaid recipients into medical homes, but lacked sufficient resources to adequately address quality improvement issues or the needs of complex patients. In response to provider and policymaker feedback, the state established the Community Care of North Carolina (CCNC) program in 1998, which created networks in which primary care, safety-net, and specialty providers were grouped with local health departments, departments of social services, and hospitals. The program, originally pilot-tested in nine networks, is overseen by a private nonprofit, the North Carolina Community Care Network, Inc. (NCCCN), and has largely been popular with providers. It has since expanded to include 14 care networks and cover nearly two-thirds of Medicaid recipients.[52]

While these initial programs were not explicitly intended to drive large-scale integrated delivery system reforms, the state has found itself moving in that direction. For example, the recent Medicare 646 demonstration project will allow the state to expand the Community Care program by bringing an anticipated 180,000 Medicare recipients into NCCCN networks with physician reimbursements set on a pay-per-performance scale based on a standardized set of quality measures.[53] Additionally, the state is leveraging the networks to create a new multipayer pilot that will seek to improve access and quality in 10 rural counties. As an enhancement to these current projects, the state has recently contracted with Blue Cross Blue Shield, the state's largest private insurance provider, to share claims data, which it will consolidate with collected Medicaid data in an effort to better monitor population health indicators and quality initiatives.

Finally, Session Law 2010–31, passed in July 2010, provides clear indication of Community Care's movement from medical home models toward accountable care models. The legislation requires NCCCN to contract with the state's Division of Medical Assistance in the development of statewide performance goals and deliverables. By October 2012, NCCCN is to release a plan to establish management methodologies that will address quality of care, access, and utilization measures, as well as performance incentives, accountable care, and shared-savings budget models.[54]

Foundations for the ACO Model in North Carolina

- A strong history of reform efforts rooted in the Medicaid program
- A growth of public and private partnerships that serve to facilitate information-sharing and program development
- Legislative and professional support for new programs and innovation in the health system

Oregon

Oregon passed Senate Bill 329, which established the Oregon Health Fund Board and tasked it with outlining a comprehensive health reform plan to submit to the state legislature in 2009. A subcommittee on delivery systems engaged with national experts to talk about various ways to reconfigure Oregon's health delivery system to promote quality while "bending the cost curve." Support for ACOs came out of these discussions; the model was among the committee's final recommendations. Subsequent legislation created the Oregon Health Authority, authorizing the creation of a unified governmental authority to oversee all aspects of health reform implementation. Building on the delivery system subcommittee report, the legislation included a broad range of other initiatives, all of which are seen as critical to health reform and many of which are elemental in the development of ACOs. The legislative initiatives included:

- the development of uniform, statewide health care quality standards for use by all purchasers of health care, including the establishment of clinical standards and guidelines;
- joint contracting for health care services on behalf of public employees and individuals covered by Medicaid;
- the creation of the Health Quality Institute; and
- a multipayer data collection program.

Oregon is now in the early stages of implementation, both of its health reform vision and of the accountable care communities recommended in the Oregon Health Fund Board's report.

The Office for Oregon Health Policy and Research participates in the Brookings–Dartmouth Accountable Care Learning Network and the office works with providers and provider associations to discuss the ACO model and identify interested provider organizations and communities and serves as a clearinghouse for information about the model. While there are no existing entities in Oregon that could yet be considered an ACO, Oregon has articulated a vision in its health reform initiative that lays the groundwork to support these organizations.

Foundations for the ACO Model in Oregon

- Multipayer database created under the Oregon Health Authority
- Combined state purchasing power consolidated in the Oregon Health Authority
- Plans to expand payment reform and medical home initiatives to include accountability for quality and cost, and future development of shared-savings models.
- The Health Quality Institute is responsible for developing key accountability measures to be used across all providers and payers

Vermont

Vermont began its major health reform initiative with the passage of legislation in 2006. Since then, the state has been engaged in a wide variety of activities aimed at increasing health care coverage, improving the quality of care, and containing costs. With the passage of the initial health reform legislation in 2006, along with subsequent legislation, the state has embarked on over 60 distinct initiatives.[55] Among these are Catamount Health, an insurance plan based on a sliding-scale fee; the Vermont Information Technology Leaders, the state's HIE infrastructure; a patient-centered medical home initiative and chronic care infrastructure; and multipayer claims capacity.

The state's Commission on Health Care Reform, the body overseeing health reform implementation, was asked to conduct a feasibility study of community-based payment reform and integration of care and included the ACO model as an area to explore. That study led to further legislative action and funding for an ACO pilot project.

The 2010 legislature continued to move the ACO work forward in Vermont. Legislative language under debate currently calls for a strategic plan for development of community health networks or systems, which is the term used for ACOs in Vermont. The first pilot is to be developed in about a year, with an additional two in 2012. Proposed language also mandates that commercial insurers participate in incentive and risk-sharing programs, such as the statewide expansion of medical home pilots and the ACO pilot. The state will put together a competitive process and application to select the pilot sites. Selection criteria include whether an organization has done medical home work, the level of IT in place, and achievement in five functional capabilities: care coordination, financial management, governance, IT support, and process improvement skills.[56]

Foundations for the ACO Model in Vermont

- Medical home initiatives
- Community health teams
- Health information technology, including a statewide, Web-based registry and clinical tracking system
- Long-standing support and involvement of insurers who have been partnering in various multipayer programs and medical homes projects
- An existing, regionally based health care system

Washington

Health reform efforts in Washington have been centered on the patient-centered medical home model. In 2007 the state legislature passed SSB 5093, directing Medicaid to explore the medical home concept for children and a directive for the Health Care Authority, which oversees seven health care programs (including the state employees health program) to also consider medical homes work. [57] In 2009, legislation was passed creating a multipayer reimbursement pilot, allowing a variety of health care payers to align payment strategies to promote quality and cost savings.[58] Further bipartisan interest was sparked in the legislature by the ACO work in Vermont, and in June 2010, SSB 6522 passed, initiating the state's ACO pilot projects. Two pilot programs will be developed, one in an integrated care system and a second among affiliated providers.

Foundations for the ACO model in Washington

- Medical homes initiatives
- Multipayer initiatives
- ACO pilot legislation
- Health information exchange work through public–private partnerships

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