Alternative Models for Medicaid Expansion

December 8, 2014

Maia Crawford
Center for Health Care Strategies
A non-profit health policy resource center dedicated to improving services for Americans receiving publicly financed care

- **Priorities**: (1) enhancing access to coverage and services; (2) advancing quality and delivery system reform; (3) integrating care for people with complex needs; and (4) building Medicaid leadership and capacity.

- **Provides**: technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.

- **Funding**: philanthropy and the U.S. Department of Health and Human Services.
## Select CHCS National Initiatives

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*Federally-funded initiatives*
27 States and the District of Columbia have Expanded Medicaid

Map: Where States Stand on Medicaid Expansion Decisions

*Map updated November 25, 2014

Source: NASHP https://www.statereforum.org/Medicaid-Expansion-Decisions-Map
States are Laboratories for Developing/Testing Health Reform Solutions

- Most Medicaid expansion states are implementing the “traditional” expansion through State Plan Amendments
- Small number of states are using 1115 waivers to implement alternative expansion models
  - Makes expansion more palatable in conservative states
  - Tailored to a state’s culture and politics
  - Innovation that might spread
  - Some key differences from traditional Medicaid, with potential implications for vulnerable populations
## Alternative Medicaid Expansion Characteristics

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Other States Considering Expansion

- **Indiana**
  - Two distinct programs based on income level: higher-income beneficiaries pay premiums and receive more benefits, lower-income individuals can choose a plan with fewer benefits and co-pay requirements (but no premiums)
  - Use of health savings accounts

- **Wyoming**
  - Premiums for individuals 100-138% FPL, co-pays for all income levels
  - Decided against private option because of high marketplace plan costs

- **Utah**
  - Seeks state innovation waiver for expansion via block grant
  - Private option, with assistance level based on: ability to work, household income, access to existing coverage, and health care needs
Themes from Alternative Medicaid Expansion Models

1. Reliance on the private insurance market through premium assistance programs;
2. An emphasis on healthy behaviors and personal responsibility;
3. Exemptions from current Medicaid rules on premiums and benefits; and
4. Limits or contingencies on the expansion if federal funding is reduced (a.k.a., the “circuit breaker” provision).
Premium Assistance

Uses Medicaid funds to pay premiums or enroll Medicaid-eligible individuals in commercial coverage; offers “private market lens” for expansion

Waiver Requirements

- Cost neutral to the federal government and “cost effective” for state Medicaid programs
- Provides the same benefits and cost-sharing protections afforded traditional Medicaid enrollees
- No eligibility or enrollment caps
- Covers the newly eligible adult group
  - Special populations, like the medically frail, not included
- Solicits public input through a minimum 30-day comment period
- Waivers end by December 31, 2016
Premium Assistance

**OPPORTUNITIES**

- Larger marketplace allows for greater competition among health plans
- Spreads the risk within the marketplace → lower premiums
- Providers could be paid commercial rates
- Reduces churn
- Leverages administrative infrastructure of the marketplace

**CHALLENGES**

- Hard to determine appropriate assistance level
- Standard Medicaid could become a high-risk pool by default
- Commercial rates for providers could increase overall Medicaid costs
- Contracting considerations for safety net providers
Personal Responsibility Provisions

Healthy Behavior Incentives
- Premiums and co-pays reduced if beneficiaries complete health and wellness activities, like health risk assessments

Co-Payments
- IA and PA plans charge co-pays for non-urgent use of ER
- MI, AR, and NH plans charge co-pays for a range of services

Health Savings Accounts
- In MI, beneficiaries deposit money for co-pays and other health expenses in health accounts
- IN proposing expansion plan with health savings accounts
Personal Responsibility Provisions

**OPPORTUNITIES**

• Steers individuals toward high-value services and providers
• Guards against excessive use of health services (e.g., improper use of the emergency room)
• Promotes greater consumer engagement in health care decision-making
• Demonstrates increasing CMS flexibility

**CHALLENGES**

• Additional administrative complexities
• Can penalize individuals without the access or ability to make behavior changes
• Effectiveness of changing behaviors among the very low income not proven
Cost Sharing and Benefit Limits

**Premiums**

- Traditional Medicaid does not allow premiums below 150% FPL
- IA was approved to charge premiums starting at 50% FPL
- MI is charging premiums starting at 100% FPL
- Premiums cannot exceed 2% of total income

**Health Benefits**

- Traditional Medicaid covers 15 mandatory benefits, including non-emergency transportation, family planning, and community health center services
- IA is not covering non-emergency transportation during Year 1
Cost Sharing and Benefit Limits

**OPPORTUNITIES**

- Potential to reduce state Medicaid spending through higher out-of-pocket costs and more limited benefits
- Provides states greater flexibility to innovate and tailor programs to meet unique circumstances

**CHALLENGES**

- Negative effects on Medicaid beneficiaries, particularly very low-income and vulnerable populations
- Provider and health plan obligations to collect/track payments
- “Slippery slope” -- where does CMS draw the line?
The IA, MI, and NH plans have “circuit breaker” or sunset provisions, terminating the expansion if the federal government reduces its enhanced Medicaid match rate below ACA levels.
“Circuit Breaker” Provision

**OPPORTUNITIES**

- Protects state from higher Medicaid costs if federal government reduces contribution
- Provides incentive for federal government to continue fully funding expansion

**CHALLENGES**

- May reduce federal flexibility to change payment policy if costs rise higher than expected
- Could result in states dropping Medicaid expansion if the federal government lowers the matching rate
State Innovation Waivers

• §1332 of the ACA, available in 2017
• Must provide comprehensive, affordable coverage to as many individuals as would be covered under the ACA
• Allows state-specific reforms that can deviate from ACA requirements, including:
  ► Qualified Health Plan provisions, including the essential health benefits package
  ► Premium tax credits
  ► Cost-sharing reduction payments
  ► Individual mandate
  ► Employer responsibility requirements
What Does the Future Hold?

- Will Arkansas continue its private option expansion?
- Will new governors in Maryland, Massachusetts and Illinois propose changes to the “traditional” Medicaid expansion models already in place?
- Could Texas and Florida choose to expand?
- Will Pennsylvania convert to a “traditional” expansion?
- Which states will be first out of the gate with state innovation waivers: Vermont, Minnesota, Oregon, others?
Questions?
Visit CHCS.org to...

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- **Learn** about cutting-edge efforts to improve care for Medicaid’s highest-need, highest-cost beneficiaries

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### Appendix: Alternative Expansion Model

#### Features by State

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| AR    | • Premium assistance for all new enrollees | • Newly eligible adults between 17-133% FPL | • No premiums  
• Co-pays for individuals 100-133% FPL; beginning in 2015 will apply to individuals from 50-133% FPL | • All regular Medicaid benefits  
• State provides non-emergency transportation and EPSDT through wrap |
| IA    | • Standard expansion for <100% FPL  
• Premium assistance for 101-133% FPL (via Marketplace or employer plans) | • Newly eligible adults up to 133% FPL (medically frail also have option to enroll in the standard expansion plan) | • $20 premiums for individuals 100-133% FPL, unless meet health goals  
• $10 co-pay for non-urgent use of ED | • Same benefits as state employees  
• No wrap for non-emergency transportation |
## Appendix: Alternative Expansion Model

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<td>MI</td>
<td>• Standard expansion with use of health savings-like accounts</td>
<td>• Newly eligible adults up to 133% FPL</td>
<td>• Co-pays for all beneficiaries&lt;br&gt;• Beneficiaries 101-133% FPL: premiums up to 2% of income (reduced with healthy behaviors)</td>
<td>• All Medicaid benefits</td>
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<tr>
<td>PA</td>
<td>• Premium assistance for all new enrollees via managed care plans (not through marketplace)</td>
<td>• Newly eligible adults up to 133% FPL</td>
<td>• Premiums for individuals 100-133% FPL, not to exceed 2% of income, with reductions if health goals met&lt;br&gt;• $10 co-pay for non-urgent use of ED</td>
<td>• EHB package&lt;br&gt;• No wrap for non-emergency transportation</td>
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<td>NH</td>
<td>• Managed care as bridge to premium assistance in 2016 (pending approval of federal waiver)</td>
<td>• Newly eligible adults up to 133% FPL</td>
<td>• Co-pays for individuals 100-133% FPL on Rx drugs and some services.</td>
<td>• All Medicaid benefits</td>
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As of February 2014, 25 states and the District of Columbia have expanded Medicaid to adults up to 133 percent of the federal poverty level (FPL), while 25 states are still considering expansion or have not chosen to expand. Of those implementing or pursuing expansions, four states—Arkansas, Iowa, Pennsylvania and Michigan—have bypassed the Affordable Care Act’s (ACA) expansion pathway and are pursuing alternative models. These states are using authority granted by the Centers for Medicare & Medicaid Services (CMS) via Medicaid state plan amendments (SPA) or 1115 waivers to pay for health insurance outside the traditional Medicaid program.

Arkansas and Iowa received CMS approval in 2013 to create premium assistance programs that use Medicaid funds to purchase private coverage for newly eligible Medicaid beneficiaries. Pennsylvania is also seeking to implement a premium assistance program; it is currently in negotiation with CMS about its proposed design. Michigan’s waiver to expand its traditional Medicaid program, but incorporate new and unconventional features—like using health savings-like accounts and tying cost-sharing to healthy behaviors—was approved by CMS in December 2013.

These new models allow states to use federal funds to cover previously uninsured populations while potentially mitigating the political consequences associated with enlarging an existing government program. This brief provides information about these alternative models and can help inform decision-makers seeking non-traditional Medicaid expansion options. Common themes from these models include:

- Reliance on the private insurance market;
- Exemptions from current Medicaid rules on cost-sharing, benefits, time limits and work requirements;
- An emphasis on healthy behaviors and personal responsibility; and
- Limits or contingencies on the expansion, including ending the expansion program if the federal government reduces its enhanced matching rate (“circuit breaker” provision).

States that have not yet expanded Medicaid can look to these non-traditional expansion proposals for ideas on expanding coverage to previously uninsured individuals. The Center for Health Care Strategies (CHCS) developed this brief in response to interest from Medicaid Leadership Institute fellows.

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*States that are in the process of submitting expansion waivers to CMS (such as Pennsylvania), or recently announced their intentions to expand Medicaid (such as Utah and New Hampshire), are not counted as expansion states.*

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Background on Premium Assistance Programs

Premium assistance programs are not new: since 1965 states have had the option to use federal Medicaid dollars to pay for private health insurance premiums through Section 1906 of the Social Security Act. In 2010, 39 states offered some sort of premium assistance program, serving as few as five and up to roughly 31,000 individuals per state. These programs generally subsidize premiums for Medicaid- and CHIP-eligible individuals enrolled in employer-sponsored insurance, though they tend not to enroll many people, as low-income individuals often do not have access to health coverage through a job. No state, however, has ever chosen to cover an entire subset of beneficiaries with a premium assistance program because of:

1. **High Costs**: Private insurance tends to cost more than Medicaid, due in large part to higher provider reimbursement rates and administrative costs; and
2. **Limited Coverage Options**: There are few suitable private insurance products available to purchase for the medically needy subset of the Medicaid population.

The post-ACA health care landscape makes the establishment of large-scale premium assistance programs a more affordable and realistic option for states for several reasons. First, state Medicaid programs have access to a significant influx of new funding: the federal government will pay 100 percent of the cost of expanding Medicaid between 2014 and 2016, phasing down to 90 percent of costs by 2020. Second, the newly operational health insurance marketplaces provide the infrastructure necessary to cover large numbers of Medicaid beneficiaries in non-employer-based plans. Marketplaces offer a range of private insurance options called qualified health plans (QHPs), all of which include a standard, comprehensive package of items and services known as “essential health benefits.” The creation of marketplaces are especially significant for states like Arkansas that lack a strong Medicaid managed care presence, as these states previously had no public or private plans available to cover Medicaid beneficiaries in a cohesive, organized fashion. Finally, marketplace plans may cost less than many pre-ACA private options thanks to greater consumer purchasing power, more plan competition, and narrower networks.

Premium Assistance Considerations

States should consider the likely effects a premium assistance expansion program will have on Medicaid beneficiaries and the state health care system as a whole when considering which type of expansion to pursue. A private Medicaid program’s anticipated benefits and downsides include:

- **Reduced Churn**: Research suggests that of the estimated 96 million Americans eligible to receive Medicaid or marketplace subsidies during a given year, up to 29 million are likely to “churn” between coverage options, and seven million are likely to experience coverage shifts between Medicaid and marketplace policies. If Medicaid-eligible individuals are enrolled in marketplace QHPs instead of traditional Medicaid and their incomes rise above the Medicaid eligibility ceiling, they can stay in private coverage rather switch insurance plans and/or providers. In states like Arkansas with low pre-ACA thresholds for adult Medicaid eligibility, this seamlessness across Medicaid and the marketplace could reduce churning by nearly two thirds, resulting in better continuity of care. In states with higher traditional income limits for Medicaid, a premium assistance model will lead to some churning between the pre-ACA Medicaid-eligible group (still covered under

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1 Prior to ACA passage, working parents in Arkansas had to make less than 16 percent FPL to qualify for Medicaid, while childless adults were not eligible for full Medicaid coverage at any income.
publicly run plans) and the newly eligible group covered by marketplace plans—though overall churning should still be reduced.\(^8\)

- **Better Access to Providers**: Individuals enrolled in private commercial plans may have better access to health care than traditional Medicaid beneficiaries, as more providers accept commercial insurance than Medicaid. A 2012 Government Accountability Office study found 7.8 percent of working-age adults with Medicaid had difficulty accessing needed services, compared with 3.3 percent of similar adults with private insurance, a statistically significant difference.\(^9\) Furthermore, a national 2011 study found that almost a third of all physicians refused to accept new Medicaid patients, compared to 19 percent refusing new commercial patients and 17 percent refusing new Medicare patients.\(^10\) Medicaid beneficiaries with private coverage may therefore gain access to a wider range of medical practitioners and care options, while those with traditional Medicaid may have a smaller pool of providers to choose from, a harder time booking appointments, and less positive provider interactions.

- **Higher Overall Costs**: Medicaid is almost always cheaper than private plans, so any proposal to cover individuals via private coverage instead of Medicaid should have a higher immediate price tag. In 2012, the Congressional Budget Office estimated that by 2022, the average person who enrolled in a marketplace plan instead of Medicaid would cost the federal government about $3,000 more ($9,000 vs. $6,000).\(^11\) Milliman, an actuarial consulting form, estimated premium assistance programs to cost 20 percent to 40 percent more than traditional Medicaid programs, though the amount depends on a state’s provider reimbursement rates.\(^12\)

**Federal Requirements for Premium Assistance Models**

States looking to use Medicaid dollars to purchase coverage through marketplace QHPs must apply to CMS for a SPA or 1115 Medicaid demonstration waiver. Under a SPA, enrollment in a private plan is optional, while a state using a waiver may require eligible beneficiaries to enroll in private coverage. If using a waiver, states must also solicit public input through a minimum 30-day comment period. All of the states featured in this brief used an 1115 waiver to implement their premium assistance demonstrations, and the information in this section is specific to waiver-based expansions.

CMS stated in a March 2013 bulletin that it will consider approving “a limited number” of premium assistance demonstration waivers, noting that these waivers will help inform the planning and approval of State Innovation Waivers, which begin in 2017.\(^13\) According to CMS, premium assistance demonstrations must further the objectives of the Medicaid program and should provide the same benefits and cost-sharing protections afforded traditional Medicaid enrollees. This means that if Medicaid-eligible individuals enroll in a private QHP with a more limited benefits package than traditional Medicaid, the state needs to provide “wrap-around” benefits that fill in any gaps. States must also pay for any out-of-pocket costs beyond what is allowed under Medicaid rules.
Despite these general guidelines entitling premium assistance enrollees to all Medicaid benefits and cost-sharing protections, CMS has approved demonstrations that provide fewer Medicaid benefits and/or additional payment requirements than under traditional Medicaid. For example, federal rules prohibit imposing premiums on traditional Medicaid beneficiaries with incomes under 150 percent FPL, yet CMS authorized Iowa to charge premiums starting at 100 percent FPL (with individuals between 100 and 133 percent FPL paying premiums up to two percent of income—the ACA’s contribution limit for marketplace consumers in this income range). CMS also waived Iowa’s obligation to provide non-emergency medical transportation through a wrap-around benefit for one year. Pennsylvania’s waiver seeks similar exemptions from standard Medicaid rules.

CMS restricts enrollment in a Medicaid premium assistance expansion program to individuals whose benefits align closely with those available in QHPs; for most states, this means limiting the eligible population primarily or exclusively to the newly eligible adult group. Special Medicaid populations, like the medically frail,* do not qualify.14 CMS also requires that premium assistance programs be “cost effective” for states and budget neutral for the federal government (see the “Cost Effectiveness” sidebar). CMS guidance15 suggests states may have a better chance at having their premium assistance waiver accepted if:

1. **Individuals below 100 percent FPL remain in state plan Medicaid:** CMS may be more inclined to approve a state’s 1115 waiver if the state limits premium assistance enrollment to new adults with incomes between 100-133 percent FPL—those beneficiaries most likely to shift between Medicaid and marketplace coverage due to income changes.16 While Arkansas enrolled the entirety of the expansion population in marketplace coverage, the medically needy group at all income levels will remain in state plan Medicaid. Iowa is the one state thus far that has chosen to limit its premium assistance program to newly eligible beneficiaries with incomes between 100-133 percent FPL, while keeping individuals under 100 percent FPL in a traditional, public Medicaid program. Other states are considering premium assistance waivers for targeted, previously-eligible groups, such as pregnant women above 133 percent FPL.

2. **No eligibility or enrollment caps are imposed:** CMS has advised that capping eligibility at an income threshold below 133 percent FPL would make the state ineligible to receive the enhanced federal match rate. States that wish to implement a “partial expansion” (e.g., at an income level below 133 percent FPL) can apply for an 1115 waiver at the state’s regular Medicaid matching rate. CMS also indicated that it will not approve expansion waivers that include enrollment caps.

3. **Waivers have short duration.** Finally, all alternative Medicaid expansion waivers will end by December 31, 2016. States looking to expand these programs into 2017 and beyond must apply for State Innovation Waivers.

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* According to 42 CFR 440.315, a state’s definition of individuals who are medically frail or otherwise have special medical needs must at least include children described in 42 CFR 438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and/or mental disabilities that significantly impair their ability to perform one or more activities of daily living.
As of February 2014, two states—Arkansas and Iowa—have approved 1115 waivers for premium assistance Medicaid expansions. Pennsylvania will submit its final waiver to CMS in 2014. Following are summaries of each state’s approach.

