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Safety-Net Provider ACOs: *Considerations for State Medicaid Purchasers*

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Introduction

The movement towards population-based payment arrangements with provider organizations is occurring rapidly in some states, and is becoming more prevalent in Medicaid programs overall.[1] Contracts can be held directly between states and provider entities, or between Medicaid managed care plans and provider organizations. From Minnesota to Oregon, Colorado to Iowa, New York and beyond, these relationships vary tremendously. In some states provider organizations are eligible to share in savings they generate through health plan contracts, while in other states they assume full risk and for all intents and purposes operate as a health plan. What they have in common is acceptance of clinical responsibility and some measure of financial responsibility for the health and health care of a defined Medicaid beneficiary population and a defined set of services. For the purposes of this brief, we will apply the term "Accountable Care Organization (ACO)" to this diverse array of provider entities and define a "safety-net provider ACO"[2] as a safety-net provider-based organization that:

1. assumes clinical responsibility for an attributed Medicaid patient population, and
2. assumes financial responsibility for that population through a shared savings or risk contract.

Experience shows that formation and operation of an ACO can be quite expensive, with budgetary requirements running into the millions of dollars.[3] For this reason, many of the early Medicaid ACOs have been organized by large, well-capitalized hospital and health systems. Safety-net providers, however, are increasingly forming ACOs to contract with Medicaid and with other payers. The organization of safety-net ACOs is sometimes driven by a state initiative, and sometimes occurs without state influence.

If states believe that population-based contracting with accountable provider entities is a potentially beneficial purchasing strategy, they will be challenged to extend this approach to safety-net providers. These providers typically lack the capital, experience and/or scale to operate as an ACO. However, given their significant role in state Medicaid programs, a state will not be able to fully implement a population-based payment strategy with ACOs if the state or its contracted health plans don't involve safety-net providers. This brief will explore the unique challenges states face in trying to achieve successful safety-net provider participation in Medicaid ACOs.

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This brief is based, in part, on work that Bailit Health completed for the Medicaid and CHIP Payment and Access Commission (MACPAC) in 2015.[4] Bailit Health studied seven safety-net ACOs across five states to understand their origins, organization, characteristics and functions and to identify federal and state policy questions associated with their emergence.

Safety-Net Providers

Safety-net providers are characterized by primarily serving uninsured, Medicaid and other low-income populations. Safety-net providers are most commonly identified as federally qualified health centers (FQHCs), rural health centers (RHCs) and disproportionate share hospitals (DSH). FQHC, RHC and DSH providers are, of course, not the only safety-net providers. Many other providers also primarily serve uninsured, Medicaid and other low-income populations.

Challenges Facing Safety-Net Providers ACO Aspirants[5]

There are four primary challenges that safety-net providers face when trying to establish and maintain an ACO:

1. Lack of capitalization: Lack of capital, particularly for non-hospital-based safety-net ACOs, appears to be a major problem. Staffing and health information infrastructure are two needed investments that undercapitalized ACOs are hard pressed to support.
2. Lack of size: Even a shared savings arrangement with no downside risk requires a significant attributed patient population. Our research suggests the population needs to number between 5,000 and 20,000[6] for there to be reasonable statistical confidence in assessment of financial impact. Many FQHCs and RHCs are relatively small primary care practices, and in states with multiple Medicaid managed care plans, their patient population will be fragmented into different risk pools.
3. Limited access to management information: ACOs must have timely, accurate and usable data to be successful. This means easy access to claims and clinical data that can be processed for analysis through sophisticated software. Most safety-net provider-led ACOs we have studied have had few analytic resources. Common deficiencies include lack of access to Medicaid claims data, lack of access to a health information exchange, poorly leveraged EHRs, lack of analysts and lack of analytic software. In some instances, safety-net provider-led ACOs have reported problems with state or health plan provision of claim data, particularly related to lack of timely access to such data.
4. The hospital conundrum: For ACOs that are led by hospitals, including safety-net hospitals, there is a conundrum. The financial imperative of the hospital is to keep beds as full as possible since most of hospital payments are still based on volume and absent significant risk-sharing arrangements, while the business interest of the ACO is to reduce hospital admissions and ED usage in order to contain costs.[7]

State Strategies to Support Safety-Net Provider Development of ACOs

There are several strategies that states can take to support safety-net providers that want to pursue ACO status and contract on a population basis with the state or Medicaid managed care plans.

1. Provide start-up investment. While Medicaid statute and regulations don't permit states to use Medicaid funds to make investments in provider ACO capacity development, states may have other options.
    - New York is investing in Delivery System Reform Incentive Payment (DSRIP)[8] funds to development ACO capacity among safety-net providers statewide.
    - Vermont has used State Innovation Model (SIM) grant funds to cover the cost of ACO medical chart abstraction for clinical quality measures and to support ACO health information capcity development.
2. Provide technical assistance. States can provide consultative support to safety-net provider ACOs.
    - The Oregon Health Authority maintains a "technical assistance bank."[9] Each contracted Coordinated Care Organization is eligible to receive up to 35 hours of consultation services per year from a state-selected contractor.
3. Create flexible contracting parameters so that small safety-net providers can come together to form an ACO. Many safety-net providers – especially primary care providers – lack the reserves or the attributed population necessary to operate as an ACO. States can help these providers by allowing them to collaborate with one another to form an ACO and addressing possible anti-trust concerns.