Arkansas
Arkansas became the first state to gain federal approval for a Medicaid premium assistance expansion plan, with CMS approving Arkansas’ three-year waiver on September 27, 2013. The state began open enrollment October 1, alongside states expanding Medicaid through traditional means, and started covering newly eligible adults on January 1, 2014. In order for Arkansas to continue its Arkansas Health Care Independence Program past the current state fiscal year on June 30, 2014, three-fourths of both legislative houses must approve a new appropriation to accept federal matching funds. It is unclear at this time whether there are enough votes to accept the funding and maintain the expansion program.17

- **Populations Covered.** Arkansas’ waiver will cover an estimated 200,000 newly eligible adults (parents 17-133 percent FPL and childless adults 0-133 percent FPL) through QHPs on the state’s marketplace. Medically frail adults are not eligible and will receive coverage via traditional fee-for-service Medicaid. Participation is mandatory for all non-medically needy, newly Medicaid-eligible adults in the state.

- **Cost-Sharing.** Arkansas is not imposing any premiums on beneficiaries; the state will pay all premium costs directly to commercial plans. Co-pays and deductibles will apply only to individuals with incomes between 100 percent and 133 percent FPL in 2014, though the state has proposed applying them to beneficiaries with incomes between 50 percent and 133 percent FPL in 2015-2016. Cost-sharing is limited to 5 percent of annual income and all other federal beneficiary cost-sharing limits apply. The state will advance monthly cost-sharing reduction payments to QHPs to cover the difference between private cost-sharing rates and Medicaid requirements.

- **Benefits.** New enrollees can choose to enroll in any silver-level QHP on the state marketplace available in their service area; at least one QHP in every service area is required to contract with a local community health center. The only notable benefits the state must provide through a ‘wrap’ of the QHP are non-emergency transportation and limited Early Periodic Screening Diagnosis and Treatment (EPSDT) benefits for 19- and 20-year-olds. Unlike other states, Arkansas did not choose to waive any benefits for its premium assistance Medicaid beneficiaries.

- **Cost-Effectiveness.** CMS officially waived Arkansas’ cost-effectiveness requirement, noting that the state may use “state developed tests of cost effectiveness that differ from otherwise permissible tests for cost effectiveness.”18 The state estimates the cost of its premium assistance Medicaid expansion to be comparable to a public Medicaid expansion plan, though this estimate takes into account “equal access” considerations (discussed in call-out box). The state’s actuaries initially estimated that per-person, per-month private option costs would be about 24 percent higher than costs under traditional Medicaid expansion. After taking into account the effects of more marketplace competition, more efficient health plan management, and more astute consumer decision-making, this initial estimate was reduced to 13-14 percent.19 Ultimately, the state’s actuaries argued that while the premium assistance program might cost 13-14 percent more, this estimate does not take into account the likely increase in Medicaid provider reimbursement rates that the state argued would be required to secure access for a Medicaid expansion population.20 In other words, the state made the case to
CMS that the higher cost of purchasing marketplace coverage for Medicaid eligible individuals buys better access to care, thereby making the program “cost effective.”

**Iowa**

Iowa’s two complimentary 1115 Medicaid demonstration waivers were approved by CMS on December 10, 2013. While the state had requested a waiver until 2018, CMS approved the demonstration through December 31, 2016. Iowa’s governor accepted the federal government’s terms and implementation began on January 1, 2014. State law contains “circuit breaker” language, making the expansion contingent upon the federal government not reducing current federal Medicaid matching funding rates.

- **Populations Covered.** Iowa’s 1115 waivers create two new programs to cover the anticipated 190,000 Iowans below 133 percent FPL:

  1. **The Iowa Marketplace Choice Plan** provides private coverage to newly Medicaid-eligible adults between 101-133 percent FPL who meet all other eligibility criteria for the Medicaid expansion and do not have access to employer-sponsored insurance. Those with access to affordable employer-based coverage will receive premium assistance for this coverage—a continuation of the state’s existing Section 1906 premium assistance program.

  2. **The Iowa Wellness Plan** is a new public Medicaid program available to newly eligible individuals below 100 percent FPL. It will be administered by Iowa Medicaid and provide access to the same providers available in the state’s current Medicaid program. Beneficiaries will be eligible for 12 months of coverage via Medicaid managed care arrangements. Medically frail individuals have the choice to enroll in the Iowa Wellness Plan or regular Medicaid.

- **Cost-Sharing.** Iowa had requested the ability to require monthly premiums for all Medicaid enrollees between 50-133 percent FPL, but the final terms and conditions issued by CMS only allow the state to charge premiums up to two percent of annual income for individuals with incomes over 100 percent FPL. Starting in the second year of the demonstration, $20 monthly premiums will be required for all beneficiaries in the Iowa Marketplace Choice Plan unless they demonstrate they have met certain health goals (this includes completing a health risk assessment and undergoing a wellness exam in Year One and completing preventive health activities in later years). Beneficiaries cannot be disenrolled if they are unable to pay the premium costs. Beginning in the second year of the demonstration, beneficiaries will also be charged a $10 co-pay for non-emergent use of the emergency room. Out-of-pocket costs cannot exceed 5 percent of income, and beneficiaries can apply for hardship waivers if they have difficulty paying their premiums.

- **Benefits.** The benefits offered in both the Iowa Wellness Plan and marketplace QHPs are equivalent to state employee coverage. CMS approved Iowa’s request to waive the requirement to provide non-emergency transportation to all new Medicaid enrollees for the first year (though the state must conduct an evaluation of this policy decision). The state will provide wrap-around EPSDT services for 19- and 20-year-olds.

- **Cost-Effectiveness.** Iowa’s waivers provided little detail on the issue of cost-effectiveness or budget neutrality.
Pennsylvania

Pennsylvania’s submitted a draft 1115 premium assistance waiver to CMS on Friday, December 6, 2013; the final waiver is expected to be submitted to CMS in early 2014, after the state reads and incorporates suggestions submitted during the public comment period. The Medicaid expansion would begin in 2015. This waiver proposal, like Iowa’s, has a strong health and wellness component, though it seeks more dramatic changes to traditional Medicaid than Arkansas or Iowa. Pennsylvania’s proposal contains 23 requests to waive or change federal law, while Arkansas's waiver included just three.

- **Populations Covered.** Pennsylvania’s premium assistance proposal would cover newly eligible adults in marketplace QHPs (parents 33-133 percent FPL and childless adults 0-133 percent FPL), including individuals currently enrolled in several state-funded programs. The Commonwealth’s proposal to CMS requires individuals who are unemployed or working less than 20 hours a week to complete work-search activities (such as enrollment in a job search or training program) as a condition of Medicaid eligibility. Those who fail to meet the work requirements risk losing Medicaid for up to nine months. CMS has never approved a waiver that included a work-search provision. The waiver also seeks to waive the 90-day retroactive eligibility provided by Medicaid.

- **Cost-Sharing.** Pennsylvania is proposing monthly premiums up to $25 for individuals and $35 for families earning more than 50 percent FPL, with exemptions for pregnant women, people with disabilities, the elderly, and residents of institutions. The waiver proposes a $13 monthly premium for individuals earning between 50-100 percent FPL and a $17 premium for families in this income range. The state would reduce premiums by 25 percent for beneficiaries who engage in certain healthy behaviors (which initially include completing a health risk assessment and physical). The waiver seeks significant flexibility to determine the types of healthy behaviors to promote. Pennsylvania’s plan would reduce premiums by another 25 percent for individuals who work 30 or more hours per week. Pennsylvania does not include any co-pays except for a $10 change for a non-emergency visit to the emergency room.

- **Benefits.** Single adults eligible for the Medicaid expansion who are not medically frail will receive the essential health benefits package through a commercial plan. The proposal seeks to waive the requirement to offer an alternative benefit plan to the Medicaid population, which would allow the state to limit benefits to the EHB package offered by QHPs. Effectively, the Commonwealth is proposing to not offer family planning services, non-emergency transportation, community health center services, and certain drugs to newly eligible beneficiaries. For the state’s currently eligible Medicaid population, Pennsylvania’s proposal creates two new benefit plans: (1) a low-risk benefits package for healthier individuals that would include a limited set of services; and (2) a high-risk package for individuals with complex health conditions that would include a more comprehensive set of benefits. Individuals’ health status will be measured using a health screening questionnaire. All newly eligible medically frail individuals, SSI beneficiaries, pregnant women, dually-eligible individuals, residents of institutions, and individuals receiving home- and community-based services will be enrolled into the High-Risk Alternative Benefit Plan. Others eligible for current Medicaid will receive the Low-Risk Alternative Benefit Plan. Children under 21 and newly eligible adults who are 19 or 20 will receive the EPSDT benefits package.

- **Cost-Effectiveness.** Pennsylvania is currently negotiating the financing mechanism for its waiver, but in its initial proposal outlined plans to use a "per capita" budget neutrality cap for the populations covered under the demonstration, including the Healthy Pennsylvania Private Coverage Option. This is a typical approach for an 1115 waiver,
which puts the state at financial risk for higher per person costs, but not overall higher than expected enrollment. 21

Other Alternative Medicaid Expansion Models

Premium assistance is not the only model states are pursuing to expand Medicaid. Michigan, for example, will enroll its expansion population in public plans, but plans to require beneficiaries to deposit money into health accounts to actively participate in paying for their care, similar to a model used by Indiana. It is also working to create incentives for healthier behaviors among beneficiaries.

Michigan

In December 2013, CMS approved Michigan’s amendment to an existing 1115 waiver to create an alternative Medicaid expansion option. The state anticipates enrollment in “Healthy Michigan” to begin April 1, 2014. The five-year demonstration will enroll newly eligible adults in Medicaid managed care plans and will require all beneficiaries to use health savings accounts to pay for health expenses. Like Iowa’s plan, cost-sharing amounts will be tied to health behaviors. Like Iowa, Michigan’s expansion contains “circuit breaker” language, making implementation contingent on sustained 100 percent federal funding for the 0-133 percent newly eligible population through 2016.

■ Populations Covered. Healthy Michigan will cover an estimated 400,000 newly Medicaid-eligible Michigan residents: childless adults between 35-133 percent FPL (those under 35 percent FPL currently qualify for a limited benefits program) and working parents between 64-133 percent FPL. The state is also separately pursuing a second waiver that would allow it to limit Medicaid enrollment for many of the newly eligible population to 48 months.

■ Cost-Sharing. Michigan’s plan will establish health savings-like accounts (called MI Health Accounts) into which Medicaid beneficiaries and the state will deposit money for health expenses. Enrollees with incomes between 100-133 percent FPL will pay a monthly premium of two percent of their income into the account (e.g., $20 a month for someone with an income of $12,000). All beneficiaries will also be required to pay co-pays after the first six months (except those exempt from paying under federal law), totaling no more than three percent of their income, with total out-of-pocket costs not exceeding five percent of income. Co-pays will not exceed amounts in the ACA’s cost-sharing regulations and will go directly to health plans instead of to providers. There will not be co-pays for preventive services, high-value drugs, emergency services, or emergency hospital admissions.

Beneficiaries who complete an annual health risk assessment and are deemed to have healthy behaviors will have their out-of-pocket costs reduced. The state is also considering collecting missing payments through a lien on tax refunds, though it has not officially requested this authority.

■ Benefits. Healthy Michigan benefits will include the ACA’s essential health benefits, which will add habilitative services, hearing aids, and additional preventive health care services to the state’s current Medicaid benefits package. The state is also planning to use enhanced Medicaid financing to help pay for early identification, care coordination, and treatment in its existing mental health and substance abuse programs.
Cost-Effectiveness. Michigan has concluded that its expansion plan has no net cost to state. The proposal is estimated to save the state $320 million in uncompensated care costs by 2022.  

Conclusion

While it is too early to tell how these Medicaid experiments will work, Arkansas has already enrolled over 80,000 individuals in Medicaid since January 1, 2014, and Iowa and Michigan are on track for implementation in early 2014. As intended in the law, these experiments could be precursors to more widespread state-driven innovations in 2017 under Section 1332 of the ACA. States that have not yet developed expansion plans can look to these early innovators for insights, though may wish to consider unique models that will further inform national Medicaid program design. Once again, states are meeting the challenge of Justice Brandeis and others who expect them to be laboratories for innovation in American domestic policy.

The authors would like to acknowledge and thank Dr. Benjamin Sommers from the Harvard School of Public Health for his comments and suggestions.
Endnotes

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10 S. L. Decker. "In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help." Health Affairs 31, no.8 (2012): 1673-1679.
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15 Ibid.
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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.
Alternative Medicaid Expansion Models: Common Themes

Of the states implementing or pursuing Medicaid expansions, four states—Arkansas, Iowa, Michigan, and Pennsylvania—have bypassed the Affordable Care Act’s (ACA) conventional expansion pathway and are pursuing alternative models. These states are using authority granted by 1115 waivers from the Centers for Medicare & Medicaid Services (CMS) to run demonstrations testing new coverage approaches. The expansion demonstrations allow states to use federal funds to cover previously uninsured populations while potentially mitigating the political consequences associated with enlarging an existing Medicaid program. Four common themes from these models include:

1. **Reliance on the Private Insurance Market: Premium Assistance Programs**
   Arkansas and Iowa received CMS approval in 2013 to create premium assistance programs that use Medicaid funds to purchase private coverage for newly-eligible Medicaid beneficiaries. Pennsylvania is also seeking to implement a premium assistance program and is in negotiation with CMS about its proposed design. Under all three demonstrations, Medicaid beneficiaries receive health coverage through qualified health plans (QHPs) in health insurance marketplaces. Anticipated benefits and downsides to providing private, marketplace-based health coverage to Medicaid beneficiaries include:
   - **Reduced churn**: Research suggests that up to 29 million Americans eligible to receive Medicaid or marketplace subsidies are likely to “churn” between coverage options, and seven million are likely to experience coverage shifts between Medicaid and marketplace policies. Medicaid beneficiaries in QHPs can stay enrolled in private coverage, rather than switch insurance plans and/or providers.
   - **Better access to providers**: Individuals enrolled in private commercial plans may have better access to health care than traditional Medicaid beneficiaries, as more providers accept commercial insurance than Medicaid.
   - **Higher costs**: Private coverage is almost always more expensive than traditional Medicaid, so premium assistance programs will likely have a higher immediate price tag. Milliman, an actuarial consulting firm, estimated premium assistance programs to cost 20 to 40 percent more than traditional Medicaid programs, though the precise amount depends on a state’s provider reimbursement rates.

2. **Healthy Behaviors and Personal Responsibility**
   Iowa, Michigan, and Pennsylvania’s alternative expansion models include policies that aim to promote healthy behaviors and individual responsibility. Their plans seek to:
   - **Deter unnecessary use of the emergency room**: Iowa and Pennsylvania plan to charge co-payments for non-emergency visits to the emergency room.
   - **Tie premiums to wellness activities**: Iowa will waive premiums for beneficiaries who meet health goals (undergoing a health risk assessment and wellness exam in the first year, and completing preventive health activities in later years); Pennsylvania’s proposed plan would reduce premiums

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1Pennsylvania’s 1115 waiver has been submitted to CMS and is currently under review. New Hampshire recently passed legislation to expand Medicaid through direct coverage starting in July 2014 and will submit a waiver to establish a premium assistance program in 2016.

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Made possible through support from the Robert Wood Johnson Foundation. April 2014
by 25 percent for engaging in healthy behaviors; and Michigan’s program reduces out-of-pocket costs for completing wellness activities — starting with a yearly health-risk assessment.

- **Require use of health savings accounts**: Michigan requires Medicaid beneficiaries to deposit money for co-pays and other health expenses into a health savings-like account to help individuals become more actively engaged in their health care decisions.

### 3. Exemptions from Current Medicaid Rules

CMS has issued guidance requiring premium assistance programs to further the objectives of the Medicaid program and provide the same benefits and cost-sharing protections afforded traditional Medicaid enrollees. CMS, however, waived some aspects of this requirement by allowing alternative expansion programs to offer fewer benefits and/or additional payment requirements than under traditional Medicaid (see table below).

**Alternative Expansion Models: Key Exemptions from Medicaid Requirements**

<table>
<thead>
<tr>
<th></th>
<th>TRADITIONAL MEDICAID REQUIREMENTS</th>
<th>ALTERNATIVE EXPANSION MODEL EXEMPTIONS</th>
</tr>
</thead>
</table>
| **PREMIUMS**           | • Medicaid programs cannot charge premiums to individuals under 150% FPL. | • Iowa is charging premiums for individuals from 100–133% FPL, capped at $10/month, after the first year of enrollment.  
• Michigan is charging premiums equal to 2% of income for individuals from 100–133% FPL.  
• Pennsylvania is proposing charging premiums for individuals from 100–133% FPL: $25 a month for an individual or $35 for a family after year one. |
| **BENEFITS**           | • Medicaid programs are required to cover 15 mandatory benefits, including non-emergency transportation, family planning services, and community health center services. | • Iowa is not covering non-emergency transportation for the first year.  
• Pennsylvania is proposing to waive the provision of Medicaid benefits not covered by QHPs, such as family planning, non-emergency transportation, and community health center services. |
| **TIME LIMITS**        | • Current federal requirements do not allow states to impose time limits for Medicaid eligibility or enrollment. | • Through a future 1115 waiver, Michigan intends to implement a “soft cap” on coverage duration: after 48 months, beneficiaries will have the choice to pay higher premiums or seek private insurance through the marketplace. |
| **WORK REQUIREMENTS**  | • Medicaid programs cannot add additional requirements for Medicaid eligibility. | • Pennsylvania is proposing a voluntary, one-year pilot program to encourage work or work search activities by reducing premiums up to 40%. |

**NOTE**: Italicized text denotes a policy that was proposed, but not yet approved.

### 4. Expansion Contingencies

Iowa and Michigan’s Medicaid expansion plans contain “circuit breaker” language, making expansion contingent on sustained 100 percent federal funding for the newly eligible population through 2016. Expanded coverage would automatically roll back if the federal government reduces its match rate.

The expansion models highlighted above could be precursors to state innovation waivers, set to begin in 2017, as well as models for states that have not yet developed expansion plans.

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Medicaid Accountable Care Organizations: A National Perspective

December 8, 2014

Rob Houston
Center for Health Care Strategies
Relevant CHCS Initiatives

- **Medicaid ACO Learning Collaborative**
  Work with eight leading-edge states (CO, MA, ME, MN, NY, OR, VT, WA) to share ideas and best practices and help design/implement Medicaid ACO programs

- **State Innovation Models (SIM) Initiative**
  Provide technical assistance for CMMI project to design and test state-based models for multi-payer payment and health care delivery system transformation

- **Value-based Purchasing Initiatives**
  Gather information from purchasers and payers regarding how and how quickly they are working with the delivery system to move away from paying for volume and towards paying for value
Accountable Care Overview

- **Types of accountable care initiatives**
  - Value-Based Purchasing initiatives (e.g., bundled payments)
  - Delivery system reforms (e.g., care coordination, care teams)
  - Accountable Care Organizations (ACOs)

- **Key accountable care features include:**
  - Payment incentives that promote value, not volume
  - Provider-level financial accountability and risk
  - Robust quality measurement
  - Data sharing and integration

- **All of these features need to be addressed when designing an accountable care model**
ACO Overview

- Accountable Care Organizations (ACOs) are designed to hold providers accountable for improving health outcomes and controlling costs.

- **Key ACO features include:**
  - Payment incentives that promote value, not volume
  - Provider-level financial accountability and risk
  - Robust quality measurement
  - Data sharing and integration
  - On the ground care management
  - Provider/community collaboration
  - Multi-payer opportunities
14 States are Currently Working on Medicaid ACOs
Medicaid ACO Organization Structures Vary

<table>
<thead>
<tr>
<th>Provider-Driven ACOs</th>
<th>MCO-Driven ACOs</th>
<th>Regional/Community Partnership ACOs</th>
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</thead>
<tbody>
<tr>
<td>• Providers establish collaborative networks and assume some level of financial risk</td>
<td>• MCOs assume greater role supporting patient care management</td>
<td>• Community orgs partner to develop care teams and manage patients</td>
</tr>
<tr>
<td>• Providers oversee patient stratification and care management</td>
<td>• MCOs retain financial risk but implement new payment models</td>
<td>• Providers partner with regional/community orgs and form part of the care team</td>
</tr>
<tr>
<td>• State or MCO pays claims</td>
<td>• Providers partner with the MCO to improve patient outcomes</td>
<td>• MCOs/states retain financial risk</td>
</tr>
<tr>
<td>• Payment model is typically shared savings arrangement</td>
<td>• Payment model is prospective global payment</td>
<td>• Payment model can be PMPM or shared savings</td>
</tr>
<tr>
<td>• States: Illinois, Maine, Minnesota, Vermont</td>
<td>• State: Oregon</td>
<td>• States: Colorado, New Jersey</td>
</tr>
</tbody>
</table>
Accountable Care Payment Options

- **ACO payment options tend to take four forms**
  - **Care coordination fees**
    Providers are paid a per member per month care coordination fee
  - **Pay for performance (P4P)**
    Fee-for-service payments with retrospective bonus payment for quality improvement
  - **Shared savings arrangements**
    Fee-for-service payments with retrospective shared savings if costs are reduced and quality is improved
  - **Capitated or global payments**
    Prospective per member per month (PMPM) payment for provision of full scope of service

- **Payment distributions within ACOs are usually determined by the ACOs**
Shared Savings are calculated retrospectively based on quality performance and cost reduction.

Most models are based on the Medicare Shared Savings Program (MSSP):

- Retrospective patient assignment based on utilization of primary care at end of performance period.
- Shared savings/losses measured by comparing actual expenditures to benchmark of average expenditures.
- Option of upside or upside/downside savings.
- Truncation of high cost individuals.

All Medicaid programs with shared savings arrangements have modified versions of MSSP.
A Closer Look: Capitated or Global Payments

- **Prospective PMPM paid for scope of services offered via accountable care arrangement**
  - Payments are determined by patient attribution method and conditional on quality performance
  - ACOs distribute the payment to affiliated organizations (e.g., hospitals, provider orgs) via a pre-determined arrangement

- **Programs may include services beyond physical health**
  - Behavioral health
  - Long term supports and services (LTSS)
  - Dental services
  - Social services
Quality Measurement and Reporting

- **Quality measurement is crucial to ACOs**
- **Number of quality metrics measured varies among programs**
  - MSSP has 33 metrics
  - Oregon Medicaid measures 33 metrics
  - Minnesota Medicaid measures 10 composite metrics
- **Improvement can be compared to prior benchmarks for providers or a collective benchmark across providers (e.g., > 50% of providers)**
- **Payment is tied to quality performance**
  - Some metrics are reporting only, others are tied to payment
  - Some metrics are optional or can be selected from a list of options
Data Sharing

- **Accountable care arrangements are dependent on sharing electronic data via electronic health records**
  - This includes sharing of patient electronic health records (EHRs), member level reports, and claims data
  - Some states provide data to assist providers with care coordination

- **Data sharing challenges**
  - EHR interoperability among ACO participants, including hospitals
  - Infrastructure costs, especially for newly-formed ACOs
ACOs and Managed Care

- If ACOs exist in a managed care environment, ACOs and MCOs must clearly delineate activities that will be performed by each entity to ensure services will not be duplicated
  - Care coordination
  - Care management
  - Quality improvement
  - Data sharing and analytics
  - Utilization and risk management

- Clear contracting arrangements between ACOs and MCOs may be made to help define roles and responsibilities
Establishing Medicaid ACOs

- There are no federal Medicaid ACO requirements
  - CMS has released some guidance to states implementing ACO programs
  - States may need federal authority to implement Medicaid ACOs
    - OR needed a 1115 Waiver
    - MN, ME, and VT needed a State Plan Amendment

- There are no regulations to preclude providers and MCOs from establishing ACOs on their own volition

- Multi-payer Alignment
  - Leveraging Medicare Shared Savings Program (MSSP), Pioneer, and commercial programs promotes provider participation and lightens the lift of program development
  - CMCS and CMMI released an RFI to explore ways that the Pioneer ACO model could be used for multi-payer alignment
ACO Activity to Date

• Few results from Medicaid ACOs
  ► New concept, only a few programs currently operating
  ► Colorado reported nearly $100M in cost avoidance savings in 2013-14
  ► Minnesota’s IHP program saved $10.5M in its first year
  ► Oregon’s CCO program showed a decrease of 32% for inpatient admissions and 17% of ED usage for patients with chronic diseases

• Key Learnings
  ► Programs that integrate behavioral health, social services, and community organizations tend to perform well
  ► Large provider groups, such as hospitals, may have an advantage due to lower start-up costs and comprehensive resources
  ► Real-time data sharing and use of advanced analytic techniques can help target patients and improve care coordination efforts
Impacts of the ACO Movement

- The ACO concept seems to be creating a gradual “cultural shift,” affecting the way providers, payers, and government entities approach medical care
  - Many payers are experimenting with risk-based ACO models in the Medicaid, Medicare, and Commercial sectors
  - State governments and CMS are supporting ACO-based initiatives, and have instituted legislation and guidance to help forward ACO development
  - Some leading-edge providers have realized that the current medical system is unsustainable, and are introducing value-based purchasing arrangements, including ACOs
Impacts on Hospital Systems

- Hospital Systems are perhaps the key part of the ACO equation since they do not have a direct financial incentive to reduce costs
  - Inpatient stays and ED usage are crucial revenue streams for hospitals, and reducing utilization of these are usually the primary foci of ACOs
  - Providers adopting ACO structures must accept a shift from volume to value-based payment and, therefore, adopt a new business model
  - Smaller and safety net hospitals are less likely to support this shift
TACOs – The Next Generation of ACOs?

- A TACO is an aspirational concept – a *Totally Accountable Care Organization*

- In its fully realized form, a TACO will:
  - Integrate all physical health services, behavioral health services, LTSS, social services, and public health
  - Be fully accountable for a target population
  - Involve all payers
  - Be financed through global payments tied to a broad set of health outcomes

- TACOs will be built modularly, but are likely closest to realization in Medicaid ACOs
The Long and Winding Road to TACOs

- There are many ways to achieve totally accountable care, and essentially all payment and delivery system reforms are progress toward this goal in some way.
- Those pursuing TACOs will likely need to approach things on an incremental basis, but should keep the end goal in mind when constructing these incremental steps.
Questions?

For more information feel free to contact me:

Rob Houston
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Medicaid Accountable Care Organizations: Program Characteristics in Leading-Edge States

As state leaders move beyond their focus on the coverage challenges arising from the Affordable Care Act (ACA), they are paying increasing attention to the payment and delivery system reform opportunities spurred by both the law itself and by changes in the broader health care marketplace. States have been actively pursuing innovative care delivery and payment models to improve the capacity of the health system to deliver high value care and increase provider accountability, particularly for high-need populations facing multiple health and social challenges.

The need to foster integrated care delivery and address social determinants of health has led to the development of accountable care organizations (ACOs) in Medicaid. The common goal of these initiatives is to coordinate a wide array of needed services to improve the quality of care and curb costly and avoidable hospitalizations of Medicaid beneficiaries, particularly those with multiple chronic conditions and behavioral health needs. Given these extensive transformation efforts, states are leveraging existing investments in managed care and primary care to guide the development of their Medicaid ACO programs.

With support from The Commonwealth Fund, the Center for Health Care Strategies (CHCS) has been working with leading-edge states to accelerate ACO program implementation. The following matrix presents key features and requirements for ACO programs in seven of the states participating in the Medicaid ACO Learning Collaborative: Colorado, Maine, Massachusetts, Minnesota, New Jersey, Oregon, and Vermont. The matrix outlines how each state has configured key ACO program features including: governance; provider eligibility; covered populations; scope of accountable services; required functions; payment models; and quality measures. The details from these seven ACO programs should inform additional states as they consider their own ACO approaches. CHCS will continue to work with these and other emerging state leaders to update the attached matrix and monitor their progress in the months ahead.

The information in this document was gathered through group discussions and from state-specific documents, such as Medicaid ACO provider solicitations (e.g., Requests for Information/Proposals/Applications and State Plan Amendments); see resource links on page two for more information.
Reference Material Links

Following are links to resources used to gather information into the ACO Program Design Matrix:

Colorado

Maine
- RFA: [http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/Accountable_Communities_RFA.pdf](http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/Accountable_Communities_RFA.pdf)

Massachusetts
- RFA: [https://www.ebidsourcing.com/displayPublicSolUniversalSummRFRList.do?menu_id=2.3.3.1.5&docId=143813&org.apache.struts.taglib.html.TOKEN=6e26d1336d4fe536c5ac7d118951f18](https://www.ebidsourcing.com/displayPublicSolUniversalSummRFRList.do?menu_id=2.3.3.1.5&docId=143813&org.apache.struts.taglib.html.TOKEN=6e26d1336d4fe536c5ac7d118951f18)

Minnesota
- RFP: [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_177103](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_177103)

New Jersey

Oregon

Vermont

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## Medicaid Accountable Care Program Design Characteristics

<table>
<thead>
<tr>
<th>State Program Name</th>
<th>Organizational Structure/Governance</th>
<th>Provider Eligibility and Requirements</th>
<th>Covered Populations</th>
<th>Scope of Accountable Services</th>
<th>Required Functions (e.g., reporting, care management, HIE)</th>
<th>Payment Models/ Risk</th>
<th>Quality Measures</th>
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</table>
| **Colorado Accountable Care Collaborative (ACC)**      | • ACC program consists of seven competitively selected Regional Care Collaborative Organizations (RCCOs).  
• RCCOs must have permanently assigned Contract Manager, Financial Manager, and Chief Medical Officer.  
• RCCOs must submit quarterly summary of stakeholder feedback.                                                                 | • Primary Care Medical Providers (PCMPs) must contract with an RCCO.  
• PCMPs must be enrolled as Colorado Medicaid providers and have interest and expertise in serving special populations, including:  
  • Physically or developmentally disabled;  
  • Children and aged; and  
  • Members with complex behavioral or physical health needs.  
• Participating PCMP practices must either be certified as providers in the Medicaid and CHP+ Medical Homes for Children Program or be a federally qualified health center, a rural health clinic, clinic or other group practice with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology. | All enrollees eligible for full Medicaid benefits can enroll in ACC, by selecting a PCMP linked to the RCCO in their region.  
Enrollment in the ACC Program is voluntary and members can “opt out.” Dual eligibles can opt in.  
Patients residing in any federal, state, or county institution at the time of enrollment are excluded; any beneficiary who becomes a resident of an institution after their enrollment in the ACC Program may choose to remain in the program or request disenrollment.  
Accountable for comprehensive primary care needs through the PCMPs, including preventive care and screenings, prenatal care, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members age 20 and under.  
Accountable for improved health outcomes in region (based on performance of noted quality measures).  
Ensure that care is coordinated with specialists in accordance with state-approved Clinical Referral Protocol. A care coordinator will be assigned to each beneficiary.  
Support PCMPs with integrated behavioral and primary care and the implementation of ACC program through formal training classes and forums.  
Apply statewide data and analytics functionality to support transparent, secure data-sharing and enable monitoring and measurement of regional health care costs and outcomes.  
Statewide Data Analytics Contractor (SDAC) makes claims data available to RCCO and PCMPs through an ACC Program Web Portal.  
Per Member Per Month (PMPM) payments based on the monthly number of enrollments in the state’s Medicaid Management Information System (MMIS).  
Quarterly incentive payments made when the RCCO meets or exceeds targets, as calculated based on region-wide performance on four measures (noted in Quality Measures column).  
Four measures and the performance targets selected by RCCO are used as the basis for measuring performance against regional baselines:  
• Emergency Room Visits per 1,000 full-time enrollees (FTEs)  
• Hospital Readmissions per 1,000 FTEs  
• Outpatient Service Utilization/ MRI, CT scans, and tests per 1,000 FTEs  
• Well-Child Visits per 1,000 FTEs  
The RCCO submits a performance improvement plan (PIP) annually that includes health and health care performance improvement goals, at least two targeted performance improvement activities, and objectives, using national standards, the state’s priorities, and the region’s needs.  
Every quarter, the RCCO submits reports that show performance on the measures included in the performance improvement plan. |  |  |  |  |  |  |
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<tr>
<th>State</th>
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</tr>
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<tbody>
<tr>
<td>Maine Accountable Communities (AC)</td>
<td>• Can be comprised of one or multiple provider organizations, of similar or different systems and ownership. • Must designate a legal lead entity to contract with the state to receive and distribute state payments (shared gains or losses); and maintain provider agreements. • Governance structure must include at least two Medicaid members – or their caregivers – served by the ACO. • Must develop partnerships with one or more public health entities, i.e., community organizations, social service agencies, local government.</td>
<td>• Eligible providers must include Medicaid physicians, nurse practitioners, certified nurse midwives, or physician assistants who: o Have a primary specialty designation of internal medicine, general practice, family practice, pediatrics, geriatric medicine, obstetrics or gynecology; and/or o Practice in a rural health center, federally qualified health center, an Indian Health Services center, or school health center. • Required to have a minimum of 1,000 Medicaid members assigned to the ACO.</td>
<td>• All Medicaid beneficiaries, including: o Those under the Categorically Needy, Medically Needy, and SSI-related coverage groups; o Participants in home and community-based and/or HIV waivers; and o Dual eligibles with full Medicaid benefits.</td>
<td>• Must deliver primary care services and coordinate care with specialty providers, including behavioral health for non-integrated practices, all hospitals in the proposed service area and long-term services and supports for those ACOs that opt to include these costs under their ACO, regardless of whether these services are directly delivered by the ACO. • Must leverage existing care coordination resources through contractual or informal partnerships with at least one provider of each of the following specialties: o Chronic conditions, including developmental disabilities; o Long-term care; and o Behavioral health.</td>
<td>• Integration of physical and behavioral health. • Practice and system transformation. • Inclusion of patients/families in leadership roles and as partners in care and in organizational quality improvement activities. • Participation in accountable community and/or ACO learning collaboratives.</td>
<td>• Model 1: Shared savings contingent on quality performance and patient experience outcomes. Shared savings payments are capped at 10% Total Cost of Care (TCOC). • Model 2: Incorporates shared risk in the second and third year, based on the inverse of the shared savings rate (may not exceed 60 percent.) Payments are capped at 15% TCOC for Years 1-3. • To qualify for shared savings, an ACO average TCOC for the performance year must be below its benchmark TCOC by 2-2.5%, depending on program size. TCOC calculated using risk-adjusted FFS claims data. • All risk/gain payments calculated/dispersed annually via a reconciliation payment. Providers will continue to receive FFS payments in the performance year.</td>
<td>Quality of care will be measured using 15 core measures and six elective measures across the following four key domains: 1) Care Coordination/Patient Safety (4 core, 1 elective, 2 monitoring/evaluation); 2) Patient Experience (1 core); 3) Preventive Health (4 core); and 4) At-Risk Populations: o Asthma (1 core, 1 elective) o Diabetes (3 core, 2 elective, 2 monitoring/evaluation) o Chronic Obstructive Pulmonary Disease (COPD) (1 elective) o Coronary artery disease (CAD) (1 elective) o Behavioral Health (2 core, 1 monitoring/evaluation) The core and elective measure sets consist of those measures for which the ACO has accountability for payment purposes. ACOs must select three of the seven elective measures on which to be measured together with the core measure set, for a total of 18 measures tied to shared savings payment per ACO. In addition, five measures have been identified for monitoring and evaluation purposes only.</td>
</tr>
<tr>
<td>State Program Name</td>
<td>Organizational Structure/Governance</td>
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| Massachusetts      | N/A                                | • Must have at least 5,000 members on panel to qualify for symmetric shared savings, 3,000 for upside-risk only.  
• Tier 2 and 3 practices must maintain a master’s or doctoral-level behavioral health provider who is co-located at each participating practice site, for no fewer than 40 hours per week.  
• Provide medically necessary services across the care continuum including physical and behavioral health services and engage patients in shared decision-making, including on palliative and long-term care services and supports.  
• Integrate the provision of behavioral health services and primary care services by implementing behavioral health (BH) elements into three tiers of services:  
  • Tier 1 - Case management/coordination services; no fee-for-service billable services.  
  • Tier 2 – Tier 1 services plus brief interventions, screening/assessment/triage; fee-for-service billable outpatient BH services by master’s and bachelor’s-level professionals.  
  • Tier 3 – Tier 1 services plus psychiatric assessments, medication management, psychotherapy; fee-for-service billable outpatient BH services provided by prescribing clinicians/psychotherapists.  
• Maintain functional capabilities to coordinate care and financial payments among providers.  
• Implementation of interoperable health information technology for the purposes of care delivery coordination and population management.  
• Electronic medical record system with patient registry functionality, including the capability to:  
  o Produce at least one report to support evidence-based protocols for chronic disease management;  
  o Support documentation of treatment plans; and  
  o Identify and assign a primary care provider to each panel enrollee. | All Medicaid managed care beneficiaries currently in the PCC Plan and MCO plans (excludes individuals who are dually eligible for Medicare and Medicaid). | • Three payment streams:  
  1) Comprehensive Primary Care Payment: Risk-adjusted, per Panel Enrollee, per month payment for a defined set of primary care services and options for a defined set of BH services.  
  2) Quality Incentive Payment: Annual incentive (as percentage bonus to base payment) for quality performance.  
  3) Shared Savings Payment: Primary care providers share in savings on non-primary-care spending, including hospital and specialist services. Each applicant may have the choice of whether to include or exclude long-term services and supports from the shared savings/risk payment calculations. | 23 quality measures have been defined in the following areas:  
  o Adult prevention and screening (5);  
  o Behavioral health (4);  
  o Pediatric health (8);  
  o Adult chronic conditions (2);  
  o Access (2); and  
  o Care coordination (2). |
<table>
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<tr>
<th>State Program Name</th>
<th>Organizational Structure/Governance</th>
<th>Provider Eligibility and Requirements</th>
<th>Covered Populations</th>
<th>Scope of Accountable Services</th>
<th>Required Functions (e.g., reporting, care management, HIE)</th>
<th>Payment Models/ Risk</th>
<th>Quality Measures</th>
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</thead>
<tbody>
<tr>
<td>Minnesota Integrated Health Partnerships (IHP)</td>
<td>• ACOs fall into two categories: 1) Virtual: Primary care providers and/or multi-specialty provider groups that are not formally integrated with a hospital or integrated system via aligned financial arrangements and common clinical and information systems. 2) Integrated: Integrated delivery system that provides a broad spectrum of outpatient and inpatient care.</td>
<td>• Provider organizations with a Medicaid population between 1,000-2,000 attributed participants are eligible only for the virtual IHP model, regardless of their level of formal integration.</td>
<td>• Eligible adults and children in Medicaid, who are enrolled under both fee-for-service and managed care programs (who are not dually eligible for Medicaid and Medicare), including:  o Pregnant women, children under 21, adults without children, and those with state-funded medical assistance; and  o Recipients receiving medical assistance due to blindness or disability.</td>
<td>• Included in the ACO’s total cost of care calculation are services provided by primary care entities as well as laboratory, radiology, pharmacy, chiropractic, vision, podiatry, rehabilitation therapies, audiology, outpatient mental health and chemical dependency services (intensive or residential services are excluded), outpatient hospital, ambulatory surgery center services, inpatient hospital, home health (except personal care assistant services) and private duty nursing services.</td>
<td>• Established processes to monitor and ensure the quality of care provided.  • Participation in quality measurement and improvement activities as required by the state.  • Demonstrate the capacity to receive data from the state via secure electronic processes  • Stratify data to identify opportunities for patient engagement and care model strategies needed to improve outcomes.</td>
<td>Virtual ACOs:  • Shared savings model contingent on quality and patient experience outcomes. Distributes the difference between annual expected and actual realized total cost of care if savings are achieved.  • Required to share gains above the 2% minimum performance threshold equally (50/50) with the state for all three years of the demonstration.  Integrated ACOs:  • Shared risk that builds toward a two-way risk sharing model that distributes difference, whether or not savings are achieved, contingent on quality and patient experience measures.  • Year 1: Share gains above the 2% minimum performance threshold equally with the state.  • Year 2: Assume some downside risk, at ratio of 2:1 (gain-sharing to loss-sharing thresholds).  • Year 3: Assume two-way risk with symmetrical risk sharing thresholds.</td>
<td>The state has defined 10 quality measures that all ACOs must report on to qualify for shared savings. Performance on the measures has an increasing effect on payment of shared savings. ACOs may propose additional or alternative quality measures where appropriate for their served population.</td>
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<td>State</td>
<td>Program Name</td>
<td>Organizational Structure/Governance</td>
<td>Provider Eligibility and Requirements</td>
<td>Covered Populations</td>
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| New Jersey | Medicaid Accountable Care Organization Demonstration Project | • Must be formed as a nonprofit corporation pursuant to New Jersey state law.                         | • Must serve at least 5,000 Medicaid patients.                                                       | • All Medicaid recipients residing in a designated geographic area for a period of at least three years, with special focus on inpatient and ED “high-utilizer” Medicaid patients (New Jersey’s ACO legislation does not explicitly preclude the inclusion of individuals who are dually eligible for Medicare and Medicaid). | • Accountable for the access to care, quality, health outcomes, and cost of care for Medicaid recipients residing in the designated area for a period of at least three years. | • Required to develop and gain approval of a gain-sharing plan for their ACO by the end of year 1 of the demo and use this methodology for years 2 and 3. | • ACOs and managed care organizations can establish a gain-sharing arrangements (upside and downside) if quality measures are met. The parties are responsible for defining the methodology that will govern their specific agreement, though Rutgers University developed a methodology that participants may use. | • ACOs can also select voluntary measures – one item from the prevention category and any five from the chronic conditions category (i.e., cardiovascular, diabetes, respiratory, resource/utilization). | • 24 mandatory quality measures in the following areas:  
  o Prevention/effectiveness of care (2)  
  o Acute care (1)  
  o Behavioral health (2)  
  o Chronic conditions (2)  
  o Resource utilization (2)  
  o Preventable hospitalizations (7)  
  o CAHPS (8) |
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<tr>
<th>State</th>
<th>Program Name</th>
<th>Organizational Structure/Governance</th>
<th>Provider Eligibility and Requirements</th>
<th>Covered Populations</th>
<th>Scope of Accountable Services</th>
<th>Required Functions (e.g., reporting, care management, HIE)</th>
<th>Payment Models/ Risk</th>
<th>Quality Measures</th>
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</table>
| Oregon | Coordinated Care Organizations (CCOs) | - Establish community advisory council (CAC) in each of the proposed service areas.  
- Representation of beneficiaries with severe and persistent mental illness and beneficiaries receiving DHS Medicaid-funded LTC services on governing board and/or CAC.  
- Encouraged (but not required) to establish a clinical advisory panel to ensure best clinical practices. | - Execute written agreements with Medicaid-certified providers.  
- Have provider, facility, and supplier contracts in place to demonstrate adequate access and availability of covered services throughout the requested service area.  
- Maintain accurate process that can be used to validate member enrollment and disenrollment based on written policies, standards, and procedures.  
- Participate in the state’s learning collaboratives. | - All Medicaid enrollees, including members who are dually eligible for Medicare and Medicaid services.  
- Coordinate the delivery of physical health care, mental health and chemical dependency services, oral health care, and covered long-term services.  
- Development of medically necessary individualized care plans for enrollees.  
- Involve enrollees in decisions regarding treatment, proper education on treatment options, and coordination of follow-up care.  
- Address barriers to enrollee compliance with prescribed treatments and regimens. | - Collect, maintain and analyze race, ethnicity, and primary language data for all members on an ongoing basis.  
- Support quality performance improvement program with sustained improvement in clinical/non-clinical care areas and improved member satisfaction and health outcomes.  
- Address barriers to enrollee compliance with prescribed treatments and regimens. | - Operate within a fixed global budget.  
- Develop and implement alternative payment methodologies based on improving health, health care, and lowering cost.  
- Manage financial risk while meeting minimum financial requirements:  
  - Maintain restricted reserves of $250,000 plus an amount equal to 50 percent of the ACO’s total actual or projected liabilities above $250,000.  
  - Maintain net of at least the greater of: (1) five percent of the ACO’s average annualized total revenue in the prior two quarters; or (2) its authorized control level risk-based capital.  
- Performance on accountability measures will affect ACOs’ contract status and eligibility for incentives. | - Two types of measures:  
  - Accountability measures, including both core and transformational measures; and  
  - Transparency measures, intended to promote community and consumer engagement (calculated by the state (not ACO) and publicly reported).  
- Year 1 Accountability Measures:  
  - Collected by the state and CCOs (one measure):  
    - Reduction of disparities - report by race/ethnicity  
  - Collected by the state, validated by the ACOs (16 measures).  
  - Collected by ACOs or an external quality organization (four measures):  
    - Planning for end-of-life care  
    - Screening/follow-up for clinical depression  
    - Timely transmission of transition record  
    - Care plan for beneficiaries with Medicaid-funded long-term care benefits. |
**Vermont Medicaid ACO Shared Savings Pilot**