- Minnesota designed its Integrated Health Partnership program so that "virtual" ACOs consisting of networks of independent providers could participate without the requirement to assume downside financial risk.[10]

4. Create a health information utility to provide timely, accurate and complete analytic information to the ACO.

    - Colorado has contracted with a third party analytics contractor to provide information to its contracted Regional Care Coordination Organizations.[11]

    - North Carolina's Community Care program has provided regional physician networks with access to the Medicaid claims database, and analytic tools to help mine the database.[12]

5. Create consistent business rules across Medicaid ACO and other agreements. Many providers, regardless of safety-net status, speak of the resource implications of payers using different performance measure sets and financial risk parameters. Some also complain about multiple non-aligned state programs (e.g., health home, ACO, managed care) affecting the same beneficiaries.

    - Minnesota specified for its Medicaid managed care plans the performance measures and financial risk parameters that would govern its Integrated Health Partnership contracts.

Conclusion

States pursuing new population-based payment models with providers should consider the impact on their Medicaid programs if safety-net providers cannot successfully participate in the new models as ACO sponsors or ACO participants.

Safety-net providers face a challenging task in evolving into their own ACOs. Absent state action, they may choose to affiliate with larger (sometimes non-safety-net) delivery systems for contracting purposes, avoid ACO participation (if given the option) or fail as ACOs. An individual state may consider one or more of these scenarios to be acceptable, but they all certainly carry some potentially negative implications in terms of the viability the safety net provides in the long term.

This brief highlights the approaches some states have made to support providers to succeed in a new Medicaid ACO environment. Working either directly with ACOs, or through contracted Managed Care Organizations (MCOs), states have a variety of steps they can take to increase the likelihood that safety-net providers will successfully transition to a new world through provision of infrastructure support and technical assistance.

Endnotes

[1] *Medicaid Accountable Care Organizations: State Update,* Center for Health Care Strategies, Inc., August 2015, http://www.chcs.org/media/ACO-Fact-Sheet-8615.pdf. Accessed January 2016.

[2] For a narrower definition of safety-net provider ACO that excludes entities operating as health plans, see Bailit Health Purchasing and Abt Associates (Waldman B and Bailit M), *A Study of Safety-Net Providers Functioning as Accountable Care Organizations*. Medicaid and CHIP Payment and Access Commission (MACPAC), July 28, 2015, https://www.macpac.gov/publication/a-study-of-safety-net-providers-functioning-as-accountable-care-organizations/. Accessed December 2015.

[3] Gamble M., "ACOs Take $4M of Startup Capital, Survey Finds" *Becker's Hospital Review* January 27, 2014, and *Adopting Accountable Care: An Implementation Guide for Physician Practices*, Engelberg Center for Health Care Reform at Brookings, November 2014. http://www.beckershospitalreview.com/accountable-care-organizations/acos-need-4m-of-startup-capital-survey-finds.html. Accessed December 2015.

[4] Waldman B and Bailit M, *A Study of Safety-Net Providers Functioning as Accountable Care Organizations*, MACPAC 2015.

[5] Ibid.

[6] A population of 5,000 may be sufficient if beneficiaries eligible due to disability are included. If the population consists of relatively healthy women and children, however, the population may need to number between 15,000 and 20,000. See Weismann JS, Bailit M, D'Andrea G and Rosenthal MB. "The Design And Application Of Shared Savings Programs: Lessons From Early Adopters" *Health Affairs* 31 (9) September 2012. http://content.healthaffairs.org/content/31/9/1959.abstract. Accessed December 2015.

[7] Bailit M, Tobey R, Maxwell J and Bateman C, *The ACO Conundrum for Hospitals: Safety-Net Hospitals in the Era of Accountable Care*, Robert Wood Johnson Foundation, Princeton, NJ, May 2015. http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=15622&thisSection=Resources. Accessed December 2015.

[8] *Delivery System Reform Incentive Payment (DSRIP) Program*, New York State Department of Health, www.health.ny.gov/health_care/medicaid/redesign/dsrip/.

[9] *Technical Assistance Bank*, Oregon.gov Transformation Center, www.oregon.gov/oha/Transformation-Center/Pages/Technical-Assistance-Bank.aspx.

[10] *Integrated Health Partnerships (IHP) Overview*, Minnesota Department of Human Services, www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441.

[11] *Statewide Data Analytics Contractor (SDAC)*, Colorado Department of Health Care Policy & Financing, www.colorado.gov/pacific/hcpf/statewide-data-analytics-contractor-sdac.

[12] *Truth in Numbers: A data-rich resource for CCNC partners*, Community Care of North Carolina, www.communitycarenc.org/informatics-center/.