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<tr>
<th>Program Name</th>
<th>Organizational Structure/Governance</th>
<th>Provider Eligibility and Requirements</th>
<th>Covered Populations</th>
<th>Scope of Accountable Services</th>
<th>Required Functions (e.g., reporting, care management, HIE)</th>
<th>Payment Models/ Risk</th>
<th>Quality Measures</th>
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<tbody>
<tr>
<td>Medicaid ACO</td>
<td>Governing body members have fiduciary responsibility to the ACO, and board is responsible for oversight and strategic direction via transparent process.</td>
<td>Must be enrolled as Medicaid providers.</td>
<td>Medicaid beneficiaries including: o Aged/blind/disabled adults and children; o General adult population (including cash assistance recipients and those receiving transitional Medicaid after the receipt of cash assistance); o Adults with incomes below 133% of the FPL; and o Children under age 21 who are eligible for cash assistance and children up to age 18 who were previously uninsured, living in families up to 300% FPL.</td>
<td>Expansion included in TCOC will follow an “encourage/incent/require” approach throughout years 1-3 of the program. In year 1, ACOs are responsible for “core-services” including: inpatient/outpatient hospital, professional services, ambulatory surgery center, clinic, FQHC, rural health center, chiropractor, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility. In year 2, ACOs can expand TCOC calculation to include “non-core services”: personal care, pharmacy, dental, non-emergency transportation, and services administered by: o VT Dept. of Mental Health; o VT Division of Alcohol/Drug Abuse Programs; o VT Dept. of Disabilities, Aging and Independent Living; o VT Dept. for Children and Families; and o VT Dept. of Education. In year 3, ACOs will be required to include additional state-defined non-core services.</td>
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<td>At least 75 percent of the ACO’s governing body must be ACO participants, including a representative from: o BH and substance abuse provider community; and o Post-acute care (such as home health or skilled nursing facilities) or long-term care services and supports.</td>
<td>Minimum number of Attributed Lives: 5,000.</td>
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<td>The ACO’s governing body must include at least two consumer members, including a Medicaid beneficiary.</td>
<td>Excluded Medicaid beneficiaries: o Individuals dually eligible for Medicare and Medicaid; o Individuals with third-party liability coverage; and o Medicaid-eligible individuals who have commercial insurance or who receive a limited benefit package.</td>
<td>Meaningfully engage beneficiaries and families as partners in care and in quality improvement activities.</td>
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<td>The ACO must have a consumer advisory board with community membership, including patients, their families, and caregivers.</td>
<td>ACOs were offered a “two track” option that aligns with the Medicare Shared Savings Program. For potential ACO participants who choose track one: no downside risk in first year with a 50 percent savings rate. Track Two involves two-sided risk equal to one minus final sharing rate applied to first-dollar losses once Minimum Loss Rate (MLR) is met or exceeded; shared losses not to exceed 10%.</td>
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<td>Vermont Medicaid ACO Shared Savings Pilot</td>
<td>In the initial years of the program, the focus will be on managing performance risk (i.e. the risk of higher costs from delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment), not “insurance risk” (i.e. the risk of whether a patient will develop a health condition).</td>
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<td>ACOs that choose to expand the TCOC in year 2, will receive an enhanced maximum sharing rate of 60 percent (±10 percent increase).</td>
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<td>29 measures have been defined for Year 1 payment and reporting:</td>
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<td>• Nine claim-based measures will be tied to payments</td>
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<td></td>
<td></td>
<td>• All-Cause Readmission</td>
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<td></td>
<td></td>
<td>• Adolescent Well-Care Visit</td>
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<td></td>
<td></td>
<td>• Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only)</td>
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<td></td>
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<td>• Follow-up After Hospitalization for Mental Illness, 7 day</td>
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<td></td>
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<td>• Initiation/Engagement of Alcohol and Drug Dependence Treatment</td>
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<td></td>
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<td>• Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis</td>
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<td></td>
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<td>• Chlamydia Screening in Women</td>
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<td>• Developmental Screening in First Three Years of Life (Medicaid only)</td>
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<td>• Depression Screening by 18 years of age (Medicaid only)</td>
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<td>20 additional measures for reporting only:</td>
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<td>o Claims-based measures (4)</td>
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<td>o Clinical data-based measures (7)</td>
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<td>o Patient experience measures (9)</td>
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<td>ACOs are required to submit these measures annually to the Green Mountain Care Board (GMCB) for monitoring and evaluation purposes.</td>
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<td>There are a number of identified “pending measures,” which may be added in subsequent years.</td>
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Accountable care organizations (ACOs) have the potential to improve health care quality and control rising costs. States can facilitate the implementation of Medicaid ACO models by complementing the existing managed care infrastructure, aligning ACOs across payers, and, clearly delineating ACO and managed care organization responsibilities and performance expectations. This brief addresses key considerations to guide state Medicaid agencies in successfully integrating ACOs within a managed care environment.

A accountable care organization (ACO) is one of the many care delivery models that payers, including Medicaid, are using to improve health care quality and lower rising costs. Generally speaking, ACOs assume responsibility for, and reap the financial rewards of, coordinating and managing care across a wide spectrum of providers. What differentiates ACO programs from managed care is the placement of greater accountability for health care costs and quality directly at the point of care, rather than at the system level. Within Medicaid, the ACO model offers particular promise as a vehicle for promoting accountability for the integration of care for beneficiaries with multiple chronic conditions and for those who face social barriers to health, while retaining the system-level benefits of an existing managed care program.

Currently, three different ACO models have emerged within Medicaid: (1) a provider-driven model (Massachusetts, Minnesota, and Vermont); (2) a health plan-driven model (Oregon); and (3) a community-driven model (Colorado, Maine, and New Jersey). The provider-driven model, which aligns closely with Medicare ACO models, is emerging in states with several Medicare and commercial ACOs offering opportunities for multi-payer alignment. In health plan-driven models, the health plan is actively engaged with providers in forming an ACO, delivering data and building the capacity of providers who assume greater accountability for coordinating patient care. Finally, community-driven ACOs emphasize community-wide care delivery infrastructures, such as care teams and standardized data feeds. This enables all providers to develop care delivery approaches that leverage partnerships with social services and community-based organizations.
States are selecting the model that best meets the underlying delivery system strengths. All three models have been implemented within a mix of Medicaid fee-for-service, managed care, and primary care case management (PCCM) environments. Several states including Massachusetts, Minnesota, New Jersey, Oregon, and Vermont are either designing or implementing Medicaid ACOs within their respective Medicaid managed care systems.

This issue brief identifies many of the common issues that states must address when implementing ACOs within a managed care environment. It outlines considerations across the following three areas to help guide state ACO design and implementation decisions:

1. Essential operational decisions;
2. Potential areas for alignment across payers; and
3. Delineation of new ACO and managed care organization (MCO) responsibilities.

**Background: ACO Implementation in a Managed Care Environment**

Implementing a Medicaid ACO program within managed care can create opportunities for ACOs and MCOs to leverage their complementary strengths and achieve a level of cooperation that will improve care delivery in the state. However, the shift toward ACO programs has the potential to create duplication as ACOs assume responsibilities previously delegated to MCOs. Such responsibilities include: (a) care management; (b) quality improvement; (c) utilization management; (d) data management; and (e) risk management, if there is global capitation.

While some MCOs view ACOs as a promising tool for containing costs, others may perceive threats to their financial viability, and therefore may resist adopting the model. States and other stakeholders can help facilitate mutually beneficial synergies for MCOs and ACOs, such as lower medical expenses for MCOs.

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**Participants for Advancing Accountable Care Organizations in Medicaid Collaborative**

<table>
<thead>
<tr>
<th>State Representatives</th>
<th>Schaller Anderson, an Aetna Company</th>
<th>United Healthcare</th>
<th>Camden Coalition of Healthcare Providers</th>
<th>Rutgers Center for State Health Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maine</td>
<td>Jim Leonard, Deputy Medicaid Director Michelle Probert, Director of Strategic Initiatives</td>
<td>Tom Kelly, Former President and CEO</td>
<td>Jeffrey Brenner, MD, Executive Director</td>
<td>Joel Cantor, Distinguished Professor and Director Derek DeLia, Associate Research Professor</td>
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<tr>
<td>Massachusetts</td>
<td>Neha Sahni, Director of Primary Care Payment Reform</td>
<td>Bill Hagan, Chief Growth Officer, Community and State</td>
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<tr>
<td>Minnesota</td>
<td>Sara Bonneville, Manager, Care Delivery and Payment Reform Marie Zimmerman, Health Care Policy Director</td>
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<tr>
<td>New Jersey</td>
<td>Valerie Harr, Medicaid Director Pamela Orton, Director, Office of Delivery System Innovation</td>
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<tr>
<td>Oregon</td>
<td>Judy Mohr Peterson, Medicaid Director Jeanene Smith, Chief Medical Officer</td>
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<tr>
<td>Texas</td>
<td>Brian Dees, Senior Policy Analyst Robin Richardson, Senior Policy Analyst</td>
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<tr>
<td>Vermont</td>
<td>Kara Suter, Director, Payment Reform</td>
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**Managed Care Organizations**

- Schaller Anderson, an Aetna Company
- United Healthcare

**Provider Organization**

- Camden Coalition of Healthcare Providers

**Academic Health Policy Experts**

- Rutgers Center for State Health Policy
through on-the-ground care for high-risk patients. Likewise, ACOs can potentially use the MCO partnership to obtain important supports for their care management activities.

Given the growing prevalence of Medicaid managed care—more than 74 percent of Medicaid beneficiaries were enrolled in managed care in 2011—states must consider how ACOs will function within a managed care environment and what roles MCOs and ACOs will assume over time. The transition of responsibility is likely to occur gradually and unevenly, as ACOs build their capabilities and MCOs adjust their activities in response. States will need to consider the levers at their disposal, as both purchasers and policymakers, to make this transition smooth, efficient, and consistent across the system.

To advance ACOs within Medicaid managed care, states can: (a) develop a functional implementation strategy within the managed care environment; (b) promote alignment of core ACO activities across payers; and (c) clearly delineate the complementary responsibilities of ACOs and MCOs. The following section outlines key considerations for addressing these tasks, including illustrative state examples.

**Essential Decisions for Implementing ACOs within Managed Care**

As states construct ACO programs, they will need to develop an approach that facilitates collaboration and accountability between ACOs and MCOs. States looking to foster ACO development will need to consider many factors, including the current managed care environment, the structure of provider organizations and hospital systems, the willingness of MCOs to participate, and the level of provider readiness. Political factors, both locally and statewide, should also be considered.

Although each state’s situation will be somewhat unique, all states will need to address these factors to varying degrees. Key areas that states will need to address initially include:

1. Weighing contracting options;
2. Sharing savings and adjusting capitation rates; and
3. Establishing performance metrics, monitoring, and oversight.

**1. Weighing Contracting Options**

States have many contracting options available for implementing an ACO program in a managed care environment. First, states must determine whether to require MCO participation in the ACO program. This decision is critical, because it will influence uptake and spread of the ACO program across the state and will impact MCO operations and costs. Early adopter states are exploring both options. For example, Minnesota requires its MCOs to participate in the shared savings program with the Health Care Delivery Systems (HCDS) in its provider network, while New Jersey decided to make Medicaid MCO participation in its ACO demonstration program optional.

While mandating the structure of the ACO-MCO arrangement through legislation or regulation is the choice most likely to assure cooperation, this may not be a politically or commercially feasible option in many states. In such cases, states may want to develop incentives that encourage voluntary MCO participation and multi-payer alignment. For example, states may consider requiring MCOs to provide face-to-face care management to high-risk patients, a responsibility that could be delegated to ACOs.

**2. Sharing Savings and Adjusting Capitation Rates**

States will need to identify vehicles to share savings with the MCOs. In the short term, this can be achieved via capitation payments. If ACOs achieve
savings over projected costs, the MCO automatically retains a portion of savings from the annual capitation payment, net of savings paid to the ACO. But, if the ACO program is effective at reducing total Medicaid costs, MCOs receive lower rates in subsequent years because capitation rates are adjusted to reflect actuarial soundness. States will need to make a policy decision whether or not to create a win-win for the MCOs and the state by mitigating the impact of this adjustment through a shared savings arrangement. Particularly in states where MCO participation in the ACO program is voluntary, the state may wish to create a shared savings arrangement in order to create incentives for health plan participation.

This can be accomplished by assessing the ACO’s impact on patient care costs over time, then adjusting MCO rates based on a fixed administrative pricing arrangement. An administrative pricing arrangement can be structured in three ways: (1) to broadly cover operational costs, but not medical services; (2) to act as a variable percentage tied to administrative costs; or (3) a hybrid of the two. States may also consider applying for a federal waiver to keep the capitation payment fixed over a set period of time, which provides stability for the MCO and built-in cost savings for the state.

As ACOs assume tasks that MCOs traditionally covered via capitation, states will also need to adjust MCO capitation rates accordingly, particularly as ACOs begin to cover a significant portion of the contracted network. Shifts in responsibilities are explored in the section “Delineating Complementary ACO and MCO Responsibilities” on page 6, but two overarching considerations are worth noting upfront. First, capitation adjustments may be straightforward for services like care management, which is calculated on a per member per month (PMPM) basis, but will be more complex for other areas, such as quality improvement. Medicaid agencies should work closely with their actuaries to make necessary adjustments. Second, states will need to consider the extent to which such adjustments impact the new medical loss ratio (MLR) requirements for health plans established as part of the Affordable Care Act (ACA). Under this provision, health plans are required to spend either 80 percent (for plans in small group or individual markets) or 85 percent (for large-market plans) of premium dollars on medical care. If they fail to meet this standard, they must provide a rebate.

3. Establishing Performance Metrics, Monitoring, and Oversight

To ensure that ACOs are functioning as desired in the managed care environment, implementation efforts should be carefully monitored. The structure of the ACO program will largely dictate which components should be monitored. Critical issues to monitor include: (a) quality of care (discussed further below); (b) gain-sharing arrangements; (c) anti-trust issues around collusion; and (d) market power and rate impacts. These areas can be monitored by the state Medicaid agency or an external contractor.

An important oversight consideration is determining how the monitoring provisions developed by the state will be enforced. Possible enforcement tools could include financial incentives or penalties, probationary periods, or decertification. However, states should be mindful to balance the benefits of monitoring against the administrative burden they place on ACOs and MCOs with their duty to protect beneficiaries.

Aligning Core ACO Activities across Payers

Within an ACO program, states will want to determine which responsibilities to mandate contractually and which to leave for ACOs and MCOs to negotiate independently. Stimulating creative innovation among MCOs and providers is
important, particularly given that ACO models are relatively new and little evidence exists on what makes models effective. To create the right balance between alignment and innovation, states may wish to identify a core set of elements that all of their MCOs are contractually required to adhere to, while providing both parties the flexibility to enhance the core model in ways they deem advantageous.

Identifying this core set of activities will be critical for ACOs to operate successfully across a range of providers and plans. Consistently defined standards can simplify implementation and monitoring of ACOs and enable self-reporting, making it easier for MCOs to administer and less expensive for providers to participate. Various elements may be essential to foster alignment and create consensus across MCOs, including:

1. Requiring standardized quality, patient experience, and efficiency metrics;
2. Standardizing payment structures;
3. Developing uniform HIT and data-sharing requirements; and
4. Establishing consistent provider supports.

1. **Requiring Standardized Quality, Patient Experience, and Efficiency Metrics**

A standardized set of metrics across Medicaid MCOs makes it easier for ACOs to coordinate interventions across payers to improve care delivery. Having one set of metrics to report simplifies the quality reporting process and facilitates the ACO’s ability to track progress across its entire patient population. Further, if metrics are universal across providers, it is much easier to generate state, regional, or community-based statistics, which are vital to track both an ACO’s impact and a state’s ACO initiative as a whole. States should consider issuing a minimum set of required metrics (to be collected and reported by MCOs, ACOs, or both) to track patient outcomes and care processes consistently, as the states of Massachusetts, Minnesota, New Jersey, and Oregon have done.

2. **Standardizing Payment Structures**

States may also want to have a single payment methodology in place upon which ACOs and MCOs can base their agreements. States should consider their current health care market and stakeholder interests when designing a payment methodology. Based on these considerations, the payment methodology can be mandated explicitly to ensure a mutually beneficial arrangement for MCOs and ACOs or can be made more flexible to allow for innovation and experimentation. Minnesota, for example, requires its plans to use a consistent shared savings methodology developed by state actuaries as part of its HCDS program. The state calculates the total cost of care and shared savings across all attributed patients. Then, the MCOs pay a predetermined portion of calculated savings to the HCDS based on the proportion of their beneficiaries attributed, not the actual experience of those beneficiaries. New Jersey, on the other hand, opted for a more flexible structure, providing MCOs with a common payment methodology, which the plans and ACOs may choose to use as the basis of their gain-sharing arrangements. The state must, however, approve the gain-sharing arrangements before an ACO can participate in the demonstration.

3. **Developing Uniform HIT and Data-Sharing Requirements**

Aligning health information technology (HIT) and data-sharing across participating payers are important to enable ACOs to make data-driven patient and cost management decisions. A lack of a uniform data formats will require ACOs to reformat files across multiple MCOs in order to combine into a single uniform database. Further, ACOs may have to
reformat this database repeatedly as individual MCOs change or update fields or record-keeping software. Performance reports that are fragmented across MCOs will make it difficult for providers to efficiently manage their attributed patient panels.

The ACO model presents an opportunity to align data collection, transmission, reporting among providers and MCOs. States can use policy and regulatory levers to require certain data fields and file formats for MCOs, thereby enabling patient records to be securely and accurately transmitted to ACOs so that they may be analyzed at patient and population levels. States can also consider requiring MCOs to use common data fields, interoperable software packages, uniform file formatting, and consistent transmission protocols that will allow claims databases and provider portals to consistently deliver data that are essential to a high-functioning ACO. Since such alignment will require MCOs to invest resources in reprogramming, states may want to identify approaches to minimize this burden, such as creating detailed specifications, coding, and templates.

4. Establishing Consistent Provider Supports

Creating uniform provider supports, such as training and coaching programs, technical assistance, learning collaboratives, and other tools and resources, may enable MCOs and ACOs to promote high-performing providers and influence continuous quality improvement. Several states, such as Maine, Massachusetts, Minnesota, Oregon, and Vermont, are working on provider learning collaboratives to help build provider capacity and share lessons broadly.

Although some supports may already be in place through existing pay for performance programs, the successful implementation of an ACO model will call for additional training and coaching to ensure that all providers understand what they are being held accountable for, how their performance will be assessed, and the financial implications of this assessment. Aside from guidance around new levels of accountability, providers could also benefit from on-site coaching to modify their workflows and day-to-day interactions with patients, care team members, other treating providers, and of course, MCOs. To promote seamless interactions across all ACO providers, it is imperative that the supports made available are consistent in design, content, and implementation.

Delineating Complementary ACO and MCO Responsibilities

ACOs could have a profound effect on how MCOs do business in the long run. As the model matures, clearly defining responsibilities will be an important aspect of program design. This delineation will provide much needed clarity on which entity is performing which duties.

States can identify ways to reallocate responsibilities to better reflect the comparative advantages of providers and health plans and to avoid costly duplication of services. Ideally, the roles that MCOs are performing effectively will remain in place, while functions better suited to the provider level will be assumed by ACOs. MCOs can also expand their existing provider support role to help ACOs build the capacity to better coordinate and manage care. In outlining ACO and MCO functions, states may want to consider: (a) whether to require or incent MCOs to assume new roles; (b) the baseline capacity of ACOs to perform specific tasks; (c) how responsibilities will be reallocated over time; (d) the implications for MCO financing changes; and (e) the level of policy guidance necessary to support these new roles. For example, as mentioned earlier, it is important to note that given the MLR requirements under ACA, states may want to consider avoiding
contractual changes that result in large shifts between medical and administrative expenses. Since medical expenses now include both medical claims paid and any funds spent on quality improvement activities, MCOs have expanded flexibility pertaining to such activities.

Key responsibilities traditionally delegated to MCOs that states may wish to reassess as ACOs evolve include:

1. Care coordination, care management, and disease management;
2. Quality improvement;
3. Data-sharing and analytics;
4. Utilization and risk management;
5. Development and distribution of evidence-based guidelines; and
6. Training and coaching.

Ultimately, there is no one-size-fits-all approach. States will base their decisions on an assessment of MCO strengths and capacity for innovation and ACO readiness to assume certain responsibilities. A state’s approach will depend on a variety of factors, including: (a) the proportion of the MCOs’ provider networks participating in the ACO program; (b) the extent to which MCOs will continue to support certain functions among non-ACO providers; (c) its provider makeup (large practices vs. small practices); and (d) the state’s geography (urban vs. rural). If MCOs and ACOs are given flexibility to develop their own innovative arrangements with one another beyond the core standardized elements identified earlier, market forces may help states to delineate further. For example, an MCO may seek a competitive advantage by working closely with robust ACOs to support tailored reports and build analytic capabilities. Indeed, over time the contractual relationships between MCOs and ACOs may move toward exclusive arrangements, as an MCO invests in certain ACOs. Finally, as these roles crystallize, state Medicaid agencies could consider creating a standardized certification process or using national certification programs, such as those established by the National Committee for Quality Assurance, to promote a clear path toward a defined set of responsibilities.

The following section addresses considerations to guide state decision-making across each of the six key responsibilities identified above.

1. **Care Coordination, Care Management, and Disease Management**

ACOs are designed to give providers financial incentives linked to the effective coordination of patient care via shared savings, shared risk, or global payment arrangements. The model presumes that providers, given their clinical training and direct patient contact, are best positioned to improve patient care in partnership with care teams, social support services, and community-based organizations. Telephonic care and disease management, where MCOs are relatively removed from patient care, is an obvious role that might be better suited to ACOs. ACOs often focus first on high-risk patients, where the opportunity for quality and cost improvement is the greatest and the impact of telephonic care management is likely to be minimal.

To ease this transition, states should consider a phased approach, working with their ACOs and MCOs to enable an efficient reallocation of resources. For example, states may explicitly transition care management responsibilities for high-cost, complex patients to ACOs in an initial phase, while keeping health plan disease management programs in place. Over time, as ACOs demonstrate capacity for broader population management, disease management and prevention programs may also shift to ACOs. Nonetheless, MCOs can still play a critical role in supporting patient care coordination efforts. For example, MCOs can notify ACOs once an attributed
patient has been admitted for an inpatient stay or help establish connections with specialists who are not affiliated with the ACO.

To avoid duplicate payments, states will want to consider reallocating the corresponding portion of MCO capitation to the ACOs. Underfunded Medicaid ACOs can benefit from upfront funding, and such reallocations would be budget neutral for states. If states decide to go this route, Medicaid agencies would need to adjust their MCO care management contractual requirements and payment methodology to exclude patients attributed to an ACO. However, states should also realize that MCOs may oppose this effort, since their role in care management will be reduced.

2. Quality Improvement

ACOs assume greater responsibility for quality improvement via shared savings and risk arrangements that are based on meeting defined quality and patient experience metrics. Under such arrangements, ACOs will have “skin in the game” for quality improvement and may be better positioned than MCOs to improve care delivery among providers, particularly if the ACOs are rooted in provider/hospital organizations or in local community-based entities. While HEDIS reporting requirements and financial arrangements such as “quality withholds” create incentives for health plans to take an active role in quality improvement across their entire provider network, MCOs often find it difficult to drive quality improvement at the point of care. However, since existing MCO quality improvement requirements may become duplicative, particularly for overlapping HEDIS and ACO metrics, states should consider developing a standard list of metrics and determine whether MCOs or ACOs should report them.

States will need to carefully evaluate the specific activities that may shift, since a broad range of activities fall under the umbrella of quality improvement. As a start, states can reexamine their MCO performance improvement plan (PIP) and quality management contract requirements to identify areas where ACOs can assume quality improvement responsibilities as well as gaps that MCOs should continue to fill. For example, states may redefine PIPs to require MCOs to support non-ACO providers or to focus on quality metrics that are not included in the ACO program. Until ACOs and other value-based provider entities make up the majority of the provider network, MCOs will continue to assume a strong quality support role.

3. Data-Sharing and Analytics

To support care coordination, quality improvement, and financial management activities, ACOs need access to patient-level data and the ability to identify high-need patients and manage patient interventions across providers. Although Medicaid providers have made progress in this area, most Medicaid MCOs continue to have more ready access to data and will likely continue to play a prominent role. ACO demand for health plan data may wane as health information exchanges become more robust, but in many cases, MCOs will likely remain the main source of expenditure data, including pharmacy, labs and diagnostics, hospital, specialty, and primary care. This may be particularly the case in rural environments and other areas with IT infrastructure challenges.

Consequently, states may wish to encourage or require plans to provide a defined set of HIPAA-compliant data and analytics to ACOs. For example, MCOs can provide recurring claims data feeds and provide in-depth analytic reports to help ACOs identify targeted opportunities for cost reduction. While some MCOs may provide these services to ACOs voluntarily, states should consider the extent to which contractual requirements will facilitate this data-sharing more efficiently.
States must also make decisions regarding how to measure quality, efficiency, and costs, including how often ACOs and MCOs must report data, which entity will report the information, what information will be reported, how the information will be transmitted, and how often performance measurement will be conducted. These are important considerations, as states should distribute these roles equitably to avoid overtaxing ACOs, MCOs, or both.

4. Utilization and Risk Management

Utilization management (UM) refers to the evaluation of the medical necessity and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan. ACOs may be able to assume aspects of UM once they hone their care management and data analytics skills, establish effective partnerships with a network of specialists and hospitals, and assume downside financial risk. For example, California health plans have established a delegated model among medical groups and independent practice associations, which receive partially capitated payments and often have close partnerships with hospitals. Delegating UM to ACOs can help to boost provider satisfaction, since MCO oversight is often perceived as a burden. As ACOs become more sophisticated and bear downside risk, the use of prior authorization may become unnecessary since the ACO will bear the cost of duplicative or expensive procedures. However, if ACOs do not have the building blocks of financial risk management, including data analytics and care management, UM may best reside with MCOs. Massachusetts, for example, has decided to leave UM responsibilities with its plans during its ACO Pilot.

5. Development and Distribution of Evidence-Based Guidelines

ACOs will eventually become proficient in adopting evidence-based medicine and adhering to standards of care on which robust care coordination, care management processes, and infrastructure are built. MCOs are likely to have far more robust knowledge in terms of up-to-date clinical guidelines, particularly related to pharmaceutical therapies and medical devices, where many have clinical advisory boards to cull emerging best practices and disseminate the information to network providers. States and ACOs may wish to partner with MCOs to improve the mechanisms through which evidence-based guidelines are shared at the point of care.

6. Training and Coaching

Most states are planning to give ACO providers some level of technical assistance. As states evaluate the technical assistance needs of their ACO providers, they may also evaluate MCO capacity to provide those resources. Given their experience with many of the above activities and their provider relations infrastructure, MCOs may be well positioned to provide training and coaching to ACOs. For example, MCOs can help ACOs build skills in areas such as data analytics, including predictive modeling and other mechanisms for high-risk patient identification. Many MCOs across the country already support the identification of high-risk patients and help providers track their performance against quality and cost benchmarks to achieve improvements. MCOs are also well positioned to train ACOs in financial management and UM. This training role can help ACOs build their capabilities more quickly. It can also establish a new MCO-ACO partnership in which to identify additional areas of collaboration.

As noted earlier, to achieve economies of scale and minimize provider burdens, there may be benefits to creating an all-payer platform to deliver provider training. However, MCOs may not choose to invest in resources that will benefit other payers. Therefore, states will need to determine the right balance of
consistency and incentives for innovation. If MCOs have a clear set of skills in this realm, states may consider letting MCOs apply to requests for applications to support such services.

**Conclusion**

ACOs and MCOs can coexist and provide improved care management services to Medicaid beneficiaries, but state Medicaid agencies must ensure that services are not duplicated and that the delivery system is improved by the advent of ACOs in a managed care environment. Given the political and financial tensions inherent with delivery system transitions of this magnitude, it is also very important for states to use their convening capacity to engage these and other stakeholders (e.g., providers, advocacy groups, and community-based organizations) early and often in the process. Clearly defining ACO and MCO roles, implementing the program effectively, and aligning ACO activities across Medicaid payers are crucial aspects of ACO success in a managed care environment. If these three strategies are put into action through a well-designed Medicaid ACO program at the state level—which may include legislation and the use of policy and regulatory levers—the ACO program will be more likely to improve health care quality and lower health care costs for Medicaid beneficiaries.

This issue brief was made possible through Advancing Accountable Care Organizations in Medicaid: A Learning Collaborative, which was generously funded by The Commonwealth Fund and the Massachusetts Medicaid Policy Institute, a program of the Blue Cross Blue Shield of Massachusetts Foundation. Through the learning collaborative, ACO innovators from seven states – Maine, Massachusetts, Minnesota, New Jersey, Oregon, Texas, and Vermont – have gathered to accelerate ACO program development and address key issues. Among the issues discussed by these states was the integration of ACOs in a managed care environment. The authors thank the states for their insights and hope that this issue brief will facilitate future ACO development in other states.

**About the Center for Health Care Strategies**

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit [www.chcs.org](http://www.chcs.org).

**Endnotes**

3 Some or all of these issues may not apply for states that adopt health plan-driven models. These models may have a less clearly defined relationship between MCOs and ACOs, especially if ACOs and MCOs act as a single entity, as in Oregon’s Coordinated Care Organization (CCO) Model.
4 “Accountable Care Organization Accreditation.” National Committee for Quality Assurance. [http://www.ncqa.org/Programs/Accreditation/AccountableCareOrganizationACO.aspx](http://www.ncqa.org/Programs/Accreditation/AccountableCareOrganizationACO.aspx).
6 Definition Utilization Review Accreditation Commission (URAC)
National Long-Term Services Numbers

- 6 million older people with disability—will more than double by 2040
- Long-term services about one-third of Medicaid expenditures nationally (Ohio 40%)
- Medicaid about 22% of state budgets (Ohio 25%)
- 60% of Medicaid LTC funds to nursing homes—varies by state
- Two-thirds of NH residents now on Medicaid
Ohio 60+ Population projections

Ohio's 60+ Population by County

2010

% 60+ Population
- 11.6% - 20%
- 20.1% - 25%
- 25.1% - 30%
- 30.1% - 35%
- 35.1% - 50.2%

Ohio's 60+ Projected Population by County

2020

% 60+ Population
- 11.6% - 20%
- 20.1% - 25%
- 25.1% - 30%
- 30.1% - 35%
- 35.1% - 50.2%

Ohio's 60+ Projected Population by County

2040

% 60+ Population
- 11.6% - 20%
- 20.1% - 25%
- 25.1% - 30%
- 30.1% - 35%
- 35.1% - 50.2%
An Aging America: Are You Aging?

- Gravity more powerful than kryptonite
- You are starting to look like your parents
- You can’t stay awake for Sat Night Live
- You have given up hope of being a professional athlete (mostly men)
- You have given up hope of finding a sensitive partner (Exclusively women)
Proportion of Ohio's Population with Physical/Cognitive Disability Receiving Care in Different Settings, 2011

- Aging Waivers: 20%
- Nursing Facility Medicaid: 26%
- Nursing Facility Private: 10%
- Privately purchased LTC: 18%
- Aging Levels: 6%
- Ohio Home Care: 5%
- Prisons: 1%
- Informal Care Only: 9%
<table>
<thead>
<tr>
<th>Year</th>
<th>Total Population</th>
<th>Physical and/or Cognitive Disability</th>
<th>Intellectual and/or Developmental Disability</th>
<th>Severe Mental Illness</th>
<th>Total Population with Severe Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 - 2030</td>
<td>Up 2%</td>
<td>Up 44% or 80,710 residents</td>
<td>Down 1%</td>
<td>Less than 1%</td>
<td>Up 10% or 75,000 residents</td>
</tr>
</tbody>
</table>
## NF Admissions by Payment Sources in thousands (1992-2011)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All Admissions</td>
<td>71</td>
<td>130</td>
<td>150</td>
<td>201</td>
<td>197</td>
<td>213</td>
</tr>
<tr>
<td>Medicare Admits</td>
<td>30</td>
<td>80</td>
<td>91</td>
<td>127</td>
<td>109</td>
<td>149</td>
</tr>
<tr>
<td>Medicaid Admits</td>
<td>18</td>
<td>19</td>
<td>24</td>
<td>25</td>
<td>27</td>
<td>29</td>
</tr>
</tbody>
</table>
Shorter Stays: Proportion of Total & Medicaid Nursing Home Residents Still Living in a Facility
<table>
<thead>
<tr>
<th>Year</th>
<th>Adjusted Nursing Facility Beds</th>
<th>Average Daily Census</th>
<th>Nursing Facility Occupancy Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>93,204</td>
<td>84,536</td>
<td>90.7</td>
</tr>
<tr>
<td>1995</td>
<td>96,579</td>
<td>86,728</td>
<td>89.8</td>
</tr>
<tr>
<td>1997</td>
<td>99,302</td>
<td>84,643</td>
<td>87.7</td>
</tr>
<tr>
<td>1999</td>
<td>95,701</td>
<td>79,910</td>
<td>83.5</td>
</tr>
<tr>
<td>2001</td>
<td>94,231</td>
<td>78,427</td>
<td>83.2</td>
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<tr>
<td>2003</td>
<td>90,712</td>
<td>76,850</td>
<td>84.7</td>
</tr>
<tr>
<td>2005</td>
<td>91,274</td>
<td>78,835</td>
<td>86.4</td>
</tr>
<tr>
<td>2007</td>
<td>92,443</td>
<td>81,108</td>
<td>87.7</td>
</tr>
<tr>
<td>2009</td>
<td>93,209</td>
<td>80,008</td>
<td>84.7</td>
</tr>
<tr>
<td>2011</td>
<td>94,710</td>
<td>78,790</td>
<td>83.6</td>
</tr>
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</table>
Changes in NH resident characteristics

<table>
<thead>
<tr>
<th></th>
<th>Today (%)</th>
<th>1994 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of all residents…</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age 60</td>
<td>12.7</td>
<td>4</td>
</tr>
<tr>
<td>Age 65 and under</td>
<td>19.1</td>
<td>7</td>
</tr>
<tr>
<td>Of Medicaid residents…</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid under age 60</td>
<td>16.7</td>
<td>NA</td>
</tr>
<tr>
<td>Medicaid Age 65 and under</td>
<td>24.2</td>
<td>NA</td>
</tr>
</tbody>
</table>
Average Number of People Age 60 and Older Receiving LTCSS, Paid by Medicaid, 1997-2011

- **Average Monthly Waivers Enrollment**
  - 1997: 47,652
  - 1999: 46,393
  - 2001: 44,872
  - 2003: 47,119
  - 2005: 45,000
  - 2007: 43,370
  - 2009: 42,379
  - 2011: 42,840

- **Average Daily NF Census**
  - 1997: 14,168
  - 1999: 15,860
  - 2001: 18,361
  - 2003: 23,302
  - 2005: 24,163
  - 2007: 26,153
  - 2009: 24,163
  - 2011: 26,153

**Notes:**
- More Types of Waivers and Increase in Enrollment
- Decline in NH Census
Percent Distribution of Ohio’s Medicaid Long-Term Care Services and Supports Utilization by People Age 60 and Older, 1993-2011

Avg. Monthly Waiver Enrollment

Avg. Medicaid NF Daily Census

<table>
<thead>
<tr>
<th>Year</th>
<th>Avg. Waiver</th>
<th>Avg. Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>91</td>
<td>9</td>
</tr>
<tr>
<td>1995</td>
<td>80</td>
<td>20</td>
</tr>
<tr>
<td>1997</td>
<td>77</td>
<td>23</td>
</tr>
<tr>
<td>1999</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>2001</td>
<td>71</td>
<td>29</td>
</tr>
<tr>
<td>2003</td>
<td>67</td>
<td>33</td>
</tr>
<tr>
<td>2005</td>
<td>65</td>
<td>35</td>
</tr>
<tr>
<td>2007</td>
<td>62</td>
<td>38</td>
</tr>
<tr>
<td>2009</td>
<td>58</td>
<td>42</td>
</tr>
<tr>
<td>2011</td>
<td>55</td>
<td>45</td>
</tr>
</tbody>
</table>
Number of People Age 60 and Older Residing in Nursing Facilities or Enrolled in HCBS Per 1000 Persons in Population

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Avg Monthly NF Census</th>
<th>Avg Monthly Waiver Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>31.8</td>
<td>24.5</td>
<td>7.3</td>
</tr>
<tr>
<td>1999</td>
<td>31.9</td>
<td>23.7</td>
<td>8.1</td>
</tr>
<tr>
<td>2001</td>
<td>31.7</td>
<td>22.5</td>
<td>9.2</td>
</tr>
<tr>
<td>2003</td>
<td>34.2</td>
<td>22.9</td>
<td>11.3</td>
</tr>
<tr>
<td>2005</td>
<td>32.5</td>
<td>21.2</td>
<td>11.4</td>
</tr>
<tr>
<td>2007</td>
<td>31.7</td>
<td>19.8</td>
<td>11.9</td>
</tr>
<tr>
<td>2009</td>
<td>32.3</td>
<td>18.8</td>
<td>13.5</td>
</tr>
<tr>
<td>2011</td>
<td>33.8</td>
<td>18.5</td>
<td>15.4</td>
</tr>
</tbody>
</table>
## Residential Care Facilities in Ohio, 2011

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>RCF only</th>
<th>Assisted Living</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Facilities</strong></td>
<td>585</td>
<td>182</td>
<td>403</td>
</tr>
<tr>
<td><strong>Total Licensed RCF beds</strong></td>
<td>44,203</td>
<td>4,984</td>
<td>39,219</td>
</tr>
<tr>
<td><strong>Total Number of Units</strong></td>
<td>31,735</td>
<td>3,870</td>
<td>27,865</td>
</tr>
<tr>
<td><strong>Average Number of Beds</strong></td>
<td>76</td>
<td>48</td>
<td>82</td>
</tr>
<tr>
<td><strong>Average Number of Units</strong></td>
<td>54</td>
<td>37</td>
<td>58</td>
</tr>
<tr>
<td><strong>Bed Occupancy (%)</strong></td>
<td>66.7</td>
<td>71.4</td>
<td>65.2</td>
</tr>
<tr>
<td><strong>Unit Occupancy (%)</strong></td>
<td>80.9</td>
<td>80.8</td>
<td>81.0</td>
</tr>
<tr>
<td><strong>Average Monthly Rate</strong></td>
<td>$3,211</td>
<td>$3,696</td>
<td>$3,157</td>
</tr>
<tr>
<td><strong>Part of CCRC (%)</strong></td>
<td>31</td>
<td>23</td>
<td>33</td>
</tr>
</tbody>
</table>
Where do we go

• Continue to lower the nursing home bed supply. Understand why younger residents are utilizing the available beds.
• Slow down the increase of Medicaid utilization by older population.
• Create a system of comparable data to understand costs and utilization.
• Integrated care
One problem Addressed– New One Gets Added to the List

• Acute and long-term care systems don’t live in the same world– provider fragmentation
• Medicare and Medicaid as funders don’t work together and in fact cost shifting has been the norm
• The lack of integration is bad for consumers --- bad for quality, bad for costs
• Overall system unsustainable
Integrated Care Demonstration

• ICDS -- MY Care Ohio being implemented in about 60% of the state
• All Medicaid/Medicare NF residents must enroll in ICDS
• Model based on participants enrolling in the Medicare Advantage Plan operated by the Medicaid Plan
• Hope is that demonstration will improve quality and lower costs
Current MyCare Story

- Too early to have systematic results
- National evaluation underway
- Have been predictable implementation challenges in Ohio similar to other states:
  - information system gaps, payment delays, ltcs and acute care culture differences
LTCSS as Proportion of Total Medicaid Per-Member, Per-Month Exp. For Ohio’s Population Using LTCSS by Age Group, 2010

<table>
<thead>
<tr>
<th>Type of Facility or Program</th>
<th>LTCSS as % of Total PMPM</th>
<th>Total Medicaid PMPM</th>
<th>LTCSS as % of Total PMPM</th>
<th>Total Medicaid PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care /Total cost</td>
<td>Under 65</td>
<td>65 +</td>
<td>Under 65</td>
<td>65 +</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>72.6%</td>
<td>$6,555</td>
<td>92.5%</td>
<td>$4,430</td>
</tr>
<tr>
<td>PASSPORT</td>
<td>41.4%</td>
<td>$2,368</td>
<td>69.5%</td>
<td>$1,550</td>
</tr>
<tr>
<td>Ohio Home Care</td>
<td>46.6%</td>
<td>$4,574</td>
<td>__</td>
<td>__</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>62.8%</td>
<td>$2,680</td>
<td>86.3%</td>
<td>$1,730</td>
</tr>
<tr>
<td>Aging Carve-Out</td>
<td>53.9%</td>
<td>$4,173</td>
<td>65.4%</td>
<td>$3,814</td>
</tr>
<tr>
<td>PACE</td>
<td>__</td>
<td>$3,083*</td>
<td>__</td>
<td>$2,437*</td>
</tr>
<tr>
<td>Choices</td>
<td>60.5%</td>
<td>$2,775</td>
<td>79.8%</td>
<td>$1,857</td>
</tr>
</tbody>
</table>
Ohio’s Challenges:

- Today Ohio has 305,000 individuals of all ages with severe disability and 122,000 (40%) receive LTC services through Medicaid.
- Today about one-quarter of the state budget is Medicaid—40% goes to LTC.
- By 2020, 348,000 with severe disability and 138,000 projected to receive Medicaid LTC services.
- By 2040, 600,000 with severe disability and 237,000 projected to receive Medicaid LTC services.
Policy and the Future

- Even with changes the current system is simply not sustainable
- Short-term window where “boomer growth” remains small, before the major increase
- The current system was never designed-- it just happened-- Meaningful change is very slow
- We often have policy changes with unplanned consequences. Hospital reform meant a new nursing home
- LTC system must be innovative and efficient-- It will need to use technology, public-private partnerships, prevention and new ideas such as aging friendly communities
- Heavy pressure driven by Medicaid budget concerns-- Big Federal role in what is pretty much a state run system
Contact info

• Bob Applebaum Applebra@Miamioh.edu

• Scrippsaging.org (Scripps web site)
Health-related Legislative Highlights of the 130th General Assembly

Telehealth

Telehealth is generally viewed as a tool used to increase access to care and improve health outcomes by overcoming geographic barriers to care through the use of information and communications technology. In the right settings and under certain parameters, telehealth can be used to improve health outcomes and increase access to health care services.

<table>
<thead>
<tr>
<th>Summary of selected legislative and rule updates</th>
</tr>
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<tbody>
<tr>
<td><strong>Enacted</strong></td>
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<tr>
<td><strong>HB 123: Telehealth</strong></td>
</tr>
<tr>
<td>• Requires the Department of Medicaid to establish Medicaid payment standards for telehealth services.</td>
</tr>
<tr>
<td><strong>Effective date:</strong> 5/20/14</td>
</tr>
<tr>
<td><strong>Pending</strong></td>
</tr>
<tr>
<td><strong>Rule – OAC 5160-1-18: Telemedicine</strong></td>
</tr>
<tr>
<td>Ohio Department of Medicaid</td>
</tr>
<tr>
<td>• Establishes policy relating to the coverage of Medicaid services delivered through telemedicine.</td>
</tr>
<tr>
<td>• For purposes of Medicaid coverage, telemedicine is the direct delivery of evaluation and management or psychiatric services to a Medicaid eligible patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements.</td>
</tr>
<tr>
<td>• Physicians (MD, DO) and licensed psychologists may be eligible for payment for eligible services rendered through telemedicine, and a physicians’ office, clinics, Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC) and outpatient hospitals may be eligible for a telemedicine originating payment.</td>
</tr>
<tr>
<td><strong>Status:</strong> Filed with JCARR, Public Hearing held on Nov. 17, 2014</td>
</tr>
<tr>
<td><strong>Rule – 4731-11-09: Prescribing to persons the physician has never personally examined</strong></td>
</tr>
<tr>
<td>State Medical Board of Ohio</td>
</tr>
<tr>
<td>• Rule is being updated to reflect advances in technology and the use of telemedicine.</td>
</tr>
<tr>
<td><strong>Status:</strong> Under review by the Medical Board, not yet filed. Will be opportunity for stakeholder comments.</td>
</tr>
</tbody>
</table>

Infant mortality

Infant mortality is defined as the death of a baby before his or her first birthday. In 2011, Ohio's infant mortality rate was 7.88 (infant deaths per 1,000 live births). This rate is higher than the U.S. average of 6.07. The Health People 2020 objective is 6.0. Furthermore, there is a significant racial disparity, with black infants dying at more than twice the rate of white infants.
Combating infant mortality has emerged as a key health policy issue for both the executive and legislative branches. Numerous bills have been introduced in the Ohio General Assembly to address the top five leading causes of infant mortality: (1) preterm birth, (2) serious birth defect, (3) sudden infant death syndrome (SIDs), (4) maternal complications of pregnancy, and (5) injuries (e.g. suffocation).

<table>
<thead>
<tr>
<th>Enacted</th>
<th>SB 278: Sudden infant death</th>
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<tbody>
<tr>
<td>Requires individuals designated to investigate the sudden death of a child who is one year of age or younger and in apparent good health to complete a “Sudden Unexplained Infant Death Investigation Reporting Form” (SUIDI) developed by the CDC or an alternative form the Director of Health may develop. This requirement replaces recently enacted law that encourages, but doesn’t require, completion of a SUIDI form.</td>
<td></td>
</tr>
<tr>
<td>Copy of form needs to be sent to the appropriate child fatality review board or regional child fatality board; forms are not public record.</td>
<td></td>
</tr>
<tr>
<td>Effective date: 9/17/14</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Pending</th>
<th>SB 276: Internal infant safe sleep policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary sponsors: S. Jones and C. Tavares</td>
<td></td>
</tr>
<tr>
<td>Requires the Ohio Department of Health (ODH) to establish the Safe Sleep Education Program by developing educational materials that present information on safe sleeping practices and possible causes of sudden unexpected infant death. The materials must be made available on the ODH website.</td>
<td></td>
</tr>
<tr>
<td>Requires facilities and locations that must participate in the Safe Sleep Education Program and that have infants regularly sleeping in their facilities to adopt an internal infant safe sleep policy.</td>
<td></td>
</tr>
<tr>
<td>Requires hospitals and freestanding birthing centers, with some exclusions, to implement an infant safe sleep screening procedure. If it is determined that an infant will not have a safe place to sleep upon discharge, a crib must be provided at no cost to the parent.</td>
<td></td>
</tr>
<tr>
<td>Status: Introduced 2/12/14; Passed by the House on 6/3/14; Assigned to the House Health and Aging committee</td>
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</table>

| SB 277: Commission on infant mortality |
| Primary sponsors: S. Jones and C. Tavares |
| Creates the 13-member Commission on Infant Mortality to conduct an inventory of certain services provided by the state to address the state’s infant mortality rate and make determinations related to the funding of services. |
| Requires the Commission to issue a report no later than six months after the bill’s effective date to the Governor and the General Assembly. |
| Commission’s responsibilities will be determined following submission of the report. |
| Status: Introduced 2/12/14; Assigned to Senate State Government Oversight & Reform committee |

| SB 280: Medicaid – postpartum care |
| Primary sponsors: S. Jones and C. Tavares |
• Requires Medicaid managed care payment reductions unless case management services for postpartum care are made available to program recipients.
• Requires case management services to include counseling regarding the optimal intervals at which pregnancies may be spaced in order to promote healthy pregnancies, reduce the risk of infant mortality and achieve other positive health outcomes.
• Requires the ODH Director of Health to award grants for community-based services that are not covered by Medicaid and are intended to reduce infant mortality rates among at-risk populations.
• Makes an appropriation of $25 million for state fiscal year 2015 to award grants.

Status: Introduced 2/12/14; Assigned to Senate Finance committee

SB 279: Prenatal group health care pilot program
Primary sponsors: S. Jones and C. Tavares
• Requires the Director of Health to establish and operate a two-year prenatal group health care pilot program based on the centering pregnancy model of care to:
  o Decrease the number of preterm infants weighing less than 2500 grams
  o Increase prenatal care during first trimester of pregnancy
  o Increase the number of women who breastfeed.
• Bill appropriates $500,000 from the GRF in both FY 2015 and FY 2016 for implementation of the program.

Status: Introduced 2/12/14; Assigned to House State and Local Government committee

HB 448: Educational materials – newborn safe-sleeping practices
Primary sponsors: M. Stinziano and S. Kunze
• Provides for the development of educational materials promoting infant safe-sleeping practices and for review of the materials with the parent, guardian, or caregiver of each newborn infant.

Status: Introduced 2/13/14; Assigned to House Health and Aging committee

Opioid Use and Addiction

The Ohio General Assembly has been active in introducing legislation addressing opioid use and addiction. Drug overdose deaths are the leading cause of accidental death in Ohio. In 2012, unintentional drug overdoses caused 1,914 deaths to state residents, which is the highest number of deaths on record for drug overdoses.\textsuperscript{vi} Prescription opioids accounted for more than a third (36.4 percent)\textsuperscript{vi} of fatal unintentional overdoses in 2012 involved prescription opioids, which is more than any other substance.

Summary of selected legislative updates\textsuperscript{vii}

<table>
<thead>
<tr>
<th>Enacted</th>
<th>HB 170: Naloxone</th>
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<tbody>
<tr>
<td>• Allows a licensed health professional to prescribe naloxone to individuals who are in a position to assist a person at risk of experiencing an opioid-</td>
<td></td>
</tr>
</tbody>
</table>
related overdose, without being subject to administrative action or criminal prosecution.
• Allows an individual to administer naloxone to a person who is experiencing an opioid-related overdose without being subject to criminal prosecution as long as they attempt to call emergency services and the naloxone prescription is obtained from a licensed health professional, or in the case of law enforcement officials, naloxone was obtained from the law enforcement agency.

**Effective date: 3/11/14**

**HB 314: Controlled substance prescriptions – minors**
• Requires a prescriber to obtain written informed consent from a parent, guardian, or another adult authorized to consent to the minor's medical treatment before issuing the minor a prescription for a controlled substance containing an opioid.

**Effective date: Effective date 9/17/14**

**HB 315: Neonatal abstinence syndrome**
• Requires maternity units, newborn care nurseries and maternity homes to report to the Ohio Department of Health regarding newborns diagnosed as opioid dependent.

**Effective date: 7/10/14**

**HB 341: Schedule II drug prescriptions**
• Prohibits a controlled substance that is a schedule II drug or contains opioids from being prescribed or dispensed without review of patient information in the State Board of Pharmacy's Ohio Automated Rx Reporting System.

**Effective date: 9/16/14**

**HB 366: Hospice-opioid diversion prevention**
• Requires hospice care programs to establish a written policy to prevent diversion of controlled substances that contain opioids.
• Requires the policy to include procedures for the disposal of any such drugs no longer needed by the hospice patient.
• Requires a program to request that the hospice patient or family relinquish any controlled substances containing opioids that are no longer needed by the patient.
• Includes various requirements including assessing the patient and family for risk factors associated with diversion.

**Effective date: 9/17/14**

**Pending**

**HB 367: Opioid abuse prevention instruction – schools**
Primary sponsors: D. Driehaus and R. Sprague
• Requires the health curriculum of each school district to include instruction in prescription opioid abuse prevention.

**Status: Introduced 12/2/13; Introduced in the Senate 3/13/14; Assigned to the Senate Education committee**

**HB 369: MBT – Medicaid-opioid addictions**
Primary sponsor: R. Sprague
• Requires the Medicaid program and health insurers to cover certain services for recipients with opioid addictions.
Status: Introduced 12/3/13; Introduced in the Senate 4/10/14; Assigned to Senate Finance committee

**HB 378: Physicians – no drugs for opioid dependence unless patient also counseled**
Primary sponsors: R. Smith and R. Sprague
- Prohibits a physician from prescribing or furnishing certain medications to treat dependence on or addiction to opioids unless certified by the medical director of the Ohio Department of Mental Health and Addiction Services and requires the patient to be actively participating in appropriate behavioral counseling or treatment.

Status: Introduced 12/5/13; Passed by the House on 12/2/14; Introduced in the Senate on 12/3/14

**HB 589: Save our children now act**
Primary sponsor: M. Lundy
- Provides funds for opioid addiction treatment and rehabilitation services, to make an appropriation of $100,000,000 for such services.

Status: Introduced 6/18/14; Assigned to House Finance and Appropriations committee

**HB 612: Opioid epidemic – state funding**
Primary sponsors: J. Rogers and N. Barborak
- Establishes a program of state financial assistance to counties, municipal corporations, and townships to help in defraying the costs of the county's sheriff, the county's drug task force, or the municipal corporation's or township's law enforcement agency in combatting the opioid abuse and heroin addiction epidemic and to make an appropriation.

Status: Introduced 8/18/14; Assigned to House Finance and Appropriations committee

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**JMOC**

The Joint Medicaid Oversight Committee (JMOC) was established by Senate Bill 206 and is responsible for overseeing reforms to Ohio's Medicaid program. The committee is comprised of five members appointed by the Senate President (three from the majority party and two from the minority party) and five members appointed by the Speaker of the House (three from the majority party and two from the minority party). A majority member from the House serves as chairperson in odd-numbered years and a majority member from the Senate serves as chairperson in even-numbered years.

The committee oversees Medicaid compliance with legislative intent, evaluates legislation for long-term impact on Medicaid, and assists in limiting the rate of spending growth, while improving quality of care and health outcomes for individuals enrolled in Ohio's Medicaid program.

**2014 Committee Membership:**
- Senator David Burke (Chair)
- Senator Chris Widener
- Senator Bill Coley
Senator Capri Cafaro
Senator Charleta Tavares
Representative Barbara Sears (Vice Chair)
Representative Ryan Smith
Representative Robert Sprague
Representative Nickie Antonio
Representative Vernon Sykes

Additional resources:

- For more information about the above legislation, visit [http://www.legislature.state.oh.us/index.cfm](http://www.legislature.state.oh.us/index.cfm) and enter the bill number.
- For more information about the Joint Medicaid Oversight Committee, visit [http://www.jmoc.state.oh.us](http://www.jmoc.state.oh.us)

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1 Status updates are as of 12/3/14. Summaries are not intended to provide a comprehensive overview of the legislation or rules. Please see additional resources for specific bill information.
4 Healthy People 2020 identifies health improvement priorities, providing measurable objectives and goals that are applicable at the national, State and local levels.
5 Status updates are as of 12/3/14. Summaries are not intended to provide a comprehensive overview of the legislation. Please see additional resources for specific bill information.
8 Status updates are as of 12/3/14. Summaries are not intended to provide a comprehensive overview of the legislation. Please see additional resources for specific bill information.
**Act** - A bill passed by the legislature. (An act becomes law if it is signed by the governor or ten days after the governor takes no action.)

**Affordable Care Act (ACA)** - The health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

**Accountable Care Community (ACC)** - A broadened concept of accountable care organizations (see below) that includes other entities, such as community-based prevention organizations, local health departments, or social service providers, in addition to health care providers, in the group held accountable for performance.

**Accountable Care Organization (ACO)** - A network of providers that collectively assumes responsibility for the care of a defined patient population and shares in payer savings if set quality and cost performance metrics are met. The provider network may also be at risk and bear financial responsibility for spending that exceeds target metrics.

**Advance Directive** - A legal document detailing individuals’ health care wishes, including the person to whom they give the legal authority to act on their behalf and what types of treatment they do and do not want to receive in the event they are unable to speak or communicate.

**Adverse Selection** - People with a higher-than-average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.

**Advocacy** - Advocacy is any action that speaks in favor of, recommends, argues for a cause, supports or defends, or pleads on behalf of others. Policy advocacy includes many different activities designed to build support for an issue or advance policy change, including educating the public and policymakers, letters to the editor, “call to action” email alerts, visiting elected officials, testifying for a legislative committee, attending rallies, etc. Lobbying is a specific form of policy advocacy (see Lobbying).

**Issue advocacy** - An organization communicating positions on issues of social, economic or philosophical concern. Advocacy might include education or attempting to influence the public on health, social or economic subjects. The term is commonly used to mean all policy-related activities that are not intended to intervene in an election for or against a candidate for public office.

**Legislative advocacy** - Efforts to change policy through the legislative branch of government. This may include lobbying or other communications with the legislative branch that do not meet the definition of lobbying.

**Media advocacy** - The process of disseminating policy-related information through the communications media, especially where the aim is to effect action, a change in policy, or to alter the public’s view of issues. The strategic use of media as a resource for advancing a social or public policy initiative.

**Aged, Blind, Disabled (ABD)** - A Medicaid designation that assists with medical expenses for poor individuals who are aged 65 years or older, blind or disabled (disability as classified by the Social Security Administration for an adult or child).

**Appropriation** - Spending authority granted by the General Assembly, usually to a state agency.
**Backbone Organization** - Described as part of the Collective Impact Model, “backbone” organizations provide supporting infrastructure for collaborative efforts through meeting facilitation, fundraising, data collection and reporting, administration and communications support.

**Best Available Research Evidence** - Evidence used to determine whether or not a prevention program, practice, or policy is actually achieving the outcomes it aims to and in the way it intends. The more rigorous a study's research design, the more compelling the research evidence, indicating whether or not a program, practice, or policy is effectively preventing violence.

**Biennium** - A two-year period. Each Ohio General Assembly meets for one biennium and each state budget lasts one biennium. For example, the current biennium runs from January 2013 to December 2014.

**Bundled Payments** - Use of a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings. (Also referred to as case rates or episode-based payment).

**Bill** - A formal written document proposing to make a change in law by amending or repealing an existing provision of law or enacting a new provision.

**Budget Bill** - The spending proposal for the state submitted by the Governor and considered by both houses of the legislature. Ohio's budget bill is for a two-year period (see: biennium).

**Capitation** - A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served without regard to the actual number or nature of services provided to each person in a set period of time.

**Case Management** - A process where a health plan identifies covered individuals with specific health care needs (usually for individuals who need high-cost or extensive services or who have a specific diagnosis) and devises and carries out a coordinated treatment plan.

**Catastrophic Coverage** - A coverage option with limited benefits and a high deductible, intended to protect against medical bankruptcy due to an unforeseen illness or injury. These plans are usually geared toward young adults in relatively good health. While catastrophic plans do not generally cover preventive care, catastrophic coverage plans under health reform will be required to exempt some preventive care services from the deductible.

**Categorically Needy** - Medicaid’s eligibility pathway for individuals who can be covered. There are more than 25 eligibility categories organized into five broad groups: children, pregnant women, adults with dependent children, individuals with disabilities and the elderly. Persons not falling into one of these groups (notably childless adults) cannot qualify for Medicaid no matter how low their income. The ACA simplifies Medicaid eligibility, expanding coverage to all adults up to 138% of FPL (133% + 5% income disregard). This will extend eligibility to an estimated 560,000 Ohioans.

**Centers for Medicare and Medicaid Services (CMS)** - The federal agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act). Formerly the Health Care Financing Administration (HCFA). [www.cms.gov](http://www.cms.gov)

**Certificate of Need (CON)** - A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, modify a health facility or offer a new or different health service. CON is intended to control expansion of facilities, services and costs by preventing excessive or duplicative development of facilities and services.
Children's Health Insurance Program (CHIP) - Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped. Formerly known as SCHIP, or State Children's Health Insurance Program, the name was changed when the program was reauthorized in 2009.

Clinical preventive services - Prevention services provided to individual patients in a healthcare setting.

Co-Insurance - A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met.

Consolidated Omnibus Budget Reconciliation Act (COBRA) - A 1986 act containing certain health benefit provisions that amend ERISA, the IRS code and the Public Health Service Act to enable qualified individuals who lose their job to maintain the group coverage in which they were enrolled for an additional 18 months after leaving employment. Individuals are required to pay the standard premium of their previously provided plan. Applies to firms with more than 20 employees.

Community-based prevention programs - Prevention programs delivered in a community setting (such as home, school, child care, workplace, or neighborhood) to program participants as individuals, families, or communities.

Community-centered health homes - An emerging health model to bridge clinical services with community-based prevention programs and population-level policy strategies. A provider practice that addresses the factors outside the healthcare system that impact patient health outcomes by advocating for policy, system and environmental change.

Consumer-Driven Health Care - Most commonly used to describe the combination of a high-deductible health insurance plan with a tax-preferred savings account used to pay for routine health care expenses.

Contextual evidence - Contextual Evidence refers to information about whether or not a strategy "fits" with the context in which it is to be implemented. In other words, contextual evidence provides prevention practitioners with information on whether a strategy is feasible to implement, is useful, and is likely to be accepted by a particular community.

Community Rating - A method for setting premium rates under which all policy holders are charged the same premium for the same coverage. "Modified community rating" generally refers to a rating method under which health insuring organizations are permitted to vary premiums based on specified demographic characteristics (e.g., age, gender, location), but cannot vary premiums based on the health status or claims history of policy holders. Under health reform, beginning in 2014, health plans will be required to adopt modified community rating. Variations in premiums will only be allowed for differences in geography, family structure, age (limited to a 3 to 1 ratio) and tobacco use (limited to a 1.5 to 1 ratio).

Co-Payment - A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by the service provided and by the health plan.

Cost-Shifting - Recouping the cost of providing uncompensated care by increasing revenues from some payers to offset losses and lower net payments from other payers. For example, hospitals may increase charges for some payers to offset losses due to uncompensated or indigent care or lower payments (e.g., Medicaid or Medicare) from other payers.

Credible - The source of the information contributes to how worthy it is of belief when compared to external (who and where it comes from) and internal (independent knowledge of the subject) criteria.
**Creditable Coverage** - Health insurance that must meet minimum standards.

**Crowd-Out** - A phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.

**Deductible** - A set amount of medical expenses a patient must pay before being eligible for benefits under an insurance program.

**Department of Health and Human Services (HHS)** - HHS is the U.S. government’s principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Many HHS-funded services, including Medicare, are provided at the local level by state or county agencies or through private sector grantees. The department’s programs are administered by 11 operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies.

**Diagnostic Related Group (DRG)** - A system used to classify patients (especially Medicare beneficiaries) for the purpose of reimbursing hospitals. Under the system, hospitals are paid a fixed fee for each case in a given category, regardless of the actual costs.

**Disease Management** - A process of identifying and delivering within selected patient populations (e.g., patients with asthma or diabetes) the most efficient, effective combination of resources, interventions or pharmaceuticals for the treatment or prevention of a disease.

**Disproportionate Share Hospital Program (DSH)** - A federal program that works to increase health care access for the poor. Hospitals that treat a “disproportionate” number of Medicaid and other indigent patients qualify for higher Medicaid payments based on the hospital’s estimated uncompensated cost of services to the uninsured.

**Doughnut Hole** - A gap in prescription drug coverage under Medicare Part D, where beneficiaries enrolled in Part D plans pay 100% of their prescription drug costs after their total drug spending exceeds an initial coverage limit until they qualify for catastrophic coverage. The coverage gap will be gradually phased out under health reform, so that by 2020, beneficiaries will only be responsible for 25% of all prescription drug costs up to the catastrophic level.

**Dual Eligible** - A person who is eligible for two health insurance plans, often referring to a Medicare beneficiary who also qualifies for Medicaid benefits.

**Electronic Medical Record (EMR)** - An individual medical record that has been digitized and stored electronically.

**Emergency Medical Service (EMS)** - Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.

**Emergency Medical Treatment and Active Labor Act (EMTALA)** - A United States Act of Congress passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) requiring hospitals and ambulance services to provide care to anyone needing emergency treatment regardless of citizenship, legal status or ability to pay.

**Employee Retirement Income Security Act (ERISA)** - A federal act passed in 1974 that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs. To date, self-funded health benefit plans operating under ERISA are exempt from state insurance laws.

**Environmental change** - Physical or material changes to the economic, social, or physical environment (such as water fluoridation, removing lead from paint, and improving the built environment with sidewalks and bike lanes).
2014 Federal Poverty Levels

<table>
<thead>
<tr>
<th></th>
<th>64%</th>
<th>90%</th>
<th>100%</th>
<th>138%</th>
<th>200%</th>
<th>250%</th>
<th>400%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$7,469</td>
<td>$10,503</td>
<td>$11,670</td>
<td>$16,105</td>
<td>$23,340</td>
<td>$29,175</td>
<td>$46,680</td>
</tr>
<tr>
<td>2</td>
<td>$10,067</td>
<td>$14,157</td>
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Source: Federal Register, January 22, 2014
Note: Annual guidelines for all states except Alaska, Hawaii and DC. For each additional person, add $4,060

Essential Benefits – As specified in the ACA, plans in the health insurance exchange are required to offer coverage for “essential benefits” that must include: emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, preventive and wellness services and chronic disease management, and pediatric services (including pediatric oral and vision care).

Evidence-based practice – Evidence-based practice involves making decisions on the basis of the best available scientific evidence, using data and information systems systematically, applying program-planning frameworks, engaging the community in decision making, conducting sound evaluation, and disseminating what is learned. Note: This is the definition was adopted by the Public Health Accreditation Board (PHAB).

Evidence-based prevention strategies – Programs or policies that have been evaluated and demonstrated to be effective in preventing health problems based upon the best-available research evidence, rather than upon personal belief or anecdotal evidence.

Experiential evidence – The collective experience and expertise of those who have practiced or lived in a particular setting. It also includes the knowledge of subject matter experts. This insight, understanding, skill and expertise is accumulated over time and is often referred to as intuitive or tacit knowledge.

Federal Medical Assistance Percentage (FMAP) – The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. The American Recovery and Reinvestment Act (ARRA) provided a temporary increase in the FMAP (also known as enhanced FMAP or eFMAP) through December 31, 2010, and additional legislation partially extends this funding through June 30, 2011.

Federal Poverty Level (FPL) – Annualy updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs. In 2014, the FPL for a family of four is $23,850 (see chart above).

Federally-Qualified Health Center (FQHC) – A health center in a medically under-served area or population that is eligible to receive cost-based Medicare and Medicaid reimbursement and provides direct reimbursement to nurse practitioners, physician assistants and certified nurse midwives. FQHCs are sometimes referred to as CHCs (Community Health Centers). A CHC is an ambulatory health care program usually serving a catchment area that has scarce or non-existent health services or a population with special needs.

Fee-for-Service – A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient’s insurance carrier for reimbursement.
Fidelity – The degree to which a program, practice, or policy is conducted in the way that it was intended to be conducted. This is particularly important during replication, where fidelity is the extent to which a program, practice, or policy being conducted in a new setting mirrors the way it was conducted in its original setting.

Fiscal year (FY) – A 12-month budget and accounting period that is named for the year in which it ends. The state’s fiscal year begins on July 1. Note that different entities (school districts, municipalities, the federal government) can have different fiscal years.

Flexible Spending Account (or a Section 125 option) – An employer-sponsored benefit plan that enables employees to use pretax (tax free) dollars to pay for medical expenses or the cost of care for children or elderly dependents, up to legislated limits and within specific guidelines.

Formulary – see Preferred Drug List

Fully insured plan – An insurance plan where the employer contracts with another organization to assume financial responsibility for the enrollees’ medical claims and for all incurred administrative costs.

Grey literature – Electronic and print format documents produced by government agencies, academic institutions and other organizations not controlled by commercial publishing.

Guaranteed Issue – Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason. Beginning in 2014, the health reform law will require guarantee issue and renewability.

Health – A state of complete physical, social, and mental wellbeing, and not merely the absence of disease or infirmity.

Health disparities – Differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities.

Health equity – The absence of differences in health that are caused by social and economic factors. Achieving health equity means that all people have the opportunity to achieve their full health potential, with no one at a disadvantage because of social or economic circumstances.

Health Impact Assessment (HIA) – A systematic process that uses an array of data sources and analytic methods, and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. An HIA provides recommendations on monitoring and managing those effects.

Health in All Policies – A collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.
**Health inequity** - A subset of health disparities that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity.

**Health Information Exchange (HIE)** - Health Information Exchange is the transmission of healthcare-related data among facilities, health information organizations and government agencies according to national standards.

**Health Information Technology (HIT)** - The secure sharing of medical information to assist health care providers in managing patient care. HIT includes the use of electronic medical records (EMRs) instead of paper medical records to maintain people’s health information.

**Health Insurance Exchange** - A way to pool risk, the Health Insurance Exchange is a competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges offer a choice of health plans that meet certain benefits and cost standards. The Exchange can set standards beyond those required by the federal government, accept bids, and negotiate contracts with insurers. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006. Under the ACA, states will have the option to either establish their own exchanges or participate in a national exchange starting in 2014.

**Health Insurance Exchange Navigators** - Health Insurance Exchanges will be required to contract with professional associations and local organizations to provide Exchange Navigator services. These services include providing education and information about qualified health plans that is culturally and linguistically appropriate; distributing fair and impartial information about enrollment; facilitating enrollment in health plans; and providing referrals for any enrollee with a grievance, complaint, or question regarding a health plan.

**Health Insurance Exchange Plans** - The Health Insurance Exchanges established under the ACA must offer four levels of coverage (bronze, silver, gold, platinum plans) based on the plan’s actuarial value.

**Health Insurance Portability & Accountability Act (HIPAA)** - Passed by Congress in 1996, HIPAA includes various health insurance coverage and patient privacy protections. The privacy rules were established to protect patients' privacy through the strict enforcement of confidentiality of medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

**Health insuring corporation (HIC)** - See Health maintenance organization.

**Health Maintenance Organization (HMO)** - Known as health insuring corporations (HICs) in Ohio, HMOs are health insurance plans that provide a coordinated array of preventive and treatment services for a fixed payment per month. HMOs provide services through a panel of health care providers. Enrollees receive medically necessary services regardless of whether the cost of those services exceeds the premium paid on the enrollees' behalf.

**Health Professional Shortage Area (HPSA)** - HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups or medical or other public facilities.

**Health promotion** - The process of enabling people to increase control over, and to improve their health.

**Health Reimbursement Account (HRA)** - A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute. HRAs are often paired with a high-deductible health plan, but do not have to be. Also know as a Health Reimbursement Arrangement.
**Health Resources and Services Administration (HRSA)** - An agency of the U.S. Department of Health and Human Services (HHS), HRSA is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

**Health Savings Account (HSA)** - An HSA is a tax exempt savings account for medical expenses. Funds can be withdrawn from an HSA to meet the deductible of the HDHP (see below) and pay for other medical services and supplies.

**Health value** - The combination of improved population health outcomes and sustainable health costs. Population health outcomes include: health behaviors, conditions and diseases, overall health and wellbeing and health equity. Health costs include: total costs and costs paid by employers, consumers, Medicare, Medicaid, and the public health and mental health systems.

**HEDIS measures** - Healthcare Effectiveness Data and Information Set (HEDIS) measures are used by health plans to measure performance on important dimensions of health care and service including effectiveness of care, access/availability of care, experience of care, and service/resource utilization.

**High Deductible Health Plan (HDHP)** - An HDHP is an inexpensive health insurance plan that generally does not pay for the first several thousand dollars of health care expenses (i.e., the “deductible”) but will generally cover medical care after the deductible is met. HDHPs may have first dollar coverage (no deductible) for preventive care and apply higher out-of-pocket limits (and co-pays and coinsurance) for non-network services.

**High-Risk Pool** - A subsidized health insurance pool organized by some states as an alternative for individuals who have been denied health insurance because of a medical condition, or whose premiums are rated significantly higher than the average due to health status or claims experience. Under federal health reform, Ohio has established a high-risk pool that is being administered by Medical Mutual of Ohio. (http://www.ohiohighriskpool.com/)

**Home and Community-Based Services (HCBS)** - Any care or services provided in a patient’s place of residence or in a non-institutional setting located in the immediate community.

**Hospice** - A facility or program designed to care for patients in the terminal phase of an illness.

**Hospital community benefit requirements** - Federal Internal Revenue Service requirements that nonprofit hospitals must meet to maintain their nonprofit status.

**Implementation guidance** - Resources such as training, coaching, technical assistance, manuals/guides, curricula, policy templates, or other documentation that help practitioners to implement a strategy as intended. Implementation guidance is typically created by the original developers of a program in order to facilitate replication.

**Indicated prevention** - Prevention interventions targeted to high-risk individuals with increased vulnerability or early signs of a problem, disease, or condition.

**Individual Mandate** - The requirement that all individuals must obtain health care insurance or pay a penalty. The individual mandate will be in place by 2014, although some exceptions do apply (financial hardship, religious reasons). The penalty, in the form of a tax, will be $95 per individual or up to 1% taxable income in 2014, whichever is lower. It increases to $325 or up to 2% taxable income in 2015 and $695 or up to 3% taxable income in 2016.

**Investment for health** - Resources which are explicitly dedicated to the production of health and improved health outcomes. They may be invested by public and private agencies as well as by people as individuals and groups. Investment for health strategies are based on knowledge about the determinants of health and seek to gain political commitment to health public policies.
**K**

**Katie Beckett Children** – Disabled children who qualify for home care coverage under a special provision of Medicaid, named after a girl who remained institutionalized solely to continue Medicaid coverage before the provision’s enactment. Also known as a “Deeming Waiver.”

**L**

**Legislation** – Action by a legislative body, including the “introduction, amendment, enactment, defeat or repeal of Acts, bills, resolutions, or similar items.” It includes actions by Congress, a state legislature, a similar local legislative body, or any actions by the general public in a referendum question, initiative petition, or proposed constitutional amendment. Note that judicial, executive, and administrative bodies, including special purpose bodies like school and zoning boards, are not legislative bodies.

**Lobbying**  – Lobbying is an attempt to influence specific legislation by communicating views to legislators or asking people to contact their legislators. See also direct lobbying and grassroots lobbying.

**Direct lobbying** – Occurs when an organization communicates with a legislator or legislative staff member (or any other government employee who may participate in the formulation of the legislation, but only if the principal purpose of the communication is to influence legislation) about a specific piece of legislation and reflects a view on that legislation. Direct lobbying also encompasses any communication with the general public expressing a view about a ballot initiative, referendum, bond measure, or similar procedure.

**Grassroots lobbying** – A communication with the general public that reflects a view on specific legislation and includes a call to action that encourages people to contact their legislative representatives or staff in order influence that legislation.

**Long-Term Care (LTC)** – A set of health care, personal care and social services provided to persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis.

**M**

**Managed Care** – Health care systems that integrate the financing and delivery of appropriate health care services to covered individuals. Managed care systems arrange with selected providers to furnish a comprehensive set of health care services.

**Media framing** – The process of selecting and organizing information in order to present relevant events and suggest what is at issue in a manner than makes sense to media producers and audiences.

**Medicaid** – A federally-aided, state-administered and jointly-funded health insurance program that provides medical benefits to qualified indigent or low-income persons in need of health and medical care. The program is subject to broad federal guidelines and states determine the benefits covered and methods of administration.

**Medical Home** – An approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need it in a culturally and linguistically appropriate manner.

**Medical Loss Ratio (MLR)** – The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits. The health reform law requires insurers in the large group market to have an MLR of 85% and insurers in the small group and individual markets to have an MLR of 80%.
Medicare – A federally funded health insurance plan that provides hospital, surgical and medical benefits to elderly persons over 65 and certain disabled persons. Medicare Part A provides basic hospital insurance, and Medicare Part B provides benefits for physicians’ professional services. Medicare Part C (Medicare Advantage Plan) allows those covered to combine their coverage under Parts A and B but is provided by private insurance companies. Medicare Part D helps pay for medications doctors prescribe for treatment.

Pay-for-Performance (P4P) – A health care payment system in which providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

Message framing – The way a story is told – its selective use of particular symbols, metaphors, and messengers, for example – and to the way these cues, in turn, trigger the shared and durable cultural models that people use to make sense of their world. Reframing changes the lens through which a person can think about an issue, so that different interpretations and outcomes become visible to them.

Mid-Biennium Budget Review (MBR) – A review of state agencies’ budgets and spending, conducted halfway through the two-year main operating budget cycle.

Pharmaceutical Assistance Program – A program to provide pharmaceutical coverage to those who cannot afford or have difficulty obtaining prescription drugs. Several states, including Ohio, operate state-funded pharmaceutical assistance programs which primarily provide benefits to low-income elderly or persons with disabilities who do not qualify for Medicaid. (http://www.rxforohio.org/)

Pharmacy Benefit Manager (PBM) – Companies that manage drug benefit coverage for employees and health plan members.

Policy – Laws, regulations, rules, protocols, mandates, resolutions and ordinances designed to guide or influence behavior. Public policy refers to legislative (laws, ballot measures), legal (court decisions), fiscal (government budgets), and regulatory actions (including administrative rules and executive orders). Organizational policy refers to internal standards and protocols established by public or private organizations, such as workplace or school wellness policies.

Policy agenda – A set of policies or issues to be addressed or pursued by an individual, group, or organization. Agenda setting refers to the process of placing issues on the policy agenda for public consideration and intervention.

Policy analysis – The use of reason and evidence to select the best policy among a number of alternatives to address a particular policy problem.
**Policymaker** - A person with power to influence or determine policies and practices at a national, state, regional, or local level. Public policymakers include elected and appointed officials and leaders of public agencies. State-level public policymakers include legislators, the governor, state agency leaders, and state boards. Local level public policymakers include mayors, county commissioners, city council members, public boards and commissions, and school superintendents.

**Policy, system and environmental change** (PSEC) - Policy, system and environmental change is a way to modify the environment to make healthy choices practical and available to all community members. See Ohio Wellness and Prevention Network’s “What is ‘Policy, System, and Environmental Change’?” fact sheet.

**Population-based prevention policies** - Policy change strategies designed to reach all residents of a geographic area or all people in a community setting (such as a school or workplace) in order to modify the environment to make healthy choices practical and available to all community members. See also, policy, systems and environmental change.

**Population health** - The health outcomes of a group of individuals, including the distribution of such outcomes within the group. The field of population health focuses on the determinants of health (including medical care, public health interventions, social environment, physical environment, genetics, and individual behavior) and the policies and programs that influence those determinants and reduce health disparities among population groups.

**Preferred Drug List (PDL)** - A list of prescription drugs which are covered by a health plan or other payer (e.g., Medicaid). Also known as a formulary.

**Preferred Provider Organization (PPO)** - A health insurance plan in which health care providers agree to provide services to members at a negotiated price. Covered individuals (members) receive all medically necessary services regardless of whether the cost of the services exceeds the premium paid, although members do have cost sharing obligations.

**Prevention** - A systematic process that promotes healthy behaviors and reduces the likelihood or frequency of an incident, condition, or illness. Ideally, prevention addresses health problems before they occur, rather than after people have shown signs of disease or injury. For more details, see Ohio Wellness and Prevention Network’s Prevention Policy and Advocacy Glossary.

**Prevention organization** - Any organization that is working to promote health and prevent illness and disability. This includes government public health agencies, community-based organizations, trade associations, coalitions, health care providers, employers, philanthropies, grass-roots groups and others who are working in the areas of prevention, wellness, population health or health promotion.

**Primary Care Provider (PCP)** - In insurance terms, a physician selected by or assigned to a patient who provides general care and supervises the patient’s access to other medical services.

**Primary prevention** - Efforts to prevent a disease, injury, or other health problem from occurring in the first place.

**Primordial prevention** - An approach to prevention that targets underlying health determinants via modifying social policies so as to improve health in general.

**Prior Authorization** - Under a system of utilization review, a requirement imposed by a health plan or third party administrator that a provider justify the need for delivering a particular service in order to receive reimbursement. Prior authorization may apply to all services or only to those that are potentially expensive and/or overused.

**Public health** - The science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society. Public health organizations include government agencies at the federal, state, and local levels, as well as nongovernmental organizations that are working to promote health and prevent disease and injury within entire communities or population groups.
Public policy - Public policy is a series of governmental decisions and actions that are intended to address a perceived public problem. They can be expressed as local, state or federal governmental action, such as legislation, appropriations, administrative practices and court decisions.

Quasi-experimental designs - Experiments based on sound theory, and typically have comparison groups (but no random assignment of participants to condition), and/or multiple measurement points (e.g., pre-post measures, longitudinal design).

Quaternary prevention - The avoidance of unnecessary or excessive medical interventions. For the purposes of this publication, quaternary prevention is included within the category of treatment.

Randomized control trial - A trial in which participants are assigned to control or experimental (receive strategy) groups at random, meaning that all members of the sample must have an equal chance of being selected for either the control or experimental groups (i.e., flipping a coin, where “heads” means participants are assigned to the control group and “tails” means they are assigned to the experimental group). This way, it can be assumed that the two groups are equivalent and there are no systematic differences between them, which increases the likelihood that any differences in outcomes are due to the program, practice or policy, and not some other variable(s) upon which the groups differ.

Regulation - A rule or order that has the force of law that originates from the executive branch (usually from an agency), and deals with the specifics of a program.

Rigorous - Extremely thorough adherence to strict rules or discipline to ensure as accurate results as possible.

Rule - Statements adopted by an agency to make the law it administers more specific to govern the agency’s organization or procedure. Administrative rules are not enacted by the legislature; instead the legislature gives agencies the authority to establish its own rules. These administrative rules have the force and effect of law.

Rural Health Clinic - A public or private hospital, clinic, or physician practice designated by the federal government as in compliance with the Rural Health Clinics Act (Public Law 95-210). The practice must be located in a medically under-served area or a Health Professional Shortage Area (HPSA) and use physician assistants and/or nurse practitioners to deliver services.

Rural Health Network - Refers to any variety of organizational arrangements to link rural health care providers in a common purpose.

Safety Net - The safety net is made up of providers and institutions that provide low cost or free medical care to medically needy, low income or uninsured populations.

Secondary prevention - Efforts to detect health problems at an early stage and/or to slow or halt the progress of an existing disease, injury, or other problem.

Selective prevention - Prevention activities targeted to specific populations with above-average risk for a problem.

Self-insured plan - A group health plan in which the employer assumes the financial risk for providing health care benefits to its employees. Also called a ‘self-funded’ plan.

Social determinants of health - Conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks. In addition to the social, economic and physical conditions of a person’s environment, social determinants also include patterns of social engagement and sense of security and well-being. Examples of resources that can influence (or, “determine”) health outcomes include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services and environments free of life-threatening toxins.
**Spectrum of prevention** - A framework for developing effective and sustainable primary prevention programs. The spectrum consists of six levels of prevention activities that are most effective when implemented together as part of a comprehensive prevention strategy: 1) Strengthening individual knowledge and skills, 2) Promoting community education, 3) Educating providers, 4) Fostering coalitions and networks, 5) Changing organizational practices, 6) Influencing policy and legislation. Sub-population - A group of individuals that is a smaller part of a population. Sub-populations can be defined by age, race, ethnicity, disabilities, gender, socioeconomic status or other shared characteristics.

**Supplemental Security Income (SSI)** - A federally funded cash assistance program for low-income elderly, blind and disabled individuals who have little or no income with basic needs, such as food, clothing and shelter. Once eligible for SSI, these individuals are also eligible for Medicaid.

**Systematic reviews** - A literature review that attempts to identify, appraise and synthesize all the empirical evidence that meets pre-specified eligibility criteria. Systematic reviews of randomized controlled trials are considered to the “gold standard” of evidence.

**Systems change** - Systems change involves change made to rules and practices within an organization, institution or system (such as school, transportation, park, food distribution or health care systems).

**Tertiary prevention** - Prevention activities targeted to the person who already has symptoms and seeks to reduce further complications, increasing pain, or death.

**Trauma System** - A trauma system is an organized, coordinated effort in a defined geographic area that delivers the full range of emergency care to all injured patients and is integrated with the local public health system.

**Treatment** - What a health care provider does to relieve, reduce, or eliminate harm once it has become manifest in an ailment.

**Triple Aim** - A term used to describe an approach for enhancing health system performance. The goals of the Triple Aim, as conceptualized by the Institute for Healthcare Improvement are: improve the patient experience of care, improve health of populations, and reduce the per capita cost of health care.

**Uncompensated Care** - Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers.

**Underinsured** - People with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

**Uninsured** - People who lack public or private health insurance.

**Universal prevention** - Prevention activities that are directed at an entire population and are likely to provide some benefit to all.

**Upstream prevention** - Health improvement approaches that address the causes of health problems rather than just the symptoms. Upstream strategies often involve non-clinical/community-based programs and policies that address the social determinants of health.

**Utilization** - Commonly examined in terms of patterns or rates of use of a single service or type of service (e.g., hospital care, physician visits, and prescription drugs). Use is also expressed in rate per unit of population at risk for a given period of time.

**Utilization Review** - The critical examination, usually conducted by an insurer or third party administrator, of the necessity and/or appropriateness of the health care services provided to an individual patient.
Value-Based Purchasing - A payment reform under which hospitals and other providers are provided bonuses based upon their performance against quality measures. The health reform law establishes a value-based purchasing program in Medicare for hospitals and requires the development of similar programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers, and the testing of pilot programs for other providers.

Wellness - Wellness is the optimal state of health of individuals and groups. There are two focal concerns: the realization of the full potential of the individual physically, psychologically, socially, spiritually and economically, and the fulfillment of one’s role expectations in the family, community, place of worship, workplace and other settings.

Acronym Appendix

| ABD: Aged, Blind or Disabled | GRF: General Revenue Fund |
| ACA: Affordable Care Act (federal health reform law) | HCBS: Home and Community Based Services |
| ACO: Accountable Care Organization | HDHP: High-Deductible Health Plan |
| CDHP: Consumer-Driven Health Plans | HIE: Health Information Exchange |
| CHIP: Children’s Health Insurance Program | HIPAA: Health Insurance Portability & Accountability Act |
| CMS: Centers for Medicare and Medicaid Services | HIT: Health Information Technology |
| COBRA: Consolidated Omnibus Budget Reconciliation Act | HMO: Health Maintenance Organization |
| CON: Certificate of Need | HPI: Health Policy Institute of Ohio |
| DME: Durable Medical Equipment | HPSA: Health Professional Shortage Area |
| DRG: Diagnosis Related Groups | HSA: Health Savings Account |
| DSH: Disproportionate Share Hospitals | HRA: Health Reimbursement Account/Arrangement |
| EHB: Essential Health Benefits | LEP: Limited English Proficiency |
| EMR: Electronic Medical Records | LTC: Long-Term Care |
| FFS: Fee for Service | MCH: Maternal and Child Health |
| FMAP: Federal Medical Assistance Percentage | MLR: Medical Loss Ratio |
| FOHC: Federally Qualified Health Center | MUA: Medically Underserved Area |
| FPD: Federal Poverty Level | OADAS: Ohio Department of Drug and Alcohol Addiction Services |
| FPL: Federal Poverty Line | OADAS: Ohio Department of Health |
| HIP: Health Information Technology | ODI: Ohio Department of Insurance |
| HPIO: Health Policy Institute of Ohio | ODI: Ohio Department of Job and Family Services |
| HPSA: Health Professional Shortage Area | ODJFS: Ohio Department of Job and Family Services |
| HSA: Health Savings Account | ODM: Ohio Department of Mental Health |
| HRA: Health Reimbursement Account/Arrangement | ODM: Ohio Department of Mental Health |
| LEP: Limited English Proficiency | ODM: Ohio Department of Mental Health |
| MCH: Maternal and Child Health | ODM: Ohio Department of Mental Health |
| MLR: Medical Loss Ratio | ODM: Ohio Department of Mental Health |
| MUA: Medically Underserved Area | ODM: Ohio Department of Mental Health |
| OADAS: Ohio Department of Drug and Alcohol Addiction Services | ODM: Ohio Department of Mental Health |

Acknowledgments

